
**Talking Pop Health**
Episode 11: Rick Goddard of Lumeris
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Eric Tower: Welcome to another episode of Talking Pop Health. Today I've got with me Rick Goddard from Lumeris. We're going to be discussing the effects of COVID on health care systems and the trends in population health for 2022. Before we really jump in here, Rick, can you give a little bit about your background, how you got here and what it is Lumeris does.

Rick Goddard: Yeah, Eric. Thanks for having me today. I'm excited to talk to you. I know we've been buddies for a long time, but honestly I've been excited to learn a little about what we can do collectively together in this really exciting time. Joining you to today I've come from a background of being a health system operator and executive by background. I worked in several of the academic medical centers here in Chicago as I sit today in a very empty building. I'd say by training, a consultant. So, spent several years at a small company, about 100 people, but called the Camden Group at the time, which was bought by GE Healthcare in 2015. But, prior to that, it was a company that was built for examining value-based care models coming out after the Affordable Care Act. And, it was in an awesome time to be involved in that say, bull rush in the value-based care models that are being deployed right out of the Obama administration's in the development of the Centers for Medicare and Medicaid Innovation. So, really got my exposure and teeth cut in that type of work, managing anywhere from a value-based care funnel payment assessment and delivery to an accountable care organization deployment. And then lastly, running anywhere from financial valuations and fair market value assessments to strategic plans on the fee for service side. So fully knowing that that timing in the early 2010s was a value-based care kick-off, kind of the reboot from the 90s, it was really a time where there still was a very heavy fee-for-service [driven] market. I'd like to think of the 2000s as the fee-for-service wild west, and thinking through how they were trying to curb that spend in 2010. It was an exciting time to be [within] that mix, curbing that very, very exponential growth in fee-for-service costs and expenditures. And so, I took that and leveraged that opportunity at Camden to get back to a market that having essentially a market span of one of the largest ACOs in the U.S. in Advocate Health Care. I joined Advocate Physician Partners, in 2015. And, part of the time where Dr. Lee Sacks, who we both know, was

leading a fantastic effort in driving and penetrating that value-based care percent of [revenue], their payor mix in a market that was still full of very expensive health systems and academic medical centers in effort to drive down the total cost of the care, in a heavily dense PPO market. So, had an opportunity to work with Dr. Sacks, Mike Engelhart, Dana Gilbert, Don Calcagno and others to really drive the management of that cost of care for well over a million value-based care lives. So, my responsibility of that was driven around overseeing the Medicare shared savings program [ACO], 150,000 live [ACO] and their commercial ACO populations in their partnership with Blue Cross Blue Shield of Illinois. And, it was a really exciting time to be a part of that success. It had achieved substantial savings during that time, which was a really good opportunity for the health systems to buy into the value-base care model given it achieved significant savings which really boosted the morale around – [and more ambitiously questioned] should we invest in this and should we continue to grow with it? I think Lee Sacks was a visionary to drive that a long time ago, and I know he was a member of your podcast, Eric. He's the type of person that thought ahead, [as] that visionary, that we could achieve this kind of success. And the organization benefitted it over the long term. So, getting that on-the-ground experience at Advocate was tremendous, where I decided to take that next and parlay it into how do we get the value-based care model and managing risk more scaled, faster/quicker – that was my turn to take on this position at Lumeris. Lumeris is a value-based care operating company, and we've helped several providers in the – payors and health systems [space], but our focus is health systems, to help grow that transition of fee-for-service based percent of revenue to a value-based care managed risk portfolio, to help them tip the scales into becoming more owners of the premium dollar instead of being price takers in the long term. So, my role at Lumeris has been a mix of marketing, corporate strategy, and product to help drive forward that penetration of risk-based contracts and management of the premium dollar within health systems. So, it's been an exciting time. I've been here 4 years. There's a lot that has been done with this company in the last several years. But I'm excited to talk to you about that and other topics today, Eric.

Eric Tower: So let's briefly touch on sort of the progression. We start off – we've got the Affordable Care Act, we've got ACOs, and we've got next gen ACOs, we've got bundled payments, and now there's this thing called a DCE. How is this affecting the health systems and we should probably cover what a DCE is?

Rick Goddard: Yeah.

