[00:00:01.290] Announcer:

Welcome to APG on American Healthcare, the official podcast of America's Physician Groups where we discuss current issues in the healthcare value movement. APG members are at the forefront of national healthcare reform, practicing at risk-based prospective payment and other population-based payment models. The very models described by federal legislation for the entire nation. Interested in learning more about APG and the value-based movement. Join us for the Colloquium 2020 Answering the Call: Value-Based Care in Public Health Emergencies, an online conference November 17 through 19.

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Learn more at APG. And now for an inspiring and educational look at the transformation of America's healthcare delivery system, here's your host, APG President and CEO Don Crane.

[00:00:52.650] Don Crane:

Mark Smith, so, such a pleasure to have you with me today. Thank you very much for doing this. Mark, good to see you. How are you doing?

[00:01:00.690] Mark Smith, MD:

I'm doing pretty well. As well as can be expected under the circumstances. Thanks for having me.

[00:01:05.340] Don Crane:

Sure. Very good. Well, so, here you are, the former CEO of the California Health Care Foundation. Actually, you were the founding CEO of very august institution here in California, well known around the country. I think you're currently a practicing physician at San Francisco General with a specialty, if that's the right word, in AIDS and AIDS patients. Former Co-Chair of the CMS Learning Action Network, the LAN, as it is known, which is perhaps important and timely.

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They just yesterday had an important meeting. You've spoken at APG events before and are almost unanimously, uniformly popular. There's a few exceptions. Maybe it may have been that one time when that tornado hit you, I guess that perhaps was the one.

[00:01:57.880]

But at any rate, it is indeed a pleasure to be able to talk with you about these matters. So, we'll just dive into one of our, you know, really most important subjects that's drawn a lot of attention around APG lately is racial disparities and population health. And so, the way I thought I would toss this first question to you,

is this as follows. As we talked about it at a board meeting it was not long ago during this amazing sort of reckoning we're having around the country.

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And I can't remember which atrocity prompted this discussion at the board meeting, but could have been any of them because there have been so many clearly such a profound problem. But the hand went up and it was basically as follows. And this was a rather large and successful group in Southern California. And the CEO said, Don, look, we need, I think, to get the following information and message and reality out.

[00:03:01.830]

We are, I think, an effective tool for combating health disparities. So, here we are responsible for the health of a population. We treat all our patients the same when we encounter problems caused by some kind of disparity, whether it's nutritional or transportation or housing or racial. It's a concern to us and where we can we even delve into it and do something about it. There's not a lot of funding for that, but we're interested in rectifying the problem.

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And of course, we don't think, given the nature of our model, we are a part of the problem. We think we're a part of the solution. We wish, frankly, we were seen in that light. And so, Mark, I ask you, what is your reaction? What do you think of that?

[00:03:52.350] Mark Smith, MD:

Well, as you know, I believe in value-based payment and I believe in the kind of model that APG members represent. They're not magicians. And so, I guess I'd say I'd like to think that they're part of the solution. I would contest the notion that they're not part of the problem, because I think the problem is pretty much ubiquitous. They have tools that I think are better prepared and incentives that are more aligned to provide evidence-based standard care without regard to the implicit bias that we as individuals carry around.

[00:04:30.630]

But the patients of APG's members are subject to the same sorts of structural disadvantages coming in that they are in other systems of care. So, I appreciate and support people working on it. But if people think that by virtue of receiving capitated payment, they are immune from racism or that inequities don't exist in their patient population. I suspect that's a bridge too far.

[00:04:57.240] Don Crane:

So, I hear some hint of partial agreement, but you're saying, Don, don't be naive. The problem is more profound and widespread and the payment method isn't going to cure it all, is what I think I'm hearing. And I wouldn't dispute that. Mark, I just think that at this point in history, as we are trying to move from volume to value when we sort of have fee-for-service on the run, up pops, this, I think, hitherto unappreciated possibility.

[00:05:27.480]

Maybe I use you that word? That organized systems where the focus is on population health might be of some help. And so, maybe I'm stretching a little bit, but I hope that's the case. We're certainly interested in the issue and I intend to do more about it.

[00:05:45.450]

So, any other thoughts on the subject on what you recommend for us?

[00:05:51.330] Mark Smith, MD:

Yeah, I think there are people of goodwill and people with systematic quality improvement efforts in various systems of care. So, as you know, I believe in this model. But many years ago, Arnie Milstein did some work for the California Health Care Foundation that suggested that are actually are small, kind of unaffiliated physician groups out there in the land who are doing a very good job both on quality and on cost effectiveness.

