SCALE+ community

CEO Leadership Series: Vol 42

MedQuest

Focus on Health System MSO Partnerships

Jason Howard

Chief Executive Officer
MedQuest Associates

Key Takeaways

Corporate MSOs & Health Systems Can Offer Each Other A Lot of Value

- The sweet spot of healthcare is where you can combine the strength and stability of a health system with the agility, the nimbleness of an organization that's got a focus such as a specialty-focused corporate MSO.
- The corporate MSO has a narrow space where they benefit from the gift of focus and has the ability to execute in a much more nimble fashion than a health system can – but where they do it in partnership with health systems.
- And that's where our focus is - partnering with, in a joint venture fashion, health systems. Pulling underneath that umbrella, both hospital based and freestanding assets under the same market. Common marketing team, common scheduling platform, common capital deployment team so that we can create those complementary models. And, being able to allow the hospitals to be able to expand out of their hospital base and become much more of an ambulatory, retail-oriented footprint for imaging.

Corporate MSO & Health System Partnerships Have Been Gaining Momentum and The Outlook Remains Bullish

- I'm also very bullish on it, and I think it's because success breeds success. And I think really the industry is almost demanding it. Additionally, the continued pressures that are going to take place, whether it's on the capital aspects of it or the payer side, will drive further momentum for corporate MSO / health system partnerships.
- In my experience, when hospital systems see their other sister health systems and there's a lot of movement among them, something that works over there, it's like, well, why are we not doing that?
- Select areas of the market with successful MSO / health system partnerships include: urgent care, post-acute, imaging, rehabilitation.

The Strategies & Realities of Structuring Hospital Partnerships

Strategy for Approaching Health Systems

- Look beyond your core offering:
  - Where can you be complimentary to them?
  - Where can you do other things that are important to them?
  - Within mammography specifically, as an example, understanding where the health system is focused in their oncology and understanding the downstream implications of it. We also talk a lot of time in imaging that we can be another flag for them out in the community, depending upon their ambulatory strategy.
- Always think about ways in which you can be innovative in your care delivery.

No Way Around Long Lead Time Development Cycles

- You start talking about a joint venture, which is effectively a marriage for life. That adds a lot more to it. And then you take something, such as imaging, which is so inherently built into the thinking of a health system - this is what we do, this is part and parcel to our offering to the community. As a result, these partnerships take not weeks and not months, but literally quarters, if not years to work out and work through.
- What's interesting is that when you're dealing with health systems, you've got the different constituents in the room. You need all the thumbs to come up on the partnerships. And it's a decent amount of time to make sure that everybody's aligned with the strategy because it is a big risk for them if something were to go wrong with their imaging platform.

A Business Plan Based on Hospital Partnerships Is Not Right For All Investors

- Know who you're partnering with and make sure that they have the same focus and the same mindset of how you want to grow and that you want to make sure you do it in the right way.
- The sponsor will need to buy into and being accepting of the realities of building hospital partnerships, including the aforementioned development cycle timelines.

A Perspective on the Ways in Which Private Equity Backed MSOs are Contributing Value to the Healthcare Market

- The other thing that that private equity brings, and it's built into the name so it feels like it's a little redundant, is the equity itself, just the capital aspect of it. More and more health systems are becoming capital starved. If you go just to the rank and file hospitals around the country, there's a lot of capital neglect that's taking place and not just in imaging, which once again is very capital intensive business by its very nature, but just sort of broadly.
- Partnerships with private equity backed MSOs can help health systems keep up with the needs of individual providers as well as compete for certain services and keep those services within the health system.
- The other thing that comes corporate MSOs is the ability to become a learning organization. You can then bring to a health system things from different markets that you import and then maybe from their market export to other markets as well.
    - We **actually start Friday of this week with the first pilot** of it a remote technologist read. Overall, certain health systems are not ready for that. But, it's an example of what we're doing in certain markets that are prepared for it. And whenever you are ready, then we can bring it to you. And I think that's another advantage of a broad footprint platform is you have the ability to beta test things across multiple markets and pull in best practices from those markets when you know, when the time is right.

Key Predictions & Drivers of Expected Growth For the Imaging Market

A Under appreciated Role for Imaging in Value-Based Care:

- Imaging has largely been relegated to a FFS role, with some consideration to the cost a site-of-service A over site-of-service B. That notwithstanding, the specialty has an under appreciated role to play in value-based care.
    - I think that there's ways for us in imaging to become much more upstream as it relates to value based care. When you think about what the technology can detect in a patient population and the difference between detecting a potential cancerous issue at an early phase versus a late phase. Not just the benefit for the patient - of course, the mortality rates, etc. –but also the cost benefit that's associated with that.

