Dan Unger: Good day everyone. I'm super excited to discuss this topic that's near and dear to my heart. As Brooke said, I started my healthcare career and physician practice consulting doing due diligence for acquisitions, physician compensation plans, benchmarking and analytics. But more importantly, my wife is a primary care physician. And so she comes home every night and I try to pick her brain and understand what's going on in the trenches around these topics. So, it should be hopefully insightful and thought provoking, and I look forward to discussing at the end of this if you have any questions.

So, we'll start off with a quick summary of the agenda. We'll briefly go through the current trends and outpatient volume, and discuss the four phases of COVID-19 financial recovery that we've gleaned from working with dozens of clients over the last few months. We'll spend the majority of the time on key considerations when shifting volume to virtual care talking, about competition, strategy, and revenue, and cost implications.

So first, this is probably not a shock to anyone. Health systems in the US are facing major financial challenges with the shutdowns related to COVID-19. This is a survey from the American Hospital Association where they are projecting that throughout 2020 or the full year, in-patient volumes will be down 19%, outpatient volumes down 34%. Overall PPE expenses are going up.

What that translates into is projected losses of $323 billion for the year. While there's been provider relief and funding, that's going to only cover about 50% to 60% of these losses.

What we've found in working with our clients is that there's some immediate need to address these financial challenges. The first is to receive an account for stimulus funding. Since health systems and provider groups were basically forced to shut down or limit volumes, getting the funding to help offset that is item number one.

Phase two is recover revenue and accelerate cash as quickly as possible. In the key areas, obviously, are bringing back elective surgeries as well as ambulatory visits which for some provider groups or large IDNs is a significant source of revenue, and while delivering the care needed for patients that have put it off.

The second is to capture revenue and accelerate cash. So, just basic rev cycle processes like making sure you're getting in high dollar accounts that have been outstanding. Making sure charges are entered and DNFB is cleared, and just getting cash in the door that you're already owed as quickly as possible.

Everyone is kind of stuck in this near term phase, trying to figure out how they can just stay on their feet. What we see coming is in the mid to long-term. There are going to be two additional phases. Phase three is reinvesting in long-term core capabilities.

So, with potentially lower volumes in the future, lower revenue, being able to understand and manage your costs is going to be mission critical. So, investing in the key systems and processes to be able to do that is something more folks will have to do.

We also think that real-time patient safety and population surveillance is going to be important. This could be going on for another couple of years depending on who you talk to. There likely will be more situations like COVID in the future, and so being able to identify and quickly address any surges so that you don't have to shut down is something people will want to focus on.

Last is reinventing care delivering operations. So, a lot of what we're going to talk about today is that with this sudden, abrupt stop in volume and shift to virtual care, reinventing how you operate and deliver care in the future is going to be something that's mission critical. So, we'll focus a lot of our time on that today.

One other trend that is obvious is the shift to telehealth. So, this is data from Medicare that just shows basically prior to March, there's almost no utilization by Medicare beneficiaries of telehealth. From mid-March to mid-June, 38% of all Medicare beneficiaries who had an E&M visit did so via telehealth. So, this is just one portion of the market, but there are other data points that just show the drastic change in adoption.

Teladoc reported 100% growth in visits from Q1 this year last year, and a significant part of it was just from the increase in March. So, what we've seen is a lot of providers have had to take the plunge into telehealth. Many of them weren't ready to do this, had kind of been dragging their feet and have had to jump in headfirst without really understanding the long-term implications. So, we'll talk about those today. But before we do it, I'll hand it off to Brooke for a quick poll question related to volumes. Brooke?

Brooke MacCourtney: Great. Thanks, Dan. So, we're going to go ahead and launch our first poll question for you. So, we'd like to know how long do you think that this decrease in outpatient clinic visits will persist? Your options are just during the pandemic, six to 12 months post pandemic and then returning to normal or permanently. We'll give you a few seconds to answer. It looks like we've got a lot of people answering, which is great. We really appreciate you engaging. And give another couple seconds. Looks like the votes are leveling off, and we'll go ahead and close the poll, and share the results.

So, it looks like 8% said just during the pandemic, 50% said six to 12 months post pandemic, then returning to normal, and 42% said permanently. What do you think, Dan? Is that kind of what you expected to see?

Dan Unger: Yeah. That's pretty interesting. I think that a mix is exactly what I expected. I think I thought there would be more people that would think it would be just during the pandemic. My thoughts are that health systems specifically will never recover. Health systems and traditional provider groups will never recover.

And the main reason being that, one, I think COVID-19 has flushed out some of the unnecessary care. We've got a colleague of mine that's a physician who says that COVID is flushed out when he calls reassurance care. I think that, that's true.

So, just in general volumes and utilization will probably be lower. But the bigger thing is that for health systems specifically, more innovative and nimble companies have and will continue to steal volume from them. And so we'll spend a significant amount of time talking about why that is. So, I think that that makes a ton of sense and just a little surprising on that one front. Let me make sure that I can share my screen again and get back into this. Everything look all right?