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That is to say, they're providing high-value care. And so, I think with the advance of technology, we need to always be a little humble about how necessary a particular form of organization is to achieve an outcome, because I don't think that in the next year or five, all of America's independent physicians are necessarily going to join a big capitated group. And I'm not willing to give up on the possibility that they can, with the right financial incentives, also improve their care.

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So, I guess I would say yes and not yes but, but yes and, I think this form of care has some natural advantages. But I wouldn't give up on smaller independent physicians and groups that are able to use modern IT. And if they're in an environment where their financial incentives are aligned with these outcomes, be able to make real improvements in the care that they provide.

[00:07:17.010] Don Crane:

Well, I think I agree. So, currently, these smaller groups that exist out there oftentimes do work with our APG members. Sometimes under contracts, sometimes not. But the extent to which they're tied into the

data warehouses, the analytics associated with the patient population isn't quite the same as those that are more integrated into the group. So, maybe we have to agree to disagree a little bit there. I just find virtue in things organized, integrated and systematized and well...

[00:07:58.370] Mark Smith, MD:

Don, have you ever used Open Table? Do you know what Open Table is?

[00:08:01.570] Don Crane:

Sure. This is how you make your reservations for dinner, right?

[00:08:03.930] Mark Smith, MD:

Right. Well, 20 years ago only…well, let's say Olive Garden or Ruth's Chris that is a big organized integrated system had that technical capability. OpenTable has now allowed a mom and pop restaurant to do some of the things that only a big corporate entity could do before. And I think the same thing is true in healthcare. So, some of what the permanent medical group has achieved over the years by virtue of being a large, multi-specialty behemoth that, by the way, has not found it terribly easy to expand into areas where it hasn't been for 50 years.

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Some of those functions can now be performed by software and other IT. So again, I believe in the model, but let's be humble about the capacity of people in different systems with the use of modern IT and with the right orientation and financial incentives to be able to achieve some of these outcomes that it used to take a big capital intensive system to achieve. I think there are lots of companies that are now providing the kind of Open Table equivalent in terms of being able to reproduce some of those outcomes in different ways.

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So, yes, and

[00:09:19.980] Don Crane:

So, agreed. There's no question that, you know, IT, copper wires, wi-fi, et cetera, is going to make a lot of difference. And I think it's going to bring smaller groups into these networks. And we're going to get the best of both, I hope, Mark. We're going to have Marcus Welby. So, I just lost the thought that I wanted to try on you.

[00:09:43.110]

Well, let me let me ask you this. We talked, made some reference here to the LAN a second ago. So, this is a learning action network. And you were Co-Chair for and I think a couple, three, four or five years now and just recently went off, and correct me if I'm wrong on that. So, as you look at the value movement across the United States right now, defined principally as moving from fee-for-service into something other than fee-for-service, probably risk-based, maybe capitation could be some, you know, variation on that theme.

[00:10:13.380]

How do you think it's going?

[00:10:15.660] Mark Smith, MD:

I think it's going. It's going not as quickly as I might like. And I think it faces a number of challenges but I'm optimistic about the future. So, when Secretary Burwell set out these targets on the basis of which the LAN was formed in the Obama administration, and one of the things that's worth noting, I think, is it's one of the very few things in healthcare that still, I think enjoys bipartisan support. I am a Democrat.

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My co-chair, Mark McClellan, is a Republican. And we were always able to find congressional leaders from both sides of the aisle who would show up at the summit and elsewhere to support the idea of value-based payment and moving to a different ethos on payment. So, I think the setting of specific goals was a good thing. I think there's lots of momentum at the same time. I wouldn't be telling you the truth if I didn't say that I'm a little disappointed in how far we have gotten.

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And I think part of the reason for that is that those of us who work in ‘wonk world’ have not been as successful as we need to be in translating these kinds of arcane issues of payment methodologies and bundled payments and capitation into a new form of care that patients can appreciate. And one of the things that we tried from the beginning to do in the LAN, and I know they're still doing, they just had their latest summit yesterday, was to make it very clear the reason we want to move to a new payment system is not to do it on its own for itself, but in order to facilitate better patient care.

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And so, I think we've still got to do a better job of translating for ordinary people and policymakers as well. How it is changing the payment system does not guarantee, but enables the unleashing of modern IT, the unleashing of science to provide a different care experience and better outcomes for patients. And I think the more we can do that, the more we can accelerate this movement that is moving forward, but not as quickly as I might like.