Eric Tower: But how is this affecting health systems, both financially and strategically at this point? Given the progression and the facts – I'm going to steal your thunder a little bit here. There's more on the table for the systems both

upside and downside now than there used to be. So can we just touch on that briefly?

Rick Goddard: Yeah. Briefly, it's a fun word …

Eric Tower: Well…

Rick Goddard: Yeah. Well, when you think about what health systems have invested today in these programs-- the Health Management Academy did a great study about a year or two ago on what the percent of revenue [care delivery] health systems had dedicated to operating budget to support value of these programs. And, it's relatively a light amount of their budget given the amount of revenue that folks could be potentially putting at risk. Now, I also say the percent of revenue dedicated to value-based programs is fairly light. So, if you say, like let's just say, a health system that is today penetrated on an at-risk value-based contract. The majority of the health systems in the U.S. are still below – well below 10% dedicated to risk-based programs. And, despite, you know, we have significant lives invested through these Medicare Shared Savings Programs, Next Gen ACOs, there's still a significant portion of their Medicare payor mix is not necessarily covered under that. You know, folks could be still coming in from non-MSSP-[driven] places that typically the leakage in a Medicare program is 50 to 70%. Unless you have a really concentrated market… So if you think about how we drive interest in these programs and growing them, it's going to take, what we call "mindshare
" at Lumeris – significantly more mind share dedicated to a value base care set of contracts as a percent of their total revenue. So, I don't think the scales have tipped yet , Eric, and so when we talk about getting into [the Medicare] Shared Savings Program, Next Gen, Direct Contracting Entities, that is usually a health system's first entrance into value based care programming because, again, it's one of the greater percentage of payor mix, there's more volume to manage to the premium amount, puts the juice for it to squeeze, to participate in these models and so a lot of folks have started their journey in MSSP, or Next Gen or Pioneer [ACOs]. And if they haven't started any of those – jumping to direct contracting, that might be a bit of an interesting strategy, but people are doing it because they see the writing on the wall and they see the opportunity that lies ahead.

So, to talk a little bit about these programs briefly. So MSSP introduced in 2012, it was a program that had three tracks. Track one was the most popular, upside only. And that many organizations wanted to stay on that past the original three year contract to another three-year contract that was basically looking to maintain that upside only and folks would balance – their percent of revenue in fee-for-service, and balance the volume that would come associated with their at-risk population. It was a bit of a hedging play. Fast forward it to risk trajectory of taking downside was

accelerated, say around 2016 the introduction of the Next Gen ACO program, folks that were solid, that were willing to take two-sided downside risk were interested in going to that model from Pioneer or they were – they just realized Track 2 and 3 of the MSSP was a bad deal, which it was. They moved into Next Gen, and that was a progressive time because organizations knew that they had more levers through the Next Gen program than they did at the time with MSSP for downside risk management and they went full bore in. And those that were in, had success. They achieved their own overall savings increase, but Medicare didn't win. Medicare lost. They lost the cost battle. They didn't achieve saving - net actuarial savings -on that program. And so, fast forward to the Trump Administration's Rollout of the Pathway to Success Program under Seema Verma, which was a great redesign of the program because it accelerated folks' path to downside risk. No more hedging and staying in those upside-only models, looking to actually having folks get more carrots. When I say carrot incentives to go to downside risk namely applying more benefit structures to encourage management of that and then also for beneficiaries – more reasons to engage a primary care provider in Medicare to not make it feel like you're under this managed care program where I'm restricted to access my doctor. Because that strictly is not the case.

And so with these programs that CMS and the carrots that they offer – they offered the most progressive one yet in the direct contracting program. Now this has been a highly controversial program since the change in administration. I don't think consumer groups or several people within the industry fully understand the power that this program offers. It was very well articulated and well strategically put together to balance the strengths of Medicare Advantage and with the open access strengths of Medicare fee-for-service, or traditional Medicare as they call it, and was able to take many of those benefit designs and lesson learned to where, okay, folks can still go see whoever they want, but this program actually offers incentives to encourage beneficiaries to stay within a family of providers, which is typically the biggest driver in management of managing inappropriate medical cost, is benefit design. And, folks can go out-of-network and their doctor has the incentive to churn and add more volume to the system and send them to a low quality SNF.