Brooke MacCourtney: Yep, looks good.

Dan Unger: All right. So now, we'll dive into some of the key financial considerations, and we'll start with kind of where we are today. I think this is a pretty well known fact, but as people went to acquire your physician groups for a variety of reasons, they found out that it wasn't really financially viable, and there are a lot of assumptions that made them do these things such as competition, assumptions around referrals, being able to manage populations with population health, negotiate different rates.

But in general, today, health systems lose around $150,000 per physician per year for PCPs. And you can see that only the 90th percentile and above are even breaking even on primary care. So, we're kind of starting from a challenging financial situation for employed physician groups and private practices are obviously different. But I think the implications are going to be the same for both of them.

So now, just level setting on where we're at, we're going to start with the new competitive landscape. It doesn't seem like a finance topic, but I think it's super important for understanding the future business implications of this abrupt and sudden shift to virtual care.

The other reason being that COVID-19 has broken down the competitive barriers between traditional providers and some of these more modern telehealth and disruptive care delivery companies.

So, we'll go through the three different buckets of new competitors that I look at. The first being pure play telehealth. So, MDLIVE, Teladoc, Doctor On

Demand, or companies that have been around for quite some time and are really, really gaining traction.

Teladoc and Doctor On Demand focus a lot of their business on working with insurance providers and self-funded health plans to provide subscriptions. They use real physicians, not just mid-levels, a variety of specialties, et cetera. Then there's direct primary care companies such as Go Forward, Crossover Health, One Medical.

Go Forward being what I think really innovative in that they're kind of like a more modern subscription concierge practice. Crossover Health partners with employers like Apple, Microsoft, most recently Amazon to deliver care directly to their employees. And then One Medical is a big company that just went public. They operate more in a traditional sense, in that they're a more modern concierge practice. There's an annual fee and then they just bill fee for service.

Then there's large corporations like Amazon, Walmart, CVS Health, that are really starting to enter the healthcare space. Amazon just announced their virtual care program last fall for their employees in the Seattle area that includes virtual care, in-home deliveries, and more. They recently just announced the partnership with Crossover Health to start piloting employee health clinics near some of their large centers. And so they're really addressing healthcare by piloting with their own employees where they obviously have the most incentive.

Walmart has opened up care clinics and their own virtual care system. And CVS Health continues to build out their hubs. So, there's a lot going on in terms of people that are looking to take traditional providers business. I think the most fascinating part about all of it is that these providers, for the most part, are operating without the shackles of traditional healthcare.

Teladoc, Doctor On Demand have business models where they don't care about coding, and CPT codes, and modifiers, and all the hurdles that other organizations have to go through. Same with Go Forward and Crossover Health. Go Forward is just pretty straightforward, $149 a month and all inclusive, the services that they offer. Same with Amazon, Walmart, CVS, they just have traditional straightforward pricing, and so they're kind of playing a different ballgame, which I think is something to keep an eye on.

Now, when it comes to pricing, we're going to talk about pricing for these competitors a little bit because it will lead into how it may impact reimbursement for current providers. MDLIVE is more traditional in terms of just paying per visit, and they charge $40 to $50 per telehealth visit.

Teladoc and Doctor On Demand, as I mentioned before, many of them work directly with insurance companies or employers, and employers pay a per

member per month fee and then get free access to the service or some low copay, and then they both charge $75 if you're not associated with an insurance company or health plan that has a contract with them.

Then in direct primary care, Go Forward, as I mentioned before, they charge $149 per month, and this includes unlimited visits both in-person and telehealth, blood testing, 24/7 messaging with providers, genetic testing, cancer screening, mental health, even vaccines and prescription delivery to your home just for one flat rate.

Crossover, I couldn't find pricing and what they charge per member per month to these employers, but the employer pays a fee and then typically for the employee, they get free or low cost copays for primary care visits, behavioral health, optometry, health coaching, and more recently, virtual care.

On the large corporation side, we have CVS Health. I think the other interesting part about these large corporations that are delivering care now is that they have pricing sheets. Really straightforward pricing sheets that you can go find online. CVS Health charges $59 for video visit. And then they have a range of $49 to $139 for various in-person visits and minor procedures.

Walmart offers office visits, annual checkups. The annual checkups are $20. Office visits are 40. Both of those which are about kind of 50% of what Medicare pays for the same thing in a traditional setting, and then they most recently started offering video visits to their employees in select states for $4.

What's important to remember is that these are large employers. They're commercial payers, and they're now redirecting care away from the traditional system into their own care delivery system.

On Amazon, they're kind of doing something similar, again, focused mostly on their own employees though for now. They, in the Seattle region, have their new virtual care program where there's free care chats, free in-home prescription deliveries, you can do video care. I couldn't find pricing on it. They're really tackling a big part of Seattle in that Washington region.