[00:12:21.730] Don Crane:

So, I want to get to that in a minute. We, in our prep call the other day, had an interesting conversation about basically patient engagement in delivery models and payment methodology. And I want to get to that in a second. But let me dig a little deeper in terms of how we're doing now. I mean, I think it is the case that we've not met Sylvia Burwell's rather ambitious targets from a number of years ago. And so, you know, what are we doing right?

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What are we doing wrong? Let me start with what's going right. Give me some detail there if you can. Are we, is the iterative approach we're taking now in just Medicare upside only then to upside to downside, is this an appropriate pathway? Is the pace adequate?

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You know, what are we doing right?

[00:13:10.080] Mark Smith, MD:

Well, the first thing we're doing right, I think, is that we're building a scaffolding for greater cooperation and collaboration between public and private sectors. And so, for providers, I think are both operationally and ethically challenged when you ask them to care for patients differently based on who pays for their care. So, what we want providers to do is to evolve a new model of care that treats people equally, hopefully.

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And to the extent that there is still great discrepancies between private providers and between private---I mean between private plans---payers between private and public payers, we're making progress on trying to get more synchronization coordination there. That's number one. Number two, I think we've learned that upside risk only is not a strong enough signal to change the way of life for providers who, let's face it, have done pretty well at the expense, I would argue, of the American public for the last several years in the old model.

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And so, if you only offer people upside risk and there's no downside risk, then I think you should only expect people to move in tentative ways. And to the extent that you offer people the opportunity to create their own measurements, I think you allow a kind of a gaming of the system. So, I think we've learned that we may have learned it the hard way. But you see CMS and I think private payers increasingly saying, first, there's got to be downside risk involved.

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And second, everybody's got to play by the same rules. You can't kind of cherry pick the outcomes that you think you're going to do better on. And so, I think we've learned through experience that those things don't work. And lastly, I would say while capitation is the kind of LAN category 4, the kind of final step in value-based payment, I don't expect that for the foreseeable future everyone will be capitated. So, I think we'll see a mix of bundled payments and fee-for-service payments with quality outcomes, hopefully, and downside risk for performance.

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I think there are some still some methodological issues with the outcomes that we are measuring, with the quality measures that we've elaborated. And the two that I would point to in particular are I think having spent, what, 10 billion dollars on patient reported outcomes, I still see very few instances of where they are rolled into actual contracts. And I think, again, to the extent that we can make this change in payment system relevant and tangible and concrete for everybody in the system, providers and patients alike, we will accelerate that movement.

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So, I am not a fan of the oft heard mantra that we need fewer, better measures. I think we need more better measures. I think we need measures for multiple sclerosis care that resonate with patients and providers around that disease. We need measures for knee replacement or for HIV care or for sickle cell disease that will resonate with both providers and patients. And to the extent that we are now or should soon be able to integrate the collection and analysis of those measures into our digitized health system, as opposed to having research nurses run around with clipboards with a whole different system of data flows, I think we'll be in a position to accelerate this forward.

[00:16:45.640] Don Crane:

So, as we talk about what's going right and what's going wrong, I couldn't help but myself I think Medicare, which is where so much of the innovation is going on. But let me break it into or parse it a little bit and ask you if you care to differentiate between how it's going right or wrong in

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Medicare and then in the private sector.

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So commercial and wherever health plans are involved. Do you see a different picture there or do you see basically the same picture there?

[00:17:17.260] Mark Smith, MD:

Well, an interesting phenomenon is that I think in the commercial world, it really does vary dramatically from one market to another. And so if you look, for instance, at the influence that Kaiser Permanente has on standard of practice and rates of hospitalization and other parameters in the communities where it operates and where other APG members have an influence on the culture of medicine in places where they are strong. When you look at the power of consolidated local payers.

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So there are some cities, say Orlando or Anaheim or Seattle, where you have payers that are big and consolidated and have enough volume in one market to be able to do direct contracting with providers and influence that market. At the same time, there are a lot of payers which, while big in total, you know, I think of banks, for instance, most banks don't have like 15,000 employees in one market. They have 800 employees in hundreds of markets.

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And so, I think the level of collaboration, cooperation between plans, the level of penetration of value-based care varies a lot, as you know, in California and varies even more between California and other parts of the country in the commercial space. The level of penetration of Medicare Advantage, though, I think it's growing quickly everywhere varies a lot. So, there's a lot of heterogeneity. And one of the things I think that makes you humble when you try to do national health policy is it's a big country and there are very few solutions that I think work uniformly in rural North Dakota and downtown L.A. And so, I think we should expect that kind of heterogeneity.