We talk about lessons learned after a decade of this – this is a graduation of all those lessons learned. CMS listens and they tried to put together a program that balances beneficiary interests at the top with trying to manage the Medicare Trust Fund's depletion which is going to come as soon as – I haven't seen the Actuary of Office Management Budget released recently, but the most one, that recent one that came out, Eric, was 2026, and we're ending 2021 and this is – we're still having fights over where to put money for earning savings for Medicare. That's – this is a dangerous time for all taxpayers, as we see this change and we're still

fighting with political issues to essentially manage a bipartisan program in Medicare and Medicare Advantage to help beneficiaries and help the Medicare Trust Fund be sustainable. So I consider DC as being the most progressive – and no doubt it's not perfect, but it has built and taken on all of the progression that we've taken the last ten years of value-based care and built it into a Medicare program that can, not only influence Medicare, but how networks operate in a given market and how it will affect commercial insurance going forward. So, I don't think, you know, if we talk about much of Medicare today – I only talk about it because it's the most influencing insurance payor on the market. And how it will interact with other major payors in isolated markets, it will have an impact if that's one takeaway today.

Eric Tower: So, if I'm the CEO of St. Elsewhere, and I've got this national health system, you know, I've been doing okay, not great, COVID came, maybe that disrupted some volumes, and I look around at the market and I'm in a market with low Medicare Advantage penetration today, why don't I just want to stay fee-for-service? I mean why would I even want to consider becoming a direct contracting entity? You know, I mean it just seems like that's going to be quite a journey. You know, what are your thoughts on that?

Rick Goddard: Yeah. So, there is that, that balancing of tiptoeing to value based care and losing your shirt and then losing the interest all of the folks around you in driving towards that goal. There are ways to do that tiptoeing that is effective, rather than just stalling. And so, there you know, we talking about folks that really work to leverage the hedge of upside only for, you know, a decade and that's not an effective strategy.

Because CMS has, you know, [identified] that slow progression came with a lot of lessons learned.

> *[CMS asks]: How do we got folks into downside faster? Integrate quality measures into influencing improvement of beneficiary outcomes?*

And, it's not just a sustainable strategy for St. Elsewhere anymore. And, I'll tell you why: Because the – well from those lessons [CMS] learned they have influenced some, several pieces of legislation to drive people to downside faster than ever before. Folks might remember the MACRA legislation of 2016. That was – looked at by different stakeholders as a burden or a driver that was more progressive than it could have been for its time. I look at it as the right catalyst to get folks moving in the right direction of managing quality. So that was one that created a lot of burden for folks no doubt. And I agree that– it had some complexities and they really worked to influence [improve] it. So MACRA's legislation led to this development of the Quality Payment Program, which involved the Merit

Based Incentive Program and the [Advanced] Alternative Payment Model, so, therefore discussed as MIPS and AAPMs and so that influence was designed to put folks in MIPS on a bell curve to insure that we're moving collectively, the U.S. Healthcare system, in a direction of better quality care by establishing a set of measures for performance on an annual basis, that providers, namely physicians, would report quality and ensure that they're managing it appropriately.

Now, those that got on the trajectory of these ACOs that we talked about, Eric, they got the trajectory of being in a risk bearing organization, two-sided risk, they could participate in these advanced alternative payment models and have the opportunity of earning a 5% Part B bonus.

Why I'm giving you these technical specifics is that nuance of behavioral interest [incentives] in driving towards a program that is national – St. Elsewhere can't sit around and say, I'm going to let my revenue drivers and physicians fall by the wayside. We need to create programs that essentially help the burden of reporting this type of stuff, integrating them into a profile that we know CMS is pushing us to be accountable. Okay, we need to take on some level of accountability with them, because they might not be capitalized to drive that behavioral and economic design that can be sustainable against the national bell curve. So, one you need to help the physicians. Two, the pressure of shifting inpatient to outpatient has substantially accelerated over the last ten years. I mean, if you've been to Association meetings the last ten years you might have heard that 100 million times. How many times, Eric?

Eric Tower: Laugh.