They most recently announced the partnership with crossover where they're going to build what they call neighborhood health centers for employees and their families. And Crossover will kind of run these clinics where employees and their families can go directly too for care, for pediatrics, family practice, testing, et cetera.

So, not only is the competition ramping up for patients, but all these large corporations and different companies now entering healthcare are going to be competing for your physicians. There's already a shortage. And traditional healthcare systems are not really known for being amazing places to work, and

not treating providers like a lot of the modern companies do with tons of perks and support and everything.

There's an article in Fierce Healthcare about a recent survey where 79% of primary care providers are experiencing some symptom of burnout. And four out of five of the employed physicians say that their health system employers are not doing anything to combat it. And I can confirm my wife has become increasingly frustrated and stressed out with her job. And the only thing, to my knowledge, that they've done is they came and handed a book on physician burnout to their clinic, which was really great and not very well received.

So, what does this look like? I think that for a long time, physicians have just thought that there's only one model. You're employed or you're in private practice. You're employed with a large health system or IDN. Now, with these new disruptive care delivery companies coming in, I think those jobs are going to be really appealing. There's less hassle. You don't have to worry about coding and documenting to get quality measures and all this stuff. Less stress because many of them are experiencing lower volumes.

So, a lot of the concierge practices and even telehealth, you can kind of choose how much volume you want as opposed to seeing 20 to 30 patients a day not being able to go to the bathroom, not being able to eat, and then coming home and writing notes for hours on end.

I think these companies will offer more support in terms of not being afraid to invest in physicians and other care providers to help deliver better care. They're very incentivized to have top notch customer service and engagement. And then more flexibility. The current way of going into the office, having 20 patients scheduled means that in times like COVID, you can't just cancel your schedule if your kid is sick. So, being able to work remotely and pick your schedule is something that will be really appealing, and so I think there's going to be a huge shift in competition for employment of physicians in the coming months and years.

So, with all that in mind, let's go to poll question two, and I'm super interested in hearing everyone's thoughts on this. So, Brooke, I'll hand it over again to you.

Brooke MacCourtney: All right. I'm going to launch our second poll question. So, for this question, we'd like to know which nontraditional competitors should providers be most worried about. So, your options are pure telehealth, that would be Teladoc or Doctor On Demand, direct primary care. That would be One Medical, Go Forward, Crossover Health, Amazon, or large brick and mortar, which would be Walmart, CVS, Walgreens or you can select other.

We'll give you a second to get your votes in. Looks like everyone is voting. Thank you again for engaging in our polls. It's really helpful to us and hopefully interesting to you. So, we'll go ahead and close that poll and share the results.

So, looks like we kind of have an interesting spread. We've got 17% said pure telehealth, 25% said direct primary care. 22% said Amazon and 36% said large brick and mortar. What do you think, Dan? It's kind of interesting. There's kind of a spread between all four answers.

Dan Unger: Yeah. Not surprised at all. I think that this question has been asked many times over. I think that it's tough to gauge. Where I sit on it actually is that it doesn't even really matter. I don't necessarily think any one of these players or even verticals is going to be…There go my dogs. If everyone can hear them, the joys of working from home.

I think that it's actually the modern way of engaging health. So anyway, I think the real disruptors, the fact that all of these companies are working together to take back care for their own employees. So, Amazon is working with both ... Sorry. Walmart is working with Teladoc. Amazon is working with one of the virtual care providers in Crossover Health.

So really, what it is, is that these large employers are setting a precedence for how to care for employees in a more affordable, convenient and higher quality way. And so I think that's the key takeaway is that it doesn't even matter if it's one of them or who it is or which vertical. It's the combination of virtual care, direct primary care and employers owning their own destiny. So, yeah, I'm not surprised by the poll results, but definitely ... I think that's the key takeaway is that it's all of these things combined. All right. I'm back on. Can you all see my screen okay? Brooke, it's all good?

Brooke MacCourtney: Yep, looks good.

Dan Unger: All right. So, we went through the competitive landscape and some of the potential strategic changes. Now, let's talk about what it means for revenue in the future. This is a survey from Advisory Board. They always have great content on what were and are the barriers to telehealth for physicians.

Number one was reimbursement. Number two question is about clinical appropriateness, et cetera, but I think reimbursement has been the main reason why. Why would I take lower payment when I can just make so much money in the clinic? One of my best friends is a dermatologist and he just said, "Oh, it's not worth doing telehealth." I can just pump through patients in the clinic really fast and make more money that way.

And so the next aspect of the advisory board article that I reviewed for transforming telehealth or how COVID is transforming telehealth is that they

said reimbursement parity is critical for really making telehealth table stakes. So, they said parity for in-person and virtual visits from payers is fundamental to continued utilization and broader adoption.

If that happens that telehealth will become table stakes, the revision of care standards and pathways will have to be redefined, and will redefine competition just like what we talked about before. One area I disagree with him on is that reimbursement parity is kind of a dream. As we just saw, there's already many companies that are delivering virtual care at a much lower rate, or a combination of virtual and direct primary care.