[00:19:05.650] Don Crane:

So that's a perfect segue to one of my favorite topics with you. So, Mark, I'm grinning as I think about this. So, I don't know, a decade ago or so, I think we were in San Diego or in some conference hall somewhere. And in your talk to the APG membership at the time, you used the baseball analogy on how really we're doing rather well in California.

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I think it was sort of the postulate, but we had trouble playing on the road. We had good home games. You know, something about Chavez Ravine worked well for us, but out on the road, didn't have the same batting averages and didn't have the same success. And, I think at the time, Mark, I think this really was probably pre-ACA. I don't know. You and I are a little more than thirty by now.

[00:19:51.670]

The time is flying. And so, it is interesting to ask you the same question now. I mean, we have members in forty-five states. You look at some of these really excellent case studies of these really excellent organizations. I did Chris Chen the other day on ChenMed. It's just amazing how successful and sophisticated. And so, I want to ask you again about your then-famous quote about the California model being really good, but somehow couldn't take it on the road.

[00:20:19.530]

Do you still feel that way?

[00:20:21.130] Mark Smith, MD:

I do, although I think ChenMed is a lot different from the Permanente Medical Group or from Beaver or HealthCare Partners or any one of a number of kind of first-generation physician groups, if you will. And that's another example of how I meant when I said I think we've got to be humble about how technology may change our view of organizational necessities and organizational scale. So, one of the interesting things about Kaiser is the fact that Kaiser has not come to dominate American healthcare.

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And many of the places where Kaiser or Kaiser-like organizations --- Group Health of Puget Sound, for example--- haven't been for 50 years. They have tried and failed to start-up new Kaiser Permanentes. Now part of the reason for that has to do with the fact that Kaiser's model has to have a certain level of scale to operate. And if you don't have certain number of physicians and specialists and be able to command a certain number of hospital beds and have kind of a compact group of doctors who want to practice in a new way and have local leadership and some other things, those efforts in a number of states have not done well.

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But I would argue that many of the new organizations that are committed to value-based care and maybe APG members are actually substantially smaller, substantially more nimble, are enabled by modern IT and actually are able to achieve some of Permanente's outcomes and approaches without Permanente's scale. So that's a good example of how I think that the, quote, California model of old is migrating. The philosophy may be the same, but the organizational requirements, the scale requirements are different.

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And frankly, I think the exhaustion of many American doctors with the hamster wheel of fee-for-service care is different from what it was 20 years ago. So, I think there's probably much more receptivity out there. But there's also a model that I think is able to take advantage of market opportunities in ways that the, quote, California model of 20 years ago, unquote, was not able to.

[00:22:34.670] Don Crane:

Well, I'll tell you, it's been interesting to observe this really great new sort of cohort of members we have at APG that are that are primary care groups.

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And so, they may have, you know, risk for total cost of care, but they don't purport to be multi-specialties. They contract with specialists and the like. They're primary care groups and the names go on and on. I mean, Village MD and Iora and ChenMed. So, it's so interesting to see that kind of variation on the California theme emerge. And it'll be interesting to see how and whether it evolves, whether it needs to or not.

[00:23:11.350] Mark Smith, MD:

And that's what I meant when I said when I invoked the Open Table model. There are now extra this external capability, this IT capability, and there are external companies. Aledade comes to mind that are able to facilitate those transitions that a generation ago required you to have a thousand doctors and 500 IT people, etc. So that's what I mean.

[00:23:35.530] Don Crane:

Let me segue now to this issue of patient engagement, because so little really has been discussed about. I mean, if you also look at the new models and so on and CMMI and so forth, you know, in some instances there's some ability to communicate with patients, but it's really the exception and not the rule.

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And you, I think, have a kind of a bold vision of a very different kind of a world. So you started by talking about, you know, a multiplicity of quality measures so that if Don Crane had RA and he knew this physician was particularly adept at dealing with rheumatoid arthritis, Don Crane would go to that physician, et cetera, et cetera, makes all the sense in the world to me. But when I think this is where I think our conversation went the other day, we have a potential opportunity.

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Maybe this is dreamland. But if for the sake of discussion, we say that CMS Seema Verma or US Congress or some policymakers in Washington, DC, really want to move this country from fee-for-service to, let's call it risk-based contracting. And that's the goal. Sylvia Burwell, had that goal. I think they all…all of the CMS administrators since Sylvia Burwell and many before…have had the same goal. It can be said clearly.