Increasing Power of Technology & Artificial Intelligence:

- It's amazing the things that couldn't be done at all years ago. The type of detection, the level of detection - AI plays a key part of that.
- How do you add AI to not replace, but to assist the professionals, to be able to operate the top of their license to call out specific abnormalities over time?
- Imaging and anesthesia markets are the two biggest professions that have a provider shortage right now. At least in the case of anesthesiologists, you have CRNAs and anesthesiologist assistants and things like that to supplement anesthesiologists. You don't have that in radiology. So to me, that's where AI will ultimately come in.
- Beyond AI, the scans that used to take half an hour, 45 minutes, an hour - now you can do in, like, seven minutes. Time is no longer a limiting factor in this space.

Retooling for an Ambulatory & Retail-Based Healthcare Consumer Market

- Health systems will continue to aim to become much more ambulatory focused and move things out of the basement of a hospital to an MOB or to a strip mall, where it can be more accessible to go in and where patients can get that scan done in a very convenient way.
- How do you arm the consumer with ways, as much as you possibly can, for them to control the scheduling process, the results process, etc. along with their referring physician.

Advancements in pharmaceuticals will have a positive cascading effect on imaging services.

- New drug testing requires imaging to be able to view the results of the drug, both as it's being dosed, but then also to see how the progression is going over a period of time. So the continued push within the space of new drugs that are coming out, new treatments that are coming out, new interventions that are coming out that require imaging is tremendous.

Background

I started out as a physical therapist. I played sports growing up, thought that was the way I wanted to go. I enjoyed being involved with it and went to school, came to physical therapy practice for a very short period of time and two things happened. One was I realized that I really liked the business side of healthcare and I liked having my hands involved in a lot of different things. The other part of it was I just wasn't that good of a clinician, possibly because of the former piece versus the latter. But, I'll say that throughout my career, that part of taking care of patients has resonated all the way through. And it sounds cliche, but it's true in everything we do, including here at MedQuest. So, I spent the first decade of my career in rehab related businesses - publicly traded, some private equity backed and, for a very short stem, not-for-profit. Just enough in the not-for-profit world for me to realize that I'm not cut out to be in the not-for-profit world - the pace, the bureaucracy and the red tape, et cetera. And then, I went in a different direction and worked for a publicly traded hospice company for a period of time. Throughout all of those pieces, I really found what we do here in healthcare services, specifically related to the interaction between a provider and the patient is really what my job has always been. From there, I, as you mentioned, spent a 10-year stint with Sound Physicians where I went through two recapitalizations. We grew tremendously, diversified and took a lot of risk – in value based care, we did some really great things. And through that, when I decided that I wanted to make a move about a year and a half ago and do something different, I had an opportunity to take a step back and say what do I want to do? What did I have the most fun doing? What were the things that I found to be the most exciting? I was kind of agnostic, as I mentioned, to individual clinical spaces because I'd worked across a variety of different ones. But, the first thing in my mind was, who's going to be the sponsor? If you're going to be in a private equity backed organization, that's going to be the difference, particularly in these roles of, of having a tolerable life, if you will, and one that, you know, you can really enjoy. I was also looking for a business that had some real meat on it but that also had an opportunity to scale up nationally - kind of like what we did at Sound Physicians over a decade. I also wanted to find a space that had a wrinkle in it. Something that was going on both from a business standpoint and from the clinical standpoint. And I got to know the investment team - this is a TPG-backed company out of their growth fund. I got to know the team from the growth fund pretty well through a sister company there's called Go Health. The CEO of that company, Todd Latz, and I have known each other for quite some time. We're both Atlanta-based and I got to see firsthand the way that TPG worked with him and his team and scaled up his organization over the last decade, which is a tremendous hold period for private equity backed organizations. So, when they looked to make the play to acquire MedQuest about two years ago at the end of 2022, it just felt like a lot of things were aligning for me. It is based here in Atlanta. That wasn't a key driver for me because Sound Physicians was based out of Seattle when I was the President & CEO there. But at the same time, I really liked the idea of having a private equity organization that I knew the people, knew the way that they treated their portfolio companies. And, number two, a business that had good operational base on it with 50 or so centers today, but really focused in on national scaling. And then, third, an industry that I'm sure we'll talk more about here in a little bit, but within the imaging space, specifically, that's just ripe for explosion and that also has a little bit of nuanced twist as it relates to the payer side.