Rick Goddard: Yeah. So the shift changed, right? So, you know, that has long been, you know, what we talked about site-based neutrality and all that kind of stuff that, you know, toying with the fee-for-service strategy of getting people to be paid on an outpatient basis. It's not necessarily – we can talk about fee-for-service service line strategies all day, service line strategy – I'm good with it. That still exists today and it's still important to a minor degree. But, when we start thinking about St. Elsewhere, even in a monopoly market [where] we're the only game in town, that pressure of insurance company and Medicare influence on how they get paid today in addition to that shift of inpatient to outpatient is unsustainable. And, if they haven't seen it now, I know I don't have the stats in front of me, but hospital closures even in those singular markets continue. And that community suffers. And the folks that are trying to create value in that community by driving in to social determinants for that community, it's suffering because of strategic change to drive, and to at least attempt to balance what's going on in national U.S. healthcare - It's a shame. So, at Lumeris, we encourage folks to at least attempt to go in that direction and,

with our supporting tools we look to drive them in that direction strategically in operation.

Eric Tower: So as head of St. Elsewhere, you know, I appreciate the vision, where does Lumeris start? How do you kick this thing off without getting everyone extremely upset that you're basically destroying their entire vision for how healthcare works?

Rick Goddard: Well, you start with trying to understand where your – everybody has a strategic plan of 5 to 10 years, but what does your community need in the long term? Is it going to be influenced by new physicians coming to town or say new physician private equity back aggregators coming to town to create influence and potentially lower that cost of care? You need to fully understand your environment first. What are the major trends that are influencing provider influence? What are the beneficiary and member consumer behaviors? And where are they finding interest in? Do they like getting that access like they like getting everything else accessed? Do they enjoy physician-to-physician traditional relationships? Do they – do the hospital system fully have a community board that's supportive of moving to a system where it's not necessarily driven on volume? And so, you have to look at these community systems as they're not-for-profits, they serve the community, they want to serve the community long term, but at the stage that they're at, they might not necessarily have the tool kits to flip their business model overnight.

So, with what we try to do early on is understand where are their payers of influence that would look to partner with them to transition their model. Naturally it is of the payer's best interest to manage their MCR, but at the same time they realize that provider can't serve members in that community if they don't a sustainable partner in a health system to survive. So, as partners of the health system, Lumeris tries to understand what is a collaborate payer and what can they do to support that transition of net moving to value. In addition, we'd like to understand what is the local provider's current work force and can they sustain potentially rebadging employees with similar skill sets to do managed care-like services.

And so, today they might be a floor nurse that is just real excited about managing patients and helping people get better and moving them to home, to discharge, but capacity constraints in the future, well there might not be as much capacity in a value base care model. That strategy of building the bed towers might not work out for that hospital CFO and so what can you do so folks don't feel threatened that "my job – I'm just going to get eliminated" – No, you try to look for ways to get them educated in the new ways of moving them to a risk-based model. That inpatient nurse could certainly become – work towards an outpatient care manager, which that type of role is incredibly attractive to this new age of healthcare. It

may not necessarily have to be a care manager, which traditional care management is built on managing the top 5% sickest. What we are really looking for in outpatient care management or if we can even change the word to- “nurses that are helping people out in the community”, these folks are to keep people healthy. And we focus on not just the top 5%, but the healthy and the moving to rising risk as a percent of the pyramid; because if folks in your community are exposed to things that are going to – environmental things that are going to drive them to grow in their chronic illnesses faster than the rest of the U.S., we need to focus those inpatient nurses who are now outpatient care managers attention on how to address those chronic care issues. And, if you look around, that investment and digital health and where private equity is investing their capital today, they’re investing in preventative. They’re investing in, how do we change the venues of care? How do we change how we communicate with the provider? How do we make things more consumer-centric. So where we try to apply many of the trends and investments is to how do we fuel the health system to redesign their thinking on how to offer access points to their community at an appropriate cost that doesn’t break the bank for their hospital CFO. So, it’s a slower transition, Eric, than I think we all want it to be, but we think that these health systems are the centers of the community and they should not be disrupted. But bear in mind, Eric, they can be and we do not want them to. And I think that’s a very important thing that we want our partners to be thinking about constantly.

Eric Tower: So you put more weight, you know the old thought of how healthcare is about cost, quality and access. Do you put a lot of weight on the access piece?

Rick Goddard: Big time.

Eric Tower: Big time. Okay. I heard you discuss a number of different factors in healthcare. One that I would like to touch on a little bit is the medical staff itself. Obviously a lot of times those doctors start with an independent. That’s changing. How do you approach them in this process?