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Well, then why not tell the seniors, if we're talking Medicare, that that's the goal?

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And further. And here's the key. This particular model or group or program think MA versus original Medicare is the higher value one in the eyes of CMS. Therefore seniors, we encourage you to sign up for please know the following facts. Here's how it works. Here's the total cost of care associated with these groups. Here are the quality measures associated with these groups. In other words, get active CMS and basically advertise and speak to the seniors so that you align them and engage them in this movement from volume to value.

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Now, is that crazy talk, Mark, or are you thinking along the same lines?

[00:25:40.350] Mark Smith, MD:

It's not crazy, but it's more a religion than science in this way. That's kind of what the STARS program is now, right? It's kind of an overall composite metric of what CMS thinks of a health plan. And you can say the same thing for HCAP scores and other kind of quality metrics that are overall composite metrics for health plans. And I think they've had very little traction because I don't think they're clinically resonant with either patients or doctors. So as opposed to CMS saying we think that APG's members or this particular model or this particular payment methodology is better for you so we encourage you to do that, I would rather see them elaborate a standard of quality measurement for multiple sclerosis and then tell people here are the quality scores for the people who take care of multiple sclerosis. I'm confident, Don, which is why I think I'm a scientist rather than a religious zealot like yourself. I'm confident that if you elaborate those quality measures, the people who are doing value-based care will come out on top. And there may be people whose organizational form doesn't fit your pattern or mind of what is desirable.

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There are people who will be creative and do things we've never thought of. Who, if they have good outcome measures, should win in the marketplace? So that's why I think, as opposed to saying we believe, kind of on faith, that this model or this organizational form or this value approach is better for patients. I think the better role for CMS is to be much more aggressive in developing, publishing and elaborating quality measures that are clinically resonant with patients and doctors and letting patients and doctors conclude on the basis of the facts that they want to go to Group A rather than Group B.

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I don't want to try to argue with someone that payment Method X is better than payment method Y. I want them to say the outcomes from Group A are better than the outcomes from Group B. Oh, and you know what? The reason they're better is because A has been freed from the constraints and the ridiculousness

of fee-for-service to invest in all sorts of capabilities that produce those outcomes. I think that's a better path to take.

[00:28:04.290] Don Crane:

So, what is the data show, though, Mark, thus far? And frankly, I don't think I fully know myself. So, we do have this STARS program, as you think about Medicare, of course, where there's pay for performance.

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And my impression is that it hasn't moved the needle a lot in terms of moving population around.

[00:28:24.100] Mark Smith, MD:

I agree

[00:28:25.350] Don Crane:

When you ask patients what they like, their first and foremost answer relates to the parking lot and whether there's sufficient spaces. And it's almost alarming that there isn't the kind of engagement you would like. So, what do we do with that?

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Are they sophisticated enough to know about RA measures or what?

[00:28:43.260] Mark Smith, MD:

I think if they have RA, they'll get sophisticated enough. My point is precisely that the STARS measures and so many of the measures we have elaborated have meaning in wonk world, but not to humans. And so, to the extent that, you know, I know two or three people now who have multiple myeloma and they do what we all do, call around and ask people like me and you “who's the expert?” Who's the man, who's the woman in multiple myeloma?

[00:29:13.110]

And we tell them what we can tell them, which is I can tell you who's famous, but I can't tell you who's good. Right? But if I could tell you who's good, I guarantee the people who get diagnosed with multiple myeloma will want to go to the places that have the best outcomes. The people who have lupus, who have multiple sclerosis or would need to have a hip replaced. I'm absolutely convinced that the more data we have on the outcomes that are relevant to patients, the better able we will be to have them use that data to make care choices which will reinforce the people who are doing well and will force the people who are not doing well to change what they're doing.

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Now, I recognize that that's a bit of faith, too, but I have more confidence that to the extent we could do that and build in the sophistication for patients and providers alike to recognize high quality care, I think that will get further than simply asserting on the basis of our ideology or even our experience that one group is better than another or one form of payment is better than another. Look, as Yogi Berra once is said to have said, "in theory, theory and practice are exactly the same. In practice, they're not." So, in theory, all this fancy value-based stuff should lead to uniformly and unquestionably better outcomes in all domains in one group as opposed to another.

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You and I both know in practice that's not so likely to be the case. So I'd much rather go to work on developing and elaborating measures that have meaning to people in the clinical choices they make, both providers and patients, and be guided by the facts about who does a better job there.