Interview

What an amazing journey you've been on, how far you've traveled and how much you've seen starting at as President of Sound Physicians, which is a very large company, very national. I don't know if everybody knows Sound Physicians, but I think the latest count is over 5,000 physicians. How do you think of Sound Physicians, the time that you were there, versus other large groups like Duly, Summit, VillageMD? How did Sound Physicians compare and contrast to those other large aggregators?

Yeah, I mean obviously there's a lot of things in the physician practice management space, particularly things that are at scale that have had some difficulties in the most recent years. I would say the nuance with Sound Physicians specifically was that it always came from a value based perspective even before we actually had true at-risk or any kind of contracts like that. It really started out initially as hospital medicine where a lot of the others were in primary care practices, outpatient practices, and in the case of the Envisions and the Team Health's of this world, were really more ER-based and then moved into other settings.

It came out of in the early 2000s being a focus with the hospital based DRG reimbursement, where there was a quality corridor that depended upon certain quality metrics that you could either have an enhanced or decreased reimbursement - a slightly nuanced payment reimbursement for the same DRG. And, for the first time, the CFO is now on the side of the CMO and the CEO being able to sway them over. So, we did need to focus a little more on the quality side of it – and, that's really where Sound Physicians started. I think that DNA carried on throughout the entire trajectory as we diversified into other service lines - critical care, emergency medicine, anesthesiology, a lot in the SNF space as well. As you mentioned, about 5,000 physicians across those service lines, about 500 hospitals. In addition, we took about $2 billion in risk across a variety of governmental and commercial payers as well. When it was truly, based upon our ability to reduce spend, particularly in the post-acute discharge segment. I think that part of it now, is that there are a lot of others that came into the market, but they came in even deeper on the value based care side as it was evolving. They were there as it was evolving, figuring things out and they made a lot of mistakes across those years, particularly as they were focusing on decreasing the post-acute spend where about 60% of the spend in the patient's 60-day care that takes place after they get discharged from the hospital. There are a lot of things that we learned by trial and quite a bit of error in that piece of it as well. So, I think that may be just some of the slight nuances we had at Sound Physicians versus the way that some others approached it that.

Experience is something that you draw upon every day at MedQuest given the nature of what MedQuest does. So maybe we transition into MedQuest, which is clinically focused on imaging centers, MRIs, mammography. In many cases, if not in every case, MedQuest does this in partnership with a health system. Do you want to just describe what MedQuest's strategy is and the connection between Sound Physicians and MedQuest?

Sure. And you hit one of the key ones. Just a quick synopsis on MedQuest. MedQuest has been around for 25 years, three primary phases. In the late 1990s until about 2007, 2008 - obviously long before my time - they were just an aggregator of imaging centers. It originally started out whenever Stark Law and anti-kickback went into place in the late 1990s. A lot of physician groups were having a vested interest, including imaging where they were self-referring. And they grew to about 120 centers, 15 states, based in Atlanta and went as far west as Arizona, Nevada, et cetera. Around that time, Novant Health, which is a large not-for-profit health system out of North Carolina, had a lot of overlap in footprint with MedQuest and liked what they were doing. And like a lot of health systems, they have their enterprise arm, their investment arm, their partnership arm - they're almost kind of quasi private equity arm if you will. And, they acquired MedQuest and then they immediately did what a lot of health systems do. They began to rationalize the acquisition and take away, in some ways, some of the things that were very unique and good about it that were a real interest in acquiring it. They shrunk it down both from a footprint standpoint took it down to about 50 or so locations where we are today, predominantly in the mid-Atlantic and the Southeast. But, at the same time, they were doing something that really wasn't happening in the space. And, this will get to your point in a second. They were operating both hospital-based and freestanding centers underneath the same umbrella in the same market in some cases literally a mile or two apart from one another. Quite honestly, even now, there are a lot of health systems that don't want to do that because they worry about the cannibalization of the very lucrative hospital-based imaging business. They worry about going into their freestanding centers and pulling that volume away from the hospital. But, that's what MedQuest did underneath the Novant umbrella at the time, from 2008 until really the end of 2022. So, over a 14, 15 year period of time, they were able to demonstrate a model in which you could both grow and actually create a complimentary sort of hub and spokes aspect to the service line. And I know that's one of the things that interested me, it's one of the things that interested TPG. There was quite a bit of private equity money looking towards imaging specifically just because of the explosion and the growth of the technology and the things that can be done in imaging. And then, in this third phase that we're just recently into, the Company is carving that business out and focusing not solely, but pretty tightly, towards healthcare partnerships. I spoke on a panel at the SCALE Healthcare Conference in New York a little over a month ago about this specifically and, I do truly believe - once again it sounds like a cliche phrase - but,

The sweet spot of healthcare is where you can combine the strength and stability of a health system with the agility, the nimbleness of an organization that's got a focus such as ours.