Rick Goddard: Well, they’re our partners. They – just like I need somebody on the medical staff and employees of the hospital, everybody has to participate in this change to moving their percentage of revenue to a risk-based model. And incentives for them, the medical staff aren’t necessarily changed and ready to move to that direction. They might be still incentivized on length of stay reduction strictly on the basis that they’re let’s say a hospitalist or, you know, the local ED physician is looking to reduce wait times. So, having a relationship to try to figure out does this patient in the ED really need to be admitted.

In a matter of, in what we're doing in COVID, our providers have been tremendous in helping the US healthcare system and they're not the problem. It is a matter of many of the incentives that they're given in the system today that is driving behaviors that basically continue to proliferate bad outcomes. And I think about, maybe not necessarily poor outcomes on patient quality but outcomes on the basis of they didn't get the most attention that they probably could have had at that point and setting of care because volume-based turn encourages faster [throughput]. There's not enough time to focus on does that person really need to be admitted versus an observation. Does that person really need to be here for a couple days versus being, you know, it could be at a more appropriate post-acute setting of care.

So I think where we're at with right setting of care, these medical staffs are starting to recognize: "I can do all the great things I want to do if I'm given the right incentives to do so." Now, they're [providers] not necessarily only fueled by financial incentives, they're fueled by quality of care. How do they come out with the right diagnosis with the right case review and the right outcome in the long term. They're very focused on the patients. It's just when you're churning and you're doing all that burn – and you're burnt out and you're doing all this work, you might get into that muscle memory zone of [subconsciously] "I'm just following what my protocols tell me to do and what I'm driving towards."

So we need our partners and medical staff and physician leadership to be a huge part of the redesign. They're the peer-to-peer communicators, they are the subject matter experts, they're the folks that know, everything there is to know about driving outcomes, but with the partnership of an aligned set of incentives, aligned set of protocols that are influenced from the top down, the CEO, the CFO, the CMO, has to push this along as this is something we're investing in and we're going to drive forward and the medical staff is bought in around that, that's when you have the powerful change to make that investment and drive forward.

Eric Tower: So you said something rather interesting that I want to just tease out a little further. Implicitly in what you were saying, you were discussing specialty-specific incentives.

Rick Goddard: Hm mm.

Eric Tower: Now if I go back in my time capsule a number of years ago, it was more, people were scored based upon the totality of the medical staff. There was not as much emphasis and there was a sense that it would be unfair to kind of single out various specialties and have different metrics and it sounds to me like that has definitely changed and at least at Lumeris, you're approaching things much more customized to the physician you're

dealing with. Is that the case and how is that working, how's that being received?

Rick Goddard: Absolutely, so I, I would say Lumeris has a tremendous background in primary care. We're built off of a primary care model and a group of physicians that were frustrated with the status quo. For those who are familiar with Lumeris, our sister company in Essence Healthcare was born out of a group of physicians in St. Louis that were frustrated with their local payer and needed to find a new way to coordinate primary care services in an effective way. So what they came out with Essence being a tremendously successful Medicare Advantage company, it also scaled to accompany that as a healthcare operator in Lumeris. So our DNA is built on primary care and its influence in managing and appropriately coordinating population health.

As we start to drive what you just described as multiple-physician-based incentives, it's not necessarily a, you can't isolate there being a primary care only strategy, you can't. There's too many players in healthcare, albeit the primary care physician is the quarterback, he specialist has to be involved in the engagement and has to be given appropriate coordination opportunity as being another member of the care team. And so we do apply both primary care, specialists, and hospital and post-acute based programs that essentially looks to engage the full care continuum

The primary care, the way a primary care physician is quality and cost motivated is different from a specialist. That's why, for example, CMS very particularly went after two sides of the coin with a bundles-based program and an ACO-based program. Specialists were driven to bundles and managing the episodes that they had control over and likewise primary care providers look to tackle them to be the quarterback of managing the total cost of care and the downstream systems. Now, they can function together. We work together quite a bit with specialists to do bundles in combination with ACO's because it is a two-prong strategy to bring down the total cost of care and coordinate them throughout the network. But it's not necessarily built on the same motivations or "how do I get through my day effectively" [physician perspective].