[00:31:04.960] Don Crane:

Sounds good. Mark, you're on a roll. We need to plumb you for all the answers we can possibly get. I've got to know what to do tomorrow morning. No, but it is this.

[00:31:17.110]

There are calls for a czar, you know, healthcare czar. And we are at this interesting inflection point. So at the LAN summit yesterday, our friend Seema Verma pointed out something that a Brad Smith has been pointing out a couple of times recently, which is the great majority, like I think 50 out of the 55 different sort of innovation models coming out of the CMMI are disappointing, I think, or what language may have been a bit stronger.

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And that's not to say that the five that are doing really well aren't doing fabulous and so on. But, you know, here I'm going to exercise my prerogative. I'm going to make you czar of American healthcare and ask you, you know, what would you do now you're freed. You can you can wave your magic wand and people are going to do what you say. What are the things you would do for American healthcare?

[00:32:05.230]

I didn't even say move from volume to value. Maybe you don't want to do that. What would you do to kind of fix American healthcare?

[00:32:12.190] Mark Smith, MD:

Yeah, well, first I would move forward on trying to get everybody covered, because once you get everybody covered, I think you first have control of a system that right now is hydraulic. Right? Medicare pays little less. Private payers have to pay a little more and everybody, you know, incentives are distorted. And it's just, it is, as a rich country, we are worthy of more than that. So that's one goal. Secondly, I would try to separate clinical decisions, particularly about Medicare from political decisions in Congress and try to establish a more rigorous scientific standard, which I know can be debated and is and will, but a more rigorous scientific as opposed to advocacy, politically-based standard about what Medicare would pay for and what it won't pay for.

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And I would move the discussion about value from just physicians and hospitals to devices and drugs as well. The fact of the matter is, over the last 30 years, a lot of the spending that has increased the price of, say, a hip replacement has not gone to surgeons, it's gone to device manufacturers. And the cost of taking care of a patient with HIV has not gone to ICU docs and primary care docs, it's gone to pharma companies.

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And the thing that many of my colleagues don't like to hear is that's the way capital works, right? To the extent that when I was in business school, people used to say, what do you worry about drug costs? It's like nine percent. 10 percent. So what? Well, first of all, it's a lot bigger than nine or 10 percent now. And secondly, as an AIDS doc, I have a patient who's on one pill once a day for HIV.

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He's seventy-six years old. You probably take more medicine than he does. The increasing scope and power of pharmaceuticals and devices as the tools that doctors use to help heal patients is only going to get bigger. And that's really where the big-ticket items are. So, we should stop paying huge amounts of money for a pill that someone takes whether or not it achieves the reported outcome. We should be willing to pay a lot of money for a pill or a shot or an infusion that achieves the outcome.

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And I think we're going to see greater and greater attention to value-based payment in what are increasingly the big-ticket items in healthcare, which are devices and drugs. And then lastly, I would move towards a regimen of continuing to accelerate people towards value-based payment, hopefully by investing in clinically resonant measures in big disease categories so that doctors and patients are both looking for who does a better job on X or Y, and that could include primary care diseases as well, diabetes, hypertension, whatever.

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But I would move that forward in such a way that people are held to the same standard, cannot pick their own measures and therefore gain them and where there is at least some modicum of downside risk to make everybody play by those rules. I would not kind of proscribe a certain delivery model, because I want to be free to apply the creativity that people in healthcare have. And as the couple of examples I have tried to cite already, use modern IT to solve problems that we had to solve with different organizational forms in another era.

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So, I'm a little, I want to get the incentives right, but I want to leave enough flexibility for people to evolve new platforms and new organizational forms as we learn how to do this better.

[00:35:58.510] Don Crane:

Well, pretty darn impressive, Mark. You've got the job. It's minimum wage. But, you know, there are big rewards.

[00:36:07.270] Mark Smith, MD:

That's alright.

[00:36:07.960] Don Crane:

I'm being funny. This was great. Really a pleasure. I think we got to wrap it up now, but I just want to, I owe you and look forward to repaying the favor, my friend.

[00:36:19.900] Mark Smith, MD:

Well, I always enjoyed talking with you, and, you know, I'm with you. We have these friendly debates, but I think we're on the same side. And I wish you good luck and more success.

[00:36:29.530] Don Crane:

OK, thank you very much.

[00:36:31.150] Mark Smith, MD:

All right. Take care.

[00:36:32.860] Don Crane:

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Thanks for listening to APG on American Healthcare with your host, APG President and CEO Don Crane.

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