HEALTHCARE REIMAGINED

Fireside Chat

TOPICS DISCUSSED INCLUDE:

PANEL:

David Francis, Managing Director, The BDO Center for Healthcare Excellence & Innovation

Lambert van der Walde, SVP & Executive Director, Center for Health Reform & Modernization, UnitedHealth Group

This conversation has been lightly edited for length and clarity.

The 21st century has seen significant change to healthcare — from consumerism to EHRs to new areas of investor interest. We deep dive on those forces of disruption with an executive who saw these shifts firsthand through work at CMS and UnitedHealth.

Introductions [0:06]

David Francis: Thank you all for being here and joining us today.

We are going to talk about how the healthcare industry has changed over the last couple of decades and look at some of the trends that are currently reshaping the industry, and then explore what the future of the industry looks like. So today, I am here with Lambert van der Walde. Lambert has worked in the industry for the last couple of decades and his experience spans the operations, finance and policies that define the healthcare industry.

Today he's joining us to share what he's learned in each of his previous lives as a capital markets advisor for the Department of Health and Human Services, president of his own healthcare, finance, and policy advisory firm, and in his current role as Senior Vice President and Executive Director of UnitedHealth Group's Center for Health Reform & Modernization. And while Lambert was the Capital Markets Advisor to the Administrator of the Centers for Medicare & Medicaid Services, he worked for both the Bush and Obama administrations. It seemed like you left about the same time the ACA passed, was there any reason or motive for that?

Lambert van der Walde: Yes, I'd been at HHS and CMS for a long time, and for those of you who know Tom Scully and Mark McClellan, I had the privilege of working for both of them. I'd been through the MMA implementation for the Part D benefit, so I knew what an implementation looked like. I knew what happened when the career staff had a big expansion to do, and I knew that the Affordable Care Act would have some hair on it. It would be tough to implement. Though I had no idea some of the challenges that would come down the road. So, I decided to leave and help from the private side and help my clients, private equity firms and hedge funds and others figure out what CMS was doing as it implemented the ACA, which, as you all know, was a monumental undertaking and it's now woven into the healthcare system for forever, or until we try amending it again.

Rise of Consumerism [2:00]

David Francis: So let me throw you a softball for the first question. Over your career, what's the most exciting or surprising change that you've seen in the US healthcare system?

Lambert van der Walde: I think it's really the rise of consumerism. For so long, and sitting at UnitedHealth Group, many of us have viewed this as a B2B interaction and the patients — the members — are on the periphery. When you think of payers, providers and patients, patients often come last. Today, that's not going to work anymore. Just about every other industry that serves Americans has pivoted, and if they didn't serve consumers and didn't try to figure out what consumers were doing, they are now. I think in healthcare, we're still behind on that. There's a lot of opportunity for us to learn and grow. It's a big focus at United. It's probably a big focus for all of you in your companies, your portfolio companies, and those that you advise.

Role of Physicians vs Consumers vs Payers [3:06]

David Francis: I know when we've spoken previously, you've referred to consumers recognizing that they are treated as second class citizens. In my experience working with physicians, physicians may argue that point. A lot of times they feel like they are the second-class citizens. Any thoughts on that?

Lambert van der Walde: Physicians obviously have a very interesting and very important role, and they're caught in the middle sometimes between what consumers want and need and what payers are willing to pay for. Prior authorization is very challenging on all providers.

Yet when payers such as UnitedHealthcare take their foot off that prior authorization brake, a lot of care is prescribed that might not have been otherwise. So, there's obviously opportunity to decrease some of that friction. We're looking at it and other payers are too, but it's important that we partner with doctors and allow them to do what they're trained to do. I think in a lot of cases, whether it's filling out information requests, providing records related to prior authorization, or other administrative hassles of being a physician, it takes away from patient care. We need to think about the workforce, we need to think about who is doing what, and we need to think about the administrative burdens that we're laying on them that I think we're all complicit with.