And so the thought that insurance companies are going to pay full price when you don't have the same infrastructure and when there are plenty other vendors out there that are offering the services, I just think that, that's unrealistic.

So, I went through and kind of did the math on a standard outpatient visit and what it would look like and how it would impact gross margins. Just in today's ... Well, not even including what the prices could be. This is from the CMS physician fee schedule lookup tool for a level four office visit, which is kind of one of the more prevalent codes that's billed.

$110 is what Medicare pays today. The physician cost of this at the median benchmark compensation per work RVU is $68 leaving a gross margin of $43 to cover overhead staff, the technology, all that good stuff.

The telehealth payment in CMS has obviously declared that they're going to be paying in parity for the duration of COVID-19 health emergency. But their standard approach is that they pay 80% of the normal visit. You bill with the place of service virtual and they pay 80%.

If you continue to pay your physicians on the work RVU associated with that code, it would reduce your margin by 15 percentage points. So, if you're just having physicians sit in the clinic and take some of these visits, you're degrading your margin, you're not doing anything different to operations, but you're just receiving lower payment.

And as we just saw, I think competitive pressures are going to push this even lower for large insurers or employers. Why would you pay $90 when you could pay $50 or pay a subscription fee and not pay anything after that? So, I think that the thought of reimbursement parity and using that as driving your strategy going forward is unrealistic.

Then there's additional headwinds right now. 25 to 43 million people are predicted to lose their employer sponsored health insurance throughout the pandemic and over the next year or two. 58% to 90% of these will either shift to

Medicaid or become completely uninsured. And what that means, it is lower overall reimbursement and higher bad debt.

So, key takeaways from the revenue side of the house. I think there's going to be lower volumes for the foreseeable future both from COVID-19 and the competitive pressures that we talked about with people eating into current volumes. Overall reimbursement rates will decrease both from shifting care next to lower paying virtual care. If people continue to shift that care delivery mix, and in declining payer mix is going to eat into reimbursement.

And competition for physicians is going to heat up. If you don't already know, physicians are what drive revenue. When you go to buy a physician practice, you aren't buying the patients or the building, you're buying the physicians that drive the revenue. And so not being able to retain physicians means it will impact revenue.

Now, on the cost side of the house. So obviously, some big things coming that could impact the top line. On the cost side of the house, over the last decade or more, many groups have acquired or built a vast network of clinics. Spread out through different geographies, various specialties, depending on the market.

And what we found in working with a few of our client partners is that many of these clinics are only utilizing 30% to 50% of their exam room slots. So, not necessarily that physicians aren't busy, but that the utilization optimization of patient rooms is way below where it could be.

It's impossible to get 100% or even maybe 8%, but many of these places are drastically underutilized for a variety of reasons. Whether it's physicians are only working part time, whether it's inappropriate staff levels and mixes to be able to scale or just not really caring and knowing that some of them are underutilized.

Now, imagine a 30% drop in volume to these already underutilized, large assets, and a potential 30% shift of that volume to virtual care. What that means is that you are sitting on these huge fixed assets, paying duplicate staffing and resources and equipment and not utilizing them. And as reimbursement goes down, as the model continues to shift, that is not sustainable.

What I think needs to happen is that you need to change the way you look at the world. Your competition, many of these places either don't have any office space or huge fixed assets, or they efficiently use them like Walmart or CVS where they generate a ton of money just from their normal business and they carve out a small space for care delivery. And so many health systems are going to have to revisit that footprint and make tough decisions to optimize their clinics and high cost MRI machines and CT machines and whatever else it might be.

I think it's been a problem for a long time that no one has been willing to deal with for political reasons. It is challenging, but it's something that's going to have to be addressed in the future if you want to say financially viable and price competitive with these other organizations.

On the physician compensation side of the house, as we showed with that example with the revenue, the economics and operations of telehealth are different. You can't just keep paying doctors the same model and even the same rate because you were paying them based on an estimate of total revenue. And so if you're getting reimbursed less, you're going to have to revisit how you pay them.

Additionally, work RVUs are abstract and misaligned. Whether the visit is five minutes or 45 minutes, you pay the same based on the level that was coded and what was billed. And so in the future, I think health systems are going to have to really focus on what matters and measuring physicians in a more realistic way.

You want to really care. Is it time? Is it coverage? Something much more simple that actually leads to operations as opposed to arbitrary work RVUs. And physician compensation is the biggest single cost on the medical group side of the house. So, it's something that people are going to have to revisit and think of. Everyone I've talked to at our client sites has not addressed the shift to virtual care and how they're going to pay physicians.

So, the key takeaways from the cost side of the house. Fixed cost can't be fixed anymore. Nothing is fixed. Everything is semi-variable at some level, and so lower revenue in competition with much lower cost structures means that you're going to have to address this problem.

Physician compensation plans need to change as we just talked about. The work RVU based compensation plans won't align with telehealth economics or incentives, especially if it starts to become more and more part of your business.