And imaging or in other spaces very analogous to what we did at Sound Physicians within hospital medicine, emergency medicine, critical care and anesthesia. A very narrow space where you have the gift of focus, you have the ability to execute in a much more nimble fashion than a health system can – but where you do it in partnership with health systems. Early in my career at a company called Rehab Care Group, we did the same thing within the rehab space as well as within outpatient rehab and home health. Very narrow focus, very strong ability to execute. In imaging, there's been the concept for a long time of site of care neutrality. Effectively, regardless of whether you're going to a hospital based or a freestanding location, you get charged the same amount. From a pure consumer's perspective, it makes sense. It's like, okay, I'm going to get the same machine, the same scan. Why is there a different rate depending upon a designation that takes place on the backside? There are some aspects to ensure higher quality and higher focus, but in many cases, on the surface there's really not a difference. In some cases, because of sort of the capital intensive nature of this business, it's some of the difficult capital procurement processes with health systems, the equipment in the hospitals is actually more antiquated than the equipment of some of the freestanding providers like the RadNets of the world. So that's really where the opportunity is. And that's where our focus is - partnering with, in a joint venture fashion, health systems, but pulling underneath that umbrella, both hospital based and freestanding assets under the same market. Common marketing team, common scheduling platform, common capital deployment team so that we can create those complementary models. But being able to allow the hospitals to be able to get out of their hospital base and become much more of an ambulatory, retail oriented footprint for imaging.

Since you took the reins at MedQuest, in a year and a half, how has the business performed in terms of partnering with a broader coalition of client partner health systems across the country? Obviously long standing, focused relationship with Novant and its footprint, but now a very different business model, open architecture, willing and able to partner with systems across the entire country. How is that going?

Yeah, and I'll kind of get to that in a second. But the first thing I'll say is - and this is an experience I had from Sound Physicians as well where we grew tremendously over a period of time - we wanted to have a deliberate focus on making sure our platform was ready for growth. The MeqQuest organization had been a wholly owned subsidiary as part of a large not-for-profit business for a decade and a half almost. So, we had to bring in, I had to bring in an entirely new executive team. I mean, everybody was new - CFO, CIO, Chief Clinical Officer, COO, Chief People Officer. The one person I kept was the former CEO who's the development officer here. So, we needed to bring in a whole new team. And, then they needed to bring in a whole new team. We had to put in new systems, IT systems moving to much more advanced, cloud-based environments with a higher level of cybersecurity because when you do partnerships with health systems, they have to have that. So, we really didn't go to market a whole lot - at some, inbound interest through relationships, through some of people I knew through Novant relationships, through TPGS relationships, etc. But, we really didn't go to market deliberately until earlier this year, mid-year, maybe Q2 to be able to go out and really start canvassing for relationships in an advanced way. Because what I did not want to have happen is we go out, we launch out of the gate and then we collapse underneath our own weight. And you know, once again, I'll go back to TPG - the private equity backing - and some thinking with it.

Know who you're partnering with and make sure that they have the same focus and the same mindset of how you want to grow and that you want to make sure you do it in the right way.

And they did. So, with that being said, yeah, we're in advanced discussions with about a dozen different health systems. Some would be transformational relationships because they would effectively double the size of MedQuest overnight. Others are much more tuck in from there. We have a target size that says if we're going to pursue a market, we want to make sure we feel like we can grow to eight to 10 imaging centers over time in that market. So, we have a certain target level of concentration. But you know, as we discussed on the panel a month ago, number one, when you're talking about doing anything with the health system, it becomes an elongated process. You start talking about a joint venture, which is effectively a marriage for life. That adds a lot more to it. And then you take something, such as imaging, which is so inherently built into the thinking of a health system - this is what we do, this is part and parcel to our offering to the community. These things take not weeks and not months, but literally quarters, if not years to work out and kind of work through. We're at the phase where we're on the cusp, knock on wood, of being able to announce some exciting things here possibly by the end of the year. We're running out a little bit of working days, if you will, to get that done. But if not, then shortly after the first of the year on a couple of the new relationships and partnerships we have. What's interesting is that when you're dealing with them, you've got the different constituents in the room. Your Chief Strategy Officer, the person who's generally in every health system now trying to drive these type of deals. They're all for it. They're aware of the pressures they're facing. They're aware how they need to be better on the ambulatory footprint and outreaching into the community using things such as urgent care and ASCs and imaging as well. Then you'll have the operations folks, who are always going to try to make the case, of "why don't we just do that ourselves?" And of course, the retort to that is oftentimes, not that I can say it, "why haven't you then?" And then the CFO. So, there's a lot of different constituents that you need all the thumbs to come up on it. And it's a decent amount of time to make sure that everybody's aligned with it because it is a big risk for them if something were to go wrong with their imaging platform.