So I mentioned hospital-based providers – that's another way you could be thinking about it. How do you coordinate them once the patients get to the hospital? How do you manage them through their acute episode in the most appropriate way?

Another one in the post-acute setting, you know. There's post-acute SNFs, for example. They're incentivized to maximize days on the basis of how they're paid. So what are the medically appropriate days that they should be at and how can a post-acute network influence the right quality

of care to be discharged at the right level and then not be readmitted into a churn of being at the same SNF over and over and over again.

So there's a fundamental problem in the care coordination industry, Eric, and that influence and how folks get paid is not the end all be all but it is the catalyst.

Eric Tower: Right now, I'm sitting at St. Elsewhere, we're ending 2021, COVID is still rattling ground. Maybe my system isn't doing as well as it could because I couldn't do elective procedures, COVID really hurt revenues, you know. A lot of systems now, at least that I've been talking to, are feeling some financial strain. What does 2022 hold for me without either one of us predicting where COVID is going necessarily.

Rick Goddard: Yeah. We talk about the major influences of catalysts. Virtual health is one I mentioned but also a catalyst to move value in the right direction. Two – is value-based models [as it] encourages management of populations. And cash flow issues have been a tremendous issue of provider groups, independent groups are closing left and right or they're finding suitors in their local markets that are cash rich. So when in this vulnerable position, health systems could be actually looking at it as an opportunity to manage PMPM or capitated risk that sustains cashflows. And, by the way, if you look at the success of insurance companies during this time of lower utilization and elective cases not being proliferating, there's an opportunity to essentially be a part of that premium share rather than just having to be reactive and be the public health support. So I'm not necessarily saying that this is a time to be taking advantage of the opportunity that insurance companies are taking, but it is an opportunity to not be just price takers and be able to participate in the cash flow and be able to, be actively engaged in managing the full continuum of care that these patients are now could be post-COVID full of chronic conditions or pulmonary conditions that are going to need to be managed and health systems, as the center of the community, Eric, and the providers that are participating in partnership with that, have to be fully coordinated post-pandemic, have to be. And if they have the right incentives and financial alignment, all the better.

If we're back to: "let's just be participants in the volume-based churn on deferred cases" and everything like that-- it's a short-sighted strategy. It's a strategy but it's short-sighted because what's going to happen at the next pandemic or what's going to happen if our community is completely changed because disrupters have come in. They've changed the referral pattern. They're continually looking to draw down the acuity site level, moving folks to home-based hospital at home. Have we heard of it? Major new program, has existed for some time in concept, but companies are heavily focused on how do we manage patients at the site of care closer

to home that's more comfortable, more consumer-friendly, not necessarily in areas that can get folks sicker and hospital-based acquired infections.

So the paradigm has changed coming out of COVID, both strategically, financially, and operationally. And so this isn't an opportunity to just, let's just go back to where our previous cost sharing strategy was on trying to make money on commercial margins supplemented by Medicaid and Medicare losses. It's not a sustainable chief strategy officer approach. Our partners that we've worked with in this space, Eric, have been incredibly progressive. They've been willing to take that – been major public health supporters to their communities, which COVID requires them to, while being able to be financially sustainable. And I'm incredible proud of our partners being a part of that and, yeah, those are our healthcare heroes regardless if you're participating in this situation.

But I would just caution folks: take a look at what's happened around you the last two years. The physicians are changing their position. The market and consumer has changed their view of healthcare. The cost and growing cost of employer-based insurance is making employers very sensitive and focused on how do we get our employees to be appropriately getting the care that they deserve at the price point that they want. Transparency on pricing is changing. It's going to be a different environment. Strategy needs to change.

Eric Tower: Well, I have to give it to you. You're one of the few people who works a lot with health systems who views payers as potential partners. You know, customarily, that's a pretty adversary relationship.

Rick Goddard: Hm mm.

Eric Tower: So I want to turn to another one, especially if I'm an avid reader of Modern Healthcare. I'm going to view private equity as pretty much being the enemy. Where do you see private equity playing with these health systems. I think we can't ignore it anymore. There are a number of new actors. If I'm a health system, you know, do I view them as potential partners, are they an adversary, do I have to change my strategy to prevent them from coming in? What do I do with them?