Next Level Healthcare Landscape Shift – Electronic Medical Record and Telehealth [4:35]

David Francis: Having said that, what do you think is going to be the next big landscape shift in healthcare?

Lambert van der Walde: This won't surprise anybody: it's a toss-up between the Electronic Medical Record and telehealth. That's the easy answer. But I think if we delve a little deeper, the pandemic pushed us forward with telehealth. With behavioral health, it makes perfect sense; the patient and the doctor don't need to be in the same room at the same time, and for other cases where services can be rendered based on a visual assessment, it works well. If you go into more complex cases, it's not going to work as well. However, I think consumers (being good consumers) are going to demand more virtual care than they've received in the past, and that requires the health system to rethink how that delivery will look going forward. We may need to rethink some of our, somewhat protectionist, physician guild-oriented rules around practicing across state lines. That was lifted because of the public health emergency, and I think we need to be more flexible to look at this more comprehensively.

Regarding the Electronic Health Record, ten years ago my go-to line was: "the healthcare industry is 30 years behind financial services. Why does my doctor's office still have paper and manila folders on a shelf?" And because of an act of Congress and a massive multibillion dollar subsidy that flowed through the Medicare program to incentivize and then penalize doctors who didn't wire up and didn't put in EHRs, doctors have EHRs in place. Now, interoperability is still an issue and meaningful use could still use some tweaks, but the power the possibility - of EMR, I think we have barely scratched the surface.

My team at UHG focuses a lot on data: claims data and EHR data. The power to use data in healthcare to learn how to treat our patients better, to think about the natural history of disease, to understand more about predictive analytics — and that's where I'm supposed to get into machine learning and AI — there is so much out there that we haven't accomplished yet that we really need to. As consumers of healthcare, we need to demand that physicians and other providers provide care and do it as seamlessly as possible. Every time I go to a doctor's office, whether it's for me or my kids, I complain when I have to write anyone's name more than once because that's crazy. A kid can program HTML to solve that problem, so why are we scribbling on paper? In fact, UHG has a big paperless initiative — we're going to move away from paper. But what we found is we have to change a lot of state laws in order to do that. We're supposed to mail out hard copies of the explanation of benefits. And when you read that it goes in the trash, it's surprising if the envelope is unsealed. There is a lot of opportunity on the digital side that remains untapped, and we need to keep pushing.

Revenue Pressure [8:00]

David Francis: **That is a great point to talk about the digitalization of healthcare. We see a lot of business out of BDO that comes to us looking for help to optimize scheduling for patients so they can schedule appointments online. I don't think there's one person in this room who would prefer to make a phone call to a call center to schedule an appointment versus being able to pull up your phone or tablet and schedule your appointment online. We know from some of the work we've done that patients actually do a better job of scheduling their appointments earlier by two days, and then they actually show up for their appointments at the right time. But that, along with cell service scheduling, along with price transparency — being able to go online and see what the cost of your care is going to be — and having your referrals and your authorizations being automated, there is a cost for that digitalization. We've seen a lot of organizations this year post billion-dollar losses. Where do you see the investment coming from for these organizations that are seeing so much pressure on their bottom line?**

Lambert van der Walde: I think it's tough when there's revenue pressure and when you have a labor market that exists as it does. But I also think any business needs to invest. If you're not growing, you're shrinking. No one's ever asked me how much it costs for me to run Outlook on a daily basis. We all live in Outlook, or some variant of it. It's a price of admission to function in this society. I remember in 1993, I was getting ready to go to college, I needed to pick one and I needed to purchase some airline tickets to go visit. I physically rode my bicycle to a travel agent to help me book the tickets. Nobody does that today. Somehow, we're getting by without travel agents. Maybe our system helps book, or maybe there's a centralized booking function to try to keep costs under control, but if I need to book a trip for my family, I look at the prices on Expedia and then I buy it directly from the airline just like everybody else. The notion that the healthcare system is somehow exempt from keeping up with the rest of the economy is unfortunate. Are these big systems going to make these IT investments in years when they're in the red? Probably not. But it's important that those investments are made in the not-too-distant future if they haven't occurred already.