What beyond it taking a very long time and the different actors that come into play representing the system's needs - you mentioned several of those C suite positions - what other advice would you give an MSO looking to knock on the door of the health system marketplace and introduce their differentiated service offering outside of imaging? And that this brings me to my second question, which is, where do you think health system MSO partnerships are heading? We've got a section on it in SCALE Community - just that question, because we think it's fascinating and we are very bullish that the number of MSO / health system partnerships will grow significantly, as it has done over the past 10 years, looking forward. And that will open the door to many more interesting developments and innovations as well. So really, a two-part question. What other advice would you give an MSO that's new to the health system partnership space? And, do health systems like to see from potential MSO partners? And where do you think the category is moving?

Yeah, I'll start with the last part, because I think it's easiest to work backward in the other direction. I'm also very bullish on it, and I think it's because success breeds success. And I think really the industry is almost demanding it. And on the success breeds success aspect of it, there are great examples of it. I mentioned several of those before that I'm very close to, but there are a lot of others as well. Whether it's urgent care, whether it's ASCs and, even now, in the imaging space - we're certainly not alone in this endeavor.

Our approach is slightly nuanced and different because of the depth and breadth that we want to take with our relationships is a lot more than others have.

But, I think people are seeing it in other health systems. And that one thing when you work with health systems - in my experience, when they see their other sister health systems and there's a lot of movement among them, something that works over there, it's like, well, why are we not doing that? I think that's just going to continue to lend itself to more of these partnerships. The second thing is the continued pressures that are going to take place, whether it's on the capital aspects of it or the payer side. It's just going to require it as well. So that piece of it I'm very bullish on as far as advice goes to people. So, I would always be looking for partnership opportunities when you're having the discussion with the health system - look beyond your core offering. Where can you be complimentary to them? Where can you do other things that are important to them? In our world, you talked about mammography, obviously that's a big play within our space itself. You've got MRI, CT, and the PET CT side of it. But, within mammography specifically, understanding, where they're focused in on their oncology, understand those downstream implications of it. So where can you be complementary to them in ways beyond just your core offering? And you do a little homework on that and understand where can you do that? We talk about a lot of time now in imaging that we can be another flag for them out in the community, depending upon their ambulatory strategy. So when you're talking to them in a broader sense, number one, they're going to view you more as a partner versus a vendor and think about you in a more meaningful way for you to understand that. I think it's very easy just to stay focused. This is my lane, this is what we do and that's important. But, it becomes a little bit of table stakes. They expect that. And once again, it can fall back to, we can just do that on our own. So, number two, always be thinking through what's happening, that you can be innovative in your care delivery as well. And that kind of goes a little bit to that first piece of it is that side of it. So it would just be, think broadly, understand broader strategies, understand how your service can be complementary to that and through your initial discussions, make sure that comes across, because those will be things that will resonate with them long after they move to another meeting or another meeting where they have these kind of key strategic priorities. If this can weave through that, it feels like it can tie in as well.

I do feel like the MSO market is perfectly positioned for these health system partnerships. And I have an interesting takeaway that I repeat often that the number one thing that private equity has done for healthcare in America is produce MSOs for the benefit of health system partnerships. And it seems an odd statement to make because it seems a little premature. But my sense of the health system space is that they're slow to move, as you mentioned, Jason, and they like to move with partners of similar large size. They don't feel that comfortable with tiny assets, startups. They want strength and certainty, low risk. And so what have we done? We've converted tens of thousands of practices that are all disparate, small onesie, twosie, tensie practices into MSOs with 500 to one thousand physicians. And we've offered those platforms and are increasingly offering those platforms, urgent care, ASCs, imaging, to health systems to partner with, which are far more likely to succeed. What are your thoughts on that?

No, I mean, I agree.