Rick Goddard: That's a great question, Eric. And so without speaking names of specific companies, I can talk about this as follows: So there is a host of private equity-backed companies that have entered this space in addition to some venture capital that are focused on entering markets and working in partnership with health systems and local providers at first but their intent is to lower the total cost of care which is a good thing for the patient and for everyone else, but the health system is the one that will suffer the most given they have very expensive hospital and, sometimes, post-acute assets on their balance sheet. That necessarily isn't a problem if you're

not a health system that's carrying all those very expensive assets. The community's always going to need that support from an acute perspective and they're always going to need post-acute settings.

Now, will the venues change and does the capacity require as much as it is today? Probably not. And so some of these companies are making the bet that if they can align physicians and appropriate incentives and coordinate care because they're the most trusted partner of the patient and the community – the physician. They have the NPS [Net Promoter Scores] scores that are well and above insurance companies and the health system. They trust that relationship to guide them to the right setting of care. So if you're a health system that is looking at these private equity companies as full-time partners, there are some that are. It's okay. There are some that are fully built around trying to reduce the total cost and box out the health system. I wouldn't say it's adversarial and sometimes I'm saying it on the basis of I'm going to enter and I'm going to cut your referral and you're going to be the price sticker to me now. Well, it's not far off. There is, a point where health systems have to pay attention how their physician CIN is being managed today and if they don't have a CIN, that's something they need to be focused on, already, that's kind of a term of the past --

Eric Tower: Let's define CIN for the audience here.

Rick Goddard: Sure. It's a clinically integrated network. So there's many different governing structures to do that. You and I are both familiar with Advocate's, physician hospital organization, that's a model of governance that essentially aligns both the physicians and hospitals in a structure to essentially take contracting in managed care like services and care management services to apply to their local communities. There's other governance organizations like, I just mentioned the clinically integrated network organization which allows you to coordinate care in a network and be able to be a Federal Trade Commission-approved entity to negotiate on the behalf of providers in some cases and that creates some strength and managing quality and the network can actually take a more collective approach to applying value-based care incentives in the community.

Now, the way people are using those today is mostly based on fee-for-service strategy containment. How can I keep my relationships in their prime position to continue to create a path of referral to my health system. Now, that necessarily isn't the finest strategy when you are trying to manage the total cost of care in a very expensive, risky contract. So at a different approach when you're creating those CINs in what we call a population health services organization, which is another governance organization, that essentially rebrands the CIN and PHO into an incentives-based company with all of the soup-to-nuts of services to help provide that seamless experience for the physician so they're not

managing one quality measure here, one quality measure there on a given contract, given multiple contracts.

So I go back to, you're preparing your clinically integrated network to combat the entry of a PE physician-based aggregator. Okay, so what is the value proposition you keep asking yourselves to your physicians? Are you simply providing them the ability to get a great malpractice premium rate? Are you around to lower the burden of MIPS reporting as I mentioned earlier in the podcast? Are you improving they're quality of life? Are you motivating the churn versus trying to get them to bring the joy back to medicine of, you know, "I could spend as much time with my patients, can I drive them to the right preventative services? Do I feel like I'm coordinating the care effectively?"

That not necessarily is always the case in existing networks in a given community. So what does that mean to you looking at these folks that are coming in offering them new services, offering them new tools to manage their network virtual tools. Offering them more surplus than they ever before – I can make you rich. Some can. But are they offering the same value proposition to coordinate with your community and effectively drive what they love to do – bringing the joy back to medicine. And I think that's what we try to do and develop PHSOs to not only align the network appropriately, but create that level of community for the physicians and their members that it's not necessarily someone that's coming in with a new bright and shiny object, it is something that is a sustainable business model where one creates that barrier entry for many of these folks that could eventually take the reins and move people out of those settings.

So if I was the chief strategy officer of St. Elsewhere, I would be thinking heavily about what that influence, those local partners are coming in to create, what is their interests, what is their business model, how are they thinking about changing, my care coordination and what can I do to either partner or many times compete with the value propositions in the market. But think very closely about how, what value proposition you're bringing to your physicians and nonphysician providers.