Greatest Financial Threat to Healthcare Systems and Providers [10:40]

David Francis: **So, let's stay on that theme of financial pressure. We've seen a lot of financial instability in the healthcare industry in the last couple of years, especially with the pandemic, but even before that. In the next year, what do you think is going to be the greatest financial threat to healthcare systems and healthcare providers?**

Lambert van der Walde: I think it's going to be chasing down a new and uncertain environment where we don't know what patient loads are. At United, our actuaries are still trying to figure out what the new normal is. We would call them every quarter and ask "are we there yet? When can we look at claims data as a nice baseline?" And we still don't know. I think this uncertainty will persist. I also think by some definition we just have to decide we're in the new normal and this is it. We have to navigate without knowing what the pent-up demand looks like. I don't think we're ever going to have that massive surge that we're expecting where everybody shows up at once for the colonoscopy. It's a good thing, right?

There was a big issue about a decade ago with HHS Secretary Kathleen Sebelius. The U.S. Preventative Services Task Force came out with a recommendation that mammography

screenings begin at 50 years old, not 40, and a lot of breast cancer groups were upset about this. It was very controversial. I can see both sides of it. Sebelius ended up taking a step back and not pushing it too hard, but they had solid data that the mammography for the 40 to 50 age group did more harm than good on a population basis. But on an individual basis, it doesn't make any sense. Of course, we want to get checked. So, there becomes a new normal and we need to find those sweet spots and we need to think about how we apply it.

Your question was more financially related. From where I sit, hospitals have a lot of negotiating leverage, a lot of market power, and I am confident they will work it out. I think physicians arguably have a tougher time, but the physicians who have thrived through the pandemic, and who were thriving before the pandemic, will continue. Those are the physicians that take on risk and share risk with the health plans through some sort of capitation.

David Francis: With the financial pressures we're seeing, we've seen a lot of credit rating downgrades in the last couple of quarters and we talked about the losses that we're seeing reported. Going back to the last point you just made about physicians and the community, what do you think that means for community hospitals and private independent practitioners?

Lambert van der Walde: For community hospitals, for those that are competing with a big system or do not have a preferential relationship with at least their local Blue Cross Blue Shield, they need to sort that out. That is probably not sustainable. One way to sort it out and remain independent is to offer more value and figure out how you can offer the same level of care for a lower cost. Figure out a way to take cost out of the system. I think a lot of hospitals have grown very reliant on overpriced, low-level care.

We're currently doing a piece on trauma care centers. Trauma care centers that treat some pretty difficult cases can charge a lot for trauma patients. But because of market leverages they are also able to charge a lot for all the run of the mill things. So, there's a price distinction there and they are reliant on it and they're able to manage their hospitals a little more loosely, I think, as a result. A community hospital that doesn't have that special status, or that's not part of a bigger system, struggles. They need to figure out how to be a lower cost center of care to drive that contracting opportunity. On the physician-side, it's tough to be a fee-for-service doctor, especially if patients don't show up in your office for a few months at the beginning of a pandemic, and I hope more of them figure out how to take on risk. We do a lot of risk in Medicare Advantage broadly across payers and with capitated physician practices, and we're looking closely at how we can do it on the commercial side, too.

Role of Retail Healthcare Providers [15:35]

David Francis: What role do you see for retail healthcare providers like the CVS and the Walgreens in the world?

Lambert van der Walde: I think it will continue to grow. We saw a big boom in investor interest in urgent care a decade or so ago and we're probably in a good, steady state there. When you step down in acuity a little bit to the MinuteClinic sort of thing, that will continue too. There is some vaccine hesitancy, but there are still a lot of people getting their vaccines and there is renewed interest in getting the flu vaccine because you want to eliminate those coughs and colds that are not socially acceptable anymore. So, I think there's still opportunity there. There's always a concern among those that think about healthcare spending and about induced demand. If I'm feeling lousy driving home from work, maybe I'll go to the doctor the next morning. But oh, there's an urgent care center, I can pop in there. I might have felt fine in the morning and skipped the doctor, so maybe that urgent care appointment wasn't necessary after all. There has certainly been induced demand in the system and we're always aware of that. But if you can find a lower cost site of care, like urgent care versus the emergency department, that's a win.