Maybe take that thought and turn it into a question. What else do you think has or is private equity doing to facilitate improvements in health care across the country?

So, first off, I agree. Obviously because of the Steward relationship and some of the things that were taking place there, private equity has taken a little bit of a hit. But you don't throw the baby out with the bathwater, if you will. There's, there's plenty of other, counter good examples that private equity to your point does drive just a greater degree of.

Yeah, but I would push back on Steward. That's another example of being an aggressive lender, sale leaseback sponsor. It's not traditional private equity. Everything gets bucketed together. But if our politicians understood the difference between a Cerberus, Apollo and even a Blackstone approach to high yield debt versus a Welsh Carson approach or a TPG approach to growth equity, the world would be a much better place.

I agree with you. I mean, once again, to your point, it's easy, particularly in an election cycle - so thank God that's over - to be able to paint things with broad brushes and throw everything in together. The other thing that I just feel like, quite honestly that private equity brings, and it's built into the name so it feels like it's a little redundant, is the equity itself, just the capital aspect of it. Where more and more health systems are becoming capital starved and they have greater needs as some of their assets will see the ivory towers that get built here and there.

But if you go just to the rank and file hospitals around the country, there's a lot of capital neglect that's taking place and not just in imaging, which once again is very capital intensive business by its very nature, but just sort of broadly. With that the ability to come in and be able to provide another equity and capital arm to the health system so that they can keep up with the individual

providers that are either equity backed, that they're competing with for certain services and keep those services within the health system. Once again, I'm the biggest advocate for the healthcare capitalist system because I feel like this builds the better mousetrap. It forces you to think about the consumer, it forces you to think about the technology and it forces you to think about the providers and what you do with them within that front.

So I think that by the very nature of all the things that we've talked about that an MSO brings gift of focus, gift of execution, being able to stay at the forefront, drive it for the health system, keeping those patient.

The other thing that comes from it, and you mentioned the aggregation, is just becoming a learning organization. You can then bring to a health system things from different markets that you import and then maybe from their market export to other markets as well. We actually start Friday of this week with the first pilot of it a remote radiologist read. I'm sorry, the technologist reads to where you don't even have the technologist on site. They're remote with somebody else on site to continue to meet the supply demand imbalance that is taking place. Overall, certain health systems are not ready for that. As I put it to them, they're not progressive enough right now. They're getting resistance from their academic, physician arms. But, it's an example of what we're doing in certain markets that are prepared for it or in markets that we control completely. And whenever you are ready, then we can bring it to you. And I think that's another advantage of sort of a broad footprint platform is you have the ability to beta test things across multiple markets and pull in best practices from those markets when you know, when the time is right.

You've led national platforms that are very diverse in terms of service offerings and physicians and national platforms that are far more focused, for example, MedQuest. You've also seen regional density and you've seen the benefits of national footprint and market penetration. How do you think about those two subjects? Because they remain paradoxical to a lot of CEOs. Should I diversify? I know that my patients would love me to offer them everything, but my managers will certainly struggle with the added complexity and risk. Should I expand into non-contiguous states, not just adjacent states? There's an opportunity on the other side of America, the west coast, either here or the east coast. Should I. Should I take the opportunity on? Should I grow slowly, incrementally and linearly? First regional, then national? How do view those two subjects? Are you, are you strongly skewed towards one versus the other or do you see them all as circumstance driven?

I would separate even those two questions into another one. I don't worry as much about geographic distribution - just for me and the businesses I've been involved with, which as you mentioned is across a variety of different sectors. I think as long as you're committed to what's required of the local infrastructure, putting that into place, it just provides you greater relevance across the country and you can fill in the gap. So that part of it has never really concerned me across time zones, across geographies, et cetera. There are certain reasons I prefer to avoid California, if I can, but that has more to do with the regulatory piece than anything else. The part about diversification though that is one that, I'll just say it, Sound Physicians, we struggled with greatly. We were always getting asked by hospital partners, "Hey, you're doing great in this service or that service. Can you also do this?" Because they were not happy with something, whether it was anesthesia or whatever. And I will say, you know, we made some mistakes in both understanding the complementary nature of it and the way we could leverage our back office MSO functions across those. And a lot of our spaces is around the recruiting, privileging, credentialing functions that you have to have in place and how those kind of crosswalk between them. And then we really we spread our teams way too thin.

I would say if you're willing to drive in every direction, you better be willing to drive in reverse.