Eric Tower: That's an interesting point because one thing I've noticed is a decent number of the PE players in the market discuss the fact that they're single specialty focused and we're all about making life easier for you and their sales pitch to be quite honest, sometimes is look at how this health system has treated you. You know, do you want this to continue because you're just an afterthought to them. All they care is that you get your patients in for surgery. You know, are you saying that you help shift that culture if it's necessary? I do think also frankly, every health system almost thinks they're physician-friendly and if you consult with their medical staff, there's often a different perception.

Rick Goddard: I'm not going to try to just say that this is not something that needs to be fixed. It's – there are strange relationships with the health system, with their local payer, physicians, depending on the environment, might come in with the situation where relationships have to be repaired. So, what I'm saying is it's not too late. So, folks might have gotten frustrated with the status quo in how relationships are built today but the local health system has to repair them or this is going to grow in, you know, this is where the value proposition these folks are coming in with and, you know, I can't blame them. So what I'm saying is you need to address the problem head on.

Eric Tower: So let's take a quick look at 2022. What are your predictions?

Rick Goddard: So, let's just say if aside from my prediction on COVID, we can, we think that virtual is going to continue to grow, folks are already putting in the necessary infrastructure to coordinate them in settings, getting them in to mental health visits if they're struggling with that, getting them into PCP and other points of office visits no matter how vulnerable you are of an individual. So that will create connection points to the settings of care that require in-person visits. It's already happening but it's a matter of do they need to get enrolled in the right chronic care program now? What are some of the alternatives to surgery that you might have been moving to cut in previous where you can move them to maintaining their health either in an independent setting or necessarily may not need the surgery at all. So I've seen a lot of great work with my physician colleagues thinking of the right medical programs to advance healthcare and not necessarily in a patient setting. But there's still going to be that type of volume.

In terms of chronic condition management, folks are setting up the right disease management programs. There's a lot of programs out there in the industry, right. There's been a significant investment in digital to address the diabetics, CHF, the kidney disease. I've seen tons of kidney disease companies that are not necessarily DaVita and Fresenius. And those folks are managing parts of the industry chronics and multi-chronic illness individuals that need those access to services that may not be their traditional partners in care.

But what I say to my relatives is, if you don't have an internist or primary care physician, those are your quarterbacks. You need to see one. It's not just seeing, you know, if you're a woman of childbearing age, seeing your gynecologist. You really need to see your internist to be that quarterback of care and it doesn't even necessarily have to be in an HMO, Eric. You could be seeing that person and, you know, occasionally and going to see the specialist. You don't need a gatekeeper to go to your PCP. But that is the group that essentially is going to say you need to change your lifestyle. And there's alternative PCPs too which I really am encouraging too, as long as you're getting the right controller of your network, it's key to

maneuvering that. So I think PCPs hopefully are growing in the medical community that trains physicians as being more appealing financially since value-based care is driving much of that growth and average compensation. So I, that's not necessarily a prediction but rather a hope.

I'm seeing also this growth in employer-based commercial self-insured management of the population. I know what of your previous guests did an excellent job describing that market so I won't try to repeat it but it is a huge opportunity because self-insured employers are frustrated and they should be. And so health systems that take advantage of those direct to employer relationships are going to be much more advantageous in their local market and regionally especially if you're a regional based health system to take advantage of the opportunity to partner with physicians and with local employers.

And then lastly, pay attention to policy. This is going to be a pivotal year for [Deputy Administrator] Liz Fowler and the Centers for Medicare and Medicaid Innovation and [CMS]Administrator Brooks-LaSureof CMS to take the next decade of value-based programs overseeing Medicare and supercharge them for the next decade thereafter as being the major influence in program design, influence in the communities of educating beneficiaries that this isn't necessarily a program that's going to be limited them but actually helping them manage their care and drive healthier behaviors. It's a supplement and we'll see obviously changes in the Medicare Advantage and Medicare supplement businesses. Medicare Advantage is growing at a rapid clip of percentage of penetration but there will always be Medicare fee for service. So we need to make sure that both sides of the Medicare eligibles have the appropriate access points and are driving to right outcomes because we as taxpayers today may not see a Medicare program if it's not paid attention to.

Eric Tower: Well, Rick, that's all I got. Thanks for coming on, I appreciate you taking the time.

Rick Goddard: Eric, thanks for having me and a pleasure to talk to you today and I look forward to staying in touch.

Eric Tower: Excellent.