And now, we'll go to poll question number three. Brooke, I'm interested to hear what everyone thinks about their groups or systems readiness for understanding the financial impacts.

Brooke MacCourtney: All right. So, this is our third poll question. We'd like to know how well does your organization understand the true financial impact of shifting buying to telehealth. Your options are very well, kind of, not very well, or you haven't even thought about it, or not applicable.

It looks like we've got some votes coming in. Thank you again for voting. I'll give you a couple more seconds to get your votes in. It looks like things are leveling off. We'll go ahead and close that poll and share the results.

It looks like that 7% said very well, 45% said kind of, 28% said not very well. 3% said they haven't even thought about it and 18% said N/A. What do you think, Dan?

Dan Unger: I think that's pretty aligned with where I'd be at. I'm surprised that 7% think very well. I'd love to potentially hear some of those comments and what people are doing because we haven't seen really anywhere that people truly understand both the revenue side, how commercial payers are going to deal with it, what the long term impacts are or the cost side. How they're going to address even the operations of where physicians do this work, the physician compensation. So, that's surprising to me that there are a few folks that feel they have it under control. So, I think that's the biggest surprise to me on that one.

Brooke MacCourtney: Yeah. If anyone responded and you want to put in questions, any comments you have, we can share those with the group. Let me go ahead and hide that.

Dan Unger: All right. Am I back at it?

Brooke MacCourtney: Yep, you're back on.

Dan Unger: All right. And then we're almost there. So hopefully, I haven't scared anyone too much that the world is ending if you're a traditional provider or health system. So now, we'll talk about what can you do about it, what can you do about these big shifts and abrupt changes that are happening. So number one is understand your costs. It's really clear that top line revenue is likely to go down and stay down for the foreseeable future. And so if you can't understand and manage your costs and make strategic decisions, it's going to be really tough to operate.

One of the biggest parts of that is optimizing clinic space and other high cost resources. So, with lower volumes, you need to really understand your assets and your really high fixed costs. So, to do so, you have to understand the utilization of these resources. Your market and where the actual patient populations are, the financials behind it, potential patient impact of addressing them. And with that, build a strategy for delivering virtual care and how that would impact your overall footprint.

Another thought is don't be penny wise and pound foolish. So, just because you need to lower cost doesn't mean you just go cut costs across the board. In my wife's clinic, they're starting to look at not back-filling care managers and nurses and trying to have a very strict model of certain support staff for a physician without really looking at the volume of a clinic and the productivity.

Additionally, I know that many doctors that I talk to said, "Holy cow. If they would just pay a scribe $12 an hour to help with my notes, I would see an extra 20% of patients. It's just that I just don't want to go home and have to write notes for another 45 minutes." So, while you need to cut costs, don't be foolish.

And make sure that you're understanding the full scope of these decisions, because hiring and investing may actually increase productivity.

Now, for physician compensation plans. Address the economic realities of virtual care. Again, you can't just keep paying the same way when the economics are different and the operations are different. Another one is to simplify. If you can't explain the model in one to two sentences, it's too complicated.

The large IDN where my wife works recently updated it to try and include more quality measures and all these other things. And it is a black box. The significant part of it is still based on work RVUs and everything else is a black box. And so if they can't understand it, and if you don't know what you're trying to incentivize and it's not the right incentives, it's not very meaningful. So, I think that's a big deal given how big of an expense physician compensation is.

And then I think the biggest piece is building a new primary care strategy and business model to compete in this new world. I really, really think that these large employers and even small ones are going to start moving volume away from traditional healthcare systems if they can't keep up from a customer service a patient access standpoint, but I know that Crossover Health says 95% of their visits have less than a five minute wait, and you can typically schedule and go forward for same day or next day almost every time.

And if you've ever been in those places, they are way, way nicer than the traditional physician office. And so I think health systems need to revisit their primary care model, start developing direct primary care models for local employers, better optimizing for virtual care and in-home care. And that's going to be the biggest shift to compete, I think.

Then lastly, learn how to take on real risk. I think that COVID-19 has exposed the flaws in the fee for service model pretty deeply. And then as soon as volumes go down, traditional health systems and their model of just managing volume kind of falls on its face.

Those systems that have really taken on risk like Intermountain, UPMC, Kaiser where they're actually insurance are going to weather the storm much more easily. Because on the payer side of the house where they may be 40% to 50% of their own volume, Kaiser obviously 100% or close to that. When they're not paying out claims and that offsets the lower revenue and volume on the provider side of the house.

And so I think that instead of grasping onto the fee for service world, or dabbling in between risk models where there's only a little bit of upside, downside and quality is not going to be enough. I think health systems can take on risk and they can succeed in it if they look at the right things like really

understanding their costs, understanding what populations they can succeed at. And so I think that these last two models are obviously the biggest strategic changes that were most risky, but are the ones that health systems are going to have to take to survive.

So, with that, Brooke ... I'll hand it over to Brooke for a couple of quick poll questions, and then we'll head into Q&A. Thank you all for sticking with us.