Yeah. And I mentioned before some of the retrenching we did in our value-based care plays there as well. One example was we entered into the bundle payment program. We were the largest episode initiator when it came out. And in the second iteration of it, BPCIA that came out. For those that aren't familiar, effectively what it was a governmental program that was put out that said that you would take risk on certain services once there was anchored admission to a hospital. It was perfect for us because if we started avoiding admissions to hospitals, we would be out of business since that was our entire business was contracted with hospitals for their acute care services. But, post-discharge, for that, you would take risk on a 60 day episode. So, the bundle payment care initiative was the program - we started taking a look at that. This is custom made for us because we know what the DRG payment effectively is going to be for the hospital. Patient gets discharged. And those were largely unmanaged in the past. So it wasn't even necessarily good healthcare. Certainly wasn't good business. People would get discharged out of the hospital. What would you do? Find the quickest place you can get them out of the hospital. And they could very well go from an inpatient rehabilitation facility to a SNF to a home health, all within a 60 day stay, where you're like, do you really need all of that? So the program itself lent itself to what we felt like we could do. Our execution upon it was horrible.

And how could it not be?

Yeah, it was a pilot.

I mean, not only you're doing something for the first time, but it's not like you're not busy doing what you normally do.

That's exactly right. And we refined it over time. We went out and we hired a bunch of nurse practitioners around the country and started deploying them to people's homes when they were discharged. Because our whole mantra was home, home, get them home, you know, keep them home. And if they ended up in a shorter facility, like a SNF or something else, get them home as quickly as possible. So went on and hired a bunch of nurse practitioners, deployed them around the country, found out that's not our business. We're not good at the logistics, size of it, that's kind of pretty common business now. My daughter's a nurse practitioner, works for United Health, does this all the time for Optum. But, it wasn't something we were doing. So, we went out and hired a bunch of nurse practitioners. A few months later, a year later, we had to let go of a lot of nurse practitioners. We went out and hired a bunch of SNFists to go see our patients that went into the skilled nursing facilities. And what we realized very quickly was that we had misaligned incentives. Their incentive, because of the way they were reimbursed, was to keep the patient in the SNF as long as they could to be able to generate the professional fees that are associated with it. Our goal is to keep that short. So,we had to kind of get rid of that as well. And we finally hit the sweet spot. It was really going to what was our core in that business, which was, you know, speaking to the physicians, educating them on what's the highest quality of care, what are the best SNFs that you go to. You look at a given community, it's amazing how the difference between a Medicare Advantage length to stay in a SNF and a Medicare fee for service stay in a SNF. Same patient population, same diagnosis, just different payer, different financial incentive for the SNF. But, we began to manage that part of it very directly and that's where we became very effective on that piece. So, coming back to your broader point with those examples...

I think it is to understand those things that you tangentially can be involved with and leverage your core strengths and your execution abilities.

Or, the alternative is be serious that this is starting an entirely new business and invest in it as such. Don't try to do it in a half-assed way to where you think, hey, this is a great opportunity to become more relevant to my partners and kind offer another thing that they need without the full commitment. And I'm going to make all this money on the margins because I've got all this built infrastructure. Just be very honest with yourself, looking in the mirror and say, what is this? How much can I leverage on my current, how much mind share from my team and myself can I leverage against it?

It's almost like the de novos versus acquisitions debate. The diversify versus remain focused debate has similar qualities in that you can sort of guarantee certain attributes and hardships.

When you open a de novo, it has its timeline to maturity. You know that it's probably not going to come with a multiple on free cash and a high degree of free cash-based leverage multiples. It's probably going to be asset-based lending, working capital revolver and it's going to be a hunt for new patients, new providers. A high degree of staff turnover initially because no one's ever worked at the de novo before. So everyone's coming together for the first time. You know that you're going to have these systemic ingredients, some of which will be reflected in your P&L and balance sheet and some will be a lot more intangible, but they'll be there. And you know, similarly when you do an acquisition that you're going to deal with a large deployment of capital, you're going to deal with integration issues because you have to take existing everything and find place for it in your existing platform and so you're not escaping those integration issues. And so, similarly, when we talk about these other approaches, we have to think about what's systemically going to be there for us. When we talk about diversifying revenues into new markets, you're talking about, to some extent, a de novo culture, right? New revenue streams require new people, new lessons learned. Timeline, like you said, essentially a timeline to maturity. How much investment, how much P&L red, how much working capital deployment, how much intellectual capital buildup do you need before you reach maturity? And so, your year zero to one is always going to look very different than year one to three. Because just like joining a new school or a new company, that first year is always, you can guarantee a high degree of chaos. And so that's just interesting that mature companies sometimes underestimate because they reach stability. How much instability resides in de novos? I want to talk to you about the future.