Risk – Value Based Care [16:53]

David Francis: Let's talk about risk. In the last couple of years, value-based healthcare has been a constant topic of discussion, but the level of interest has wavered. As you consider the intersection of policy and finance and the structure of the healthcare industry, what do you see the care model of the future being?

Lambert van der Walde: There's been a lot of talk about value-based care. It was a big, prominent feature in the Affordable Care Act and the Accountable Care Organizations, which a lot of people had had high hopes for. They ran some pilots through Medicare with mixed results, nothing too shocking or surprising. The fundamental flaw was they were offering physicians and hospitals single digit bonuses on hitting certain benchmarks in return for potentially significantly reducing top line revenue. The math didn't work, it didn't make a lot of sense. I think this comes back to sharing risk with physicians. It comes back to capitation and the opportunity for those physicians who are not capitated, who don't know how to take on at least some level of risk, to help give those doctors the skill sets and the tools they need in order to manage a patient population.

Capitation has been going on for a long time in South Florida. The South Florida market has a lot of quirks, but those physician practices know that if they can get a patient to call

the office afterhours number and they can make sure there's an Uber or town car at the patient's home the next morning, once they determine in triage that it's not an emergency, that's an opportunity to keep that patient out of the hospital. The hospital doesn't get the admission that night, but that's better for the health system overall.

Quality of Care and Risk Arrangements [18:52]

David Francis: In my recollection of meeting with physicians, especially primary care physicians, routinely to talk about performance — we focus on quality of care and the performance measures that were in the risk arrangements — the physicians, more often than not, will complain that the patient doesn't show up for the appointment. I don't mean to put you on the spot being with United, but the idea of patients carrying more risk rather than just reward, what's your feeling about that?

Lambert van der Walde: We as a country have been talking for a long time now about making sure patients have more skin in the game. You may remember in the Medicare Modernization Act of 2003, going back 20 years, there was this notion of health savings accounts and the concept of doing a high deductible health plan, which were already growing, and having patients putting money away and treating this as more of a savings model and less as insurance. But that didn't really take off. As far as getting consumers to think more about their purchasing, we didn't move the ball that much. When it comes to consumers on health, you'd think adherence wouldn't be that big of a problem. Maybe we're a victim of our own success, our healthcare system is actually pretty good; you can get pretty sick, and the healthcare system can bring you back, and patients know that. So maybe they get to be a little lazy or a little careless. I do think there need to be ways to get more adherence. Some of these capitated practices have programs set up to make sure the patients are in once a month - that makes sense for a Medicare population, but younger, healthy working age people obviously don't need that. I think there are opportunities for payers and employers to provide incentives, to encourage wellness, and to encourage good behavior. The reality is, when someone is sick enough or has an injury that's bad enough that it needs medical care, they are generally uncomfortable enough that they go in. I think the underlying question is a good one that I don't have an answer to. But we do need to find ways for patients to take on some accountability and some responsibility in a way that's consumer oriented, and maybe that's more carrots and fewer sticks.

Investment Community in the Healthcare System [21:37]

David Francis: Let's talk about the investment community — well represented here today. How well do you feel the investment community understands healthcare operations and what misconceptions do you run into when working with investors? I'll give you a brief example: about a year ago we were working with a private equity firm, and I received a phone call from one of my colleagues, and he said, "Hey, what's the value of primary care? I just got asked why would anyone want to invest in or acquire a primary care group?" So now I throw that question to you.