Brooke MacCourtney: Thanks, Dan. Thanks, everybody. As Dan mentioned, we will move into our Q&A in just a minute. So, if you have any questions, now would be a good time to submit them in the questions pane. And so before we do that, I wanted to remind everyone about our annual healthcare analytic summit, or HAS as you might know. HAS will be held virtually this year, September 1st to the 3rd. And our theme is the transformative role of data and analytics in the new normal.

So, we'll feature speakers who battled COVID-19 in the trenches as well as other speakers who will discuss how they're pivoting and adjusting to the new normal. We plan to provide a unique and innovative virtual experience that will include national recognized keynote speakers, a few of which you can see listed here on the slide, and we'll also facilitate individual connections with other summit attendees through our walkabout through networking on brain date and other virtual activities.

So, we're really excited about what we have planned for this year, and we hope you'll be able to join us. You can get more information and register to attend at hassummit.com. And Dan, if you'll just jump to the next slide. We're going to give away three complimentary passes to HAS right now. So, if you know that you're able to attend September 1st to the 3rd and you'd like to be considered for one of these passes, I'm going to launch a poll question right now.

So, you can just go ahead and answer yes if you're interested in being considered and we will notify the winners probably within the next week. So, if you'll just go ahead and answer that. We'll give you a couple seconds to answer. And one more second. If you're interested, now is the time to reply. And we'll go ahead and close that.

And then we will move into our next question. Dan, if you'll just jump to that last question I have. Perfect. Okay. This is our last poll question. I know we've had a lot today, so thank you for everyone for still participating.

So, while today's webinar was focused on ... Sorry, let me launch this poll first. So today's webinar is focused on the shift from ambulatory to virtual care as part of the COVID-19 recovery strategy. Some of you may want to learn more about Health Catalysts, other products or maybe our services. So, if you'd like to learn more, please answer this poll question.

And we'll go ahead and leave that open for a few minutes while we start our Q&A session. I think we've got some great questions that have come in. So Dan, I'm just going to kind of start down the list and we'll try and get as many as we can done before the top of the hour.

So, our first question comes from Lucila. I think she was referring to you when you're talking about the competitive pricing. She asked, "Are these prices for primary care or urgent care?"

Dan Unger: Depends on which side of the house. So, on the virtual side, it's basically just a flat rate regardless of type of care. On the direct primary care, most of it is just primary care. They do, do some procedures like sutures and stuff like that, but I think for true urgent care, the companies I listed don't address the full spectrum of urgent care needs.

Brooke MacCourtney: Okay, perfect. All right. Looks like Lucila had another question she asked. Are the providers APPs or physicians?

Dan Unger: In the true pure play telehealth providers, Doctor On Demand, Teladoc, MDLIVE, the majority of them are MDs and DOs, and so they've got ... Most of them have dermatology, internal medicine or family practice and pediatrics, and the majority of them are physicians.

I believe in Walmart and CVS Health, most of them are APPs. And then at Crossover, it's a combination, so it's staffed similar to a traditional physician setting where you've got physicians, mid-levels, nurses, but they are typically staffed with MDs and looked at as a primary care provider for patients where there's continuity. So, great questions. Thanks for contributing.

Brooke MacCourtney: Okay. Our next question is from Maureen. She asks, "How will the fact that these docs do not need to worry about coding the offset since coding is necessary for health plan payment from CMS and other payers?"

Dan Unger: So for many of these, like Teladoc, Doctor On Demand, Crossover, et cetera, they're working with either commercial payers or self-funded health plans. And so they don't have to bill to CMS. Teladoc doesn't have to report or do anything to CMS. The self-funded health plans can pay for these on their own.

I think in the traditional setting where they're going to be doing a little bit of both where you do have to still bill, CMS, or Medicaid, or commercial payers in the traditional way, they will still have that burden. Hopefully, it's lower from a documentation standpoint. But to your point, it still will persist kind of in the traditional fee for service business.

But as I mentioned, when it's a self-funded plan for Walmart or Amazon treating their own employees, they don't have the same shackles and same with a lot of

these telehealth providers. So, it's definitely much reduced on that side in terms of burden for documentation.

Brooke MacCourtney: Perfect. Thanks, Dan. Okay. Our next question comes from Joshua. He asks, "What will compensation look like at these disruptive companies in comparison to legacy? Are these disruptive companies only appealing less stress, less volume? Currently, its patients are still using the standard models. Won't they experience the same issues as they become more established and introduce more patients and services?"

Dan Unger: Great question. So, I can share a little bit. I don't have a good lens into the future, but I can share a little bit about what they're doing now. Teladoc typically pays a fixed fee per video visit. Anywhere from, I believe, $25 to $30. And most physicians can see three to five patients an hour or visits an hour, and so many of them are making over $200,000 an hour if they're working full time, and some can do even more than that.

The cool part on that side of the house is that they have flexibility. You can schedule yourself ahead for what blocks you want to work, what times. You can be licensed in as many states as you want so that you can take on additional patients or have a higher likelihood of volume. And you can even get alerts to just get sent and say, "Hey, there's a surge, do you want to come and take some visits?" So, they have a lot more flexibility in terms of how many patients they see when they do it.

On the direct primary care side of the house, they have their business model set up so that they have certain staffing levels. Just like a concierge practice where they will only take a certain number of patients per provider. And so their goal is to maintain that level of service and be able to spend more time with their patients.

So, I think in those two areas, it is different and they won't experience that same type of burnout and stress because it would be either the flexibility or the way the business model is set up to minimize that, because they want to deliver a higher level of care and have the economic model to do so. The APPs that will be working in Walmart clinics or CVS clinics, I think, will have more traditional stress in volumes if it picks up and ramps up. So, a great question. Hopefully that answers it.

Brooke MacCourtney: Perfect. Thanks, Dan. All right. Brian asked, "What type of doc is your wife?"

Dan Unger: She is a pediatrician.

Brooke MacCourtney: Perfect.

Dan Unger: I married her and I thought I would be able to retire by this time, but it turns out pediatricians are the lowest paid provider. So, she loves her job and she's amazing at it, but didn't help me meet my dreams of early retirement.

Brooke MacCourtney: There you go. All right. Okay. Next question says, "Can you elaborate on what is way nicer than the traditional physician office?"

Dan Unger: Yeah. It's a great question. I haven't been into Crossover Health, but we've worked with them, and we've had some of our team members be able to go over there, and so I'll just give that example and go forwards. What it is, is online scheduling. Being able to go look for yourself and select a slot and when you want to meet with your provider.

Messaging where it's not like just sending it into my health inbox that the doctor may or may not respond to within a day or two. These are direct messages with the provider and they're way more responsive, again, because they're less busy and dedicated to these groups of people. Then you just go into the clinics and they look like beautiful places that you'd want to hang out and spend time.

There's almost no weight as I said before. Go forward, you can book out within a day or two 90% of the time. My wife and most pediatricians and family practice doctors are booked out months for a well visit. Literally, I think our friend just called us yesterday and said, "Hey ..." They would choose to see my wife and she said, "There were no available slots until the end of September." And so that's one aspect of it.

Another one is that many of them are using technology, so go forward. When you sign up with them, they do a huge biometric screening, lab results, and they use technology to monitor you over time. And everything is included, so you don't get nickel and dime. You don't have to worry about billing everything they do, blood tests, follow-up, appointments. Everything is included in that fee.

So, not only are they nicer, there's easier access, self-service in terms of online booking, more consistent communication with providers. So, that's just a few of the ways I think that they're much better.

Brooke MacCourtney: Great. Okay, next question comes from Ash. He asks, "What does the future ..." Or maybe she. Sorry. "What does the future of acute services look like if these disruptors tank health system revenue but not replace all the acute health system services?"

Dan Unger: That is another awesome question that I'd love to hypothesize about. So, I'll take a stab at what I think. I think if traditional health systems don't start to compete and change on the ambulatory primary care side of the house, many of the acute care settings that will still be needed and they will be fighting for specific ownership of markets and employers.

For example, who will do direct contracting for specific high cost procedures? So, I think that the acute care settings will be left with emergency. Obviously, emergency needs to continue to be there. The emergency department is not something any of these companies are really interested in doing.

But I think that there will be competition for outpatient surgeries that are high dollar where you can do direct contracting with employers. And Walmart, and many of these organizations are already doing it where they'll kind of pay the best in the nation for really high cost procedures and funnel their employees there.

So, I think acute care is going to not necessarily change drastically, but I think how you engage with consumers, at least those that pay, could change in the future and you'll be competing for specific business. But I think that the need for acute care will always be there, and there may be disruption in the future, but I think that those are kind of the biggest ways that acute care will be addressed.

Brooke MacCourtney: Okay. Our next question is from Daniel. He asked, "What type of PC services are most ineligible for telecare?"

Dan Unger: That's a good question, and one of a lot of debate. His name is Dr. Jay. I can't remember his last name. Jay Parkinson, I think, started one of the first virtual direct primary care companies called Sherpa, which was actually acquired by Crossover and he's a primary care physician himself. And he thinks that 80 to ... I think it was 80% to 85% of the current visits could be done virtually in terms of primary care.

I think that there are others that feel differently. If you talk to physicians, that's one of the biggest sticking points. My wife always goes bonkers when you see that many of these current telehealth companies that are using mid-levels prescribe antibiotics 55% to 60% of the time when you don't even get to look in an ear for an ear infection or something like that.

So, I think that there's varying degrees of what can or can't be done, but I do think there are obvious things like med checks, potentially rashes. A lot of dermatologists are starting to do that. Mental Health follow-up visits. So, there's a lot that's really obvious. And so my guess is that the number is somewhere between 30% and 85% of the volume can be handled in high quality virtually.