Lambert van der Walde: I think investors are very sophisticated when it comes to the healthcare system, especially those in this room at a BDO conference. Healthcare is complicated. To invest in healthcare, you have to understand a complex system, or at least a piece of it. I found in my 20 years talking to investors about their healthcare activities, they know a lot and have really spent the time because that's where you can get a return: if you understand the intricacies, the dislocation, the inefficiencies in the health system. I think on the product side, this is often the case with venture capital and early-stage investments, biotech, medtech, there's often a hope or a business plan assumption that once you get FDA approval, you are off to the races. This started changing in about 2005 when CMS led the way, and I was there at the time, with the notion of coverage with evidence development and the notion that if the evidence isn't super strong, CMS may not cover it. CMS has a very clear statutory direction on what it pays for and what it doesn't, and just because it's FDA approved doesn't mean it gets paid for. So, there's often been friction when the payers come along. As we saw recently with the Alzheimer's drug Aduhelm, FDA fast tracked an approval and it was the first Alzheimer's drug in 20 years, who would have anticipated the degree of outcry and upset over this new Alzheimer's drug? It was remarkable. And what CMS did, and I think the payers were glad, is they basically said we don't think there's enough data here to cover this drug and we'll cover it if it's part of a trial. That really restricted coverage and caused some tumult at the sponsor. So, one area is really understanding coverage/coding/payment: is it covered, does it have a name in the coding system, and is there a payment amount associated with it?

On the services side, if the business case that you're presented with is we're going to buy a bunch of this asset, we're going to roll it up, we're going to grow, it's all about scale. If there's not also an argument in there about taking cost out of the system,

or serving as an alternative to the status quo, the investment case is a little tricky. As you think about the investments you're making, or that your clients are considering, how does it fit into the overall system? How can you explain to that curious regulator, whether it's a healthcare regulator or someone on the antitrust side or wherever it may be, how do you explain that the overall health system is somehow improving from this transaction? At the end of the day, it may not be the reason not to do it, but it's definitely something to keep in mind.

David Francis: Do you have an example of the perfect investment, or close to that?

Lambert van der Walde: I think site of service is a good one. If you can develop a service offering that takes patients out of the hospital and puts them in a lower cost site of care with equivalent quality and better cost, that's a winner.

Impactful Technological Advancements in the Industry [26:04]

David Francis: You talked about remote patient monitoring, another hot topic as we move toward a more tech-enabled healthcare industry. In your career, what's the most impactful technological advancement that you've seen in the industry?

Lambert van der Walde: I think consumers, especially after the pandemic, are going to be a lot more engaged in their own care, or at least some of them. I think that's terrific. Who wants to sit in a doctor's waiting room around other sick people who are coughing and oozing virus.So, I think remote patient monitoring and self-monitoring are going to be big. Before I mentioned telemedicine and EHR and that all fits in too.

We're still in the early innings of applying technology. We've seen the big tech companies that we all use on a regular basis go through fits and starts exploring healthcare, and they haven't figured it out yet, but I think eventually they will. For a large company like ours, and for the companies that you're involved with, it's a threat and an opportunity on the horizon. We need to hold ourselves accountable and I think that gets back to consumerism. If these big tech giants are very consumer focused, I think they'll put some pressure on the health system and create some good, healthy competition.

Community Care and Home Care [27:37]

David Francis: How do you see that cascading into community care and home care? We've seen a lot of pandemic disparities around how care is received and delivered.

Lambert van der Walde: When it comes to anything that's remote, such as telemedicine or remote monitoring, we still have an issue in rural areas and in some blighted urban areas with Internet access. Luckily an infrastructure bill passed recently and now we're going to get that last mile, or that last 50 miles in rural areas, wired up so we have strong Internet access broadly. I think that's where you'll see a fair amount of convergence between technology and consumerism and helping to push that along. But it's federal funds, there's rulemaking involved, there's a process, so we'll see how that plays out. It's probably not a panacea and it's probably not right around the corner, but I think it's on its way and it's something to be aware of for those of you that can have the luxury of looking over the long term.

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