But again, that's one of the biggest points of debate and obviously one of the biggest things everyone needs to figure out to be able to leverage the technology in in-person care for the highest quality and lowest cost. So, great question, and hopefully that gives you a little bit of context.

Brooke MacCourtney: And that's a really good one. We got a few more questions come in. We have about five minutes left, so if you have a question you're wanting to ask, now would be a great time to submit that so we can make sure we address it.

Brian asks, "What are and what will be the major sources for ranking the quality of telehealth doctors advised by plan service individual doctor that potential patients will readily have available? Will it be social media, a government site? What are your thoughts on that?"

Dan Unger: I don't know, because we haven't figured it out anywhere, really. Yeah, I think there's no silver bullet, because we really haven't figured that out in any healthcare setting to my knowledge that everyone feels comfortable. Everyone is being measured, and it's clearly available to see to define what quality is and who's delivering high quality care.

So, I think it's a really tough question, but I think one of the benefits of virtual care is that I think we're likely to get a lot more feedback. So, many of these companies are a lot more data driven, and it's a lot easier to get feedback when you just finished a video visit and it pops up and says, "How was your visit?" And you can send a text message and get feedback after the visit.

Whereas in the traditional care settings, someone leaves your four walls and you don't typically find out what happens to them unless they get readmitted or they call back. And even from a survey standpoint, we got like an 18 page survey when our child was born. I get random phone calls two weeks after a sick visit for our child, and you're just way less likely to get feedback.

So, I think that the data gathering and the ability to connect the dots in some of these areas will be a lot easier. It will allow us to measure physicians better. I think one of the hard parts is that the virtual care will be disconnected from some of the traditional care. So, being able to know that someone had a video visit and then got admitted to the hospital is going to be harder to do.

So, the integration for these employers and health plans to really combine the virtual care data with clinical data is going to be key. But I think once they do that, they're actually set up to do it significantly better than we can today. Then there's always the problem of just defining what's quality. We'll experience some similar struggles on that specific part. Really good questions.

Brooke MacCourtney: Yeah, we're getting lots of great questions. I have a couple more minutes. We'll try and get to a couple more. Maureen asks, "How does taking risk at the health plan level sync with the reduced reimbursement to the physicians?"

Dan Unger: I'm trying to think if you're talking about kind of provider sponsored health plans where the large health system is the health plan or not. So, I don't know if,

Brooke, we can get clarification on that because I could be way off in my assumption.

Brooke MacCourtney: Yeah. Maureen, if you want to write in and clarify that. We'll move on to another question and circle back to that.

Dan Unger: Okay.

Brooke MacCourtney: Okay. Brian asks, "Will telehealth services be linking up with providers like Apple Watch for continuous health data collection or at least have patient access to that data through permission by the patient?"

Dan Unger: I think in some places, yes. I think that's a lot of what Go Forward strategy is. I think that the pure play telehealth providers probably won't be as involved with that, but the direct primary care like Go Forward or crossover technology is a big part of their strategy.

The close contact with the patients, the ability to deliver personalized care and help monitor, and their focus on technology means that I think they will try and tap into that. They already are. I know with Go Forward, they are. I'm not sure about Crossover. I think that's definitely a trend and that may be the place where we'll be able to actually kind of see that come to fruition.

Brooke MacCourtney: Okay. So, circling back to that question that Maureen had about risk. She wrote in and said, "Yes, provider sponsored health plans taking risks. How do you expect physician compensation to change?"

Dan Unger: Oh, okay. Great question. Yeah. That's where I think that in that model, it's really funny because they try to keep those two completely separate. And so they keep doing the traditional way on the physician side of the house by paying for productivity mostly based on work RVUs. Then sometimes, Intermountain has a Select Health bonus if physicians do certain things. With the Select Health patients, they'll get a quality bonus.

But in my mind, when you are a health plan, and the vast majority of your expenses are for your own patients, you're paying out for ... Sorry, for your own members. You're paying out to your own care delivery system, that you should be looking at it more holistically.

So instead of just paying purely off of productivity, which is what they do today, they should be paying more on coverage and managing lives. Because what they do right now is it's so hard for physicians to truly care about those members and follow up with, and because all they get paid on is volume.

So, I think some sort of mix of salary with either panel size or visit incentives that are smaller percent of it will better align physicians with caring for those

health plan members. Because right now, there's no incentive to call someone after hours or do research on the best way to take care of them. They're just so busy and completely incentivized to pump out volume.

So, I think in hope, that's where they'll start going in that, "Hey, you're an employee that helps manage our population." Instead of a widget producer. And there are certain places. I believe UPMC actually shifted a lot of their compensation plans to be more salary focused a couple years ago.

Rob DeMichiei is a strategic advisor for Health Catalyst. He's the former CFO there, and he pushed really heavily for that. And so I think it's been great right now where the health plan is doing well, I assume. Providers would be typically losing money, like they're in a lot of places. But because of that move, it's kind of been kept in balance. So, a great question, and that's kind of my perspective on how I think it should work.