Just one final point on that, but I'll also now to talk on the other side of my mouth. I also feel like it's an equally big mistake to just kind of go into your insular shell and say, "hey, I do this one thing" and don't look for opportunities to become more relevant. In the case of health system partners, as I mentioned there, I think that's one of the key things to think through or just in case, in relation to the market. Otherwise, you become Kodak or you become Xerox, you become another company that just does not look at the world around them and understand it. But the point being, you've got to do that side, particularly as the

strategy leader for your organization. But, also you've got to be very conscious about the tactical execution that takes place so you don't put yourself in a bad place. It is truly trying to strike the balance between the two. Because as much as we made those mistakes at Sound Physicians, the organization wouldn't have grown. We certainly wouldn't have had the success that we had across those years and, the recapitalizations, if we had them just sort of say, singularly threaded on the one thing that we offered out of the game.

I couldn't agree with you more. That's, that's our philosophy too. We sort of compare and analogize leading a company to skiing. And with skiing, they always say if you're not falling, then you're not really skiing. And with running companies, if it's too easy, that's a sign that you've delegated the future of the company to macro conditions. And if it's hard, that means you're looking beyond macro conditions and creating opportunities that may preempt macro conditions and might even influence macro conditions. So the difference between harvesting and sowing. All right, so let's talk about the future. So we've got a few trends going on here and they're really exciting. We spoke about hospital partnerships, health system partnerships with MSOs accelerating. We also spoke in our last month's leadership series with Wyatt, who runs the healthcare team at Cain, and he spoke about the likelihood of health systems coming into the MSO space from an acquisition standpoint. We can't private equity exclusively forever. At some point a sponsor is going to look for strategics to sell to. And lo and behold, GI Alliance announced its exit to Cardinal Health in the last few weeks since we had that conversation with Wyatt and made that prediction (granted that's pharma but it's very strategic). So, our prediction is proving to true. Within a matter of weeks, here comes the large strategic and buys the largest GI MSO in the country for I think north of $4 billion. An unbelievable valuation for a group that I met with about 10 years ago. Eight years ago had no more than 60 physicians at the time. Today it's 900 physicians. And so there is a strong argument that partnerships lead to investments and even acquisitions and health systems and other large healthcare strategics will become an active buyer of best in class MSOs in this country. So maybe that's one momentum play for the future. But I want to hear your thoughts on that balanced with other key themes and trends in the imaging space, specifically none smaller than AI in healthcare technology, in healthcare analytics, increased efficacy and efficiency in healthcare, lots of imaging going on in this country. How efficient is it today? How efficient is it likely to be in the future? Patient risk stratification - what role does imaging play in that? Value based care is sort of the large theme - these floating bubbles of trend and direction. Which ones are you most excited about? Where do you think the imaging space is going?

I agree that I mentioned early on about the enterprises arms that a lot of these health systems have and those effectively are operating almost as kind of quasi private equity inside of health systems. And I do feel like there's going to be some more combinations or some announcements that will be made. A joint venture that's getting started between Memorial, Herman, Baylor Scott & White, Providence and Novant. That's kind of this arm that's going to be looking at some of this stuff as well. And I think you're going to see more and more of that where they're going to want to have at least a passive investment. I mean, we obviously have quite a few passive health system investors that are part of our organization today. When I say passive, they don't control the majority of the organization that private equity does. I can see where there's going to be more of that because it is a way for them to combat, number one, the perception of private equity and, number two, optimize in many ways as well. So anyway, that's just kind of on the macro health system space. On imaging specifically, you hit on a ton of them. I mean, what I'm going to start with is really the basis of it. It's just the continued advancements with the technology itself. As I started looking into it two years ago, it's amazing the things that couldn't be done at all years ago. The type of detection, the level of detection - AI plays a key part of that. So, that part of it to me is kind of the precursor to everything else we'll talk about. The second piece of that comes in is the advancement in the pharmaceuticals. And when those two crossover with one another is kind of what's referred to as theranostics. You hear what the Leqembi, the Alzheimer drug that was announced about a year and a half, two years ago. But this idea that some of these clinical trials and pharmaceutical testing and now the things that aren't even pharmaceutical testing that are being treated, it requires imaging to be able to view the results of it, both as it's being dosed, but then also how the progression is going over a period of time. And that is just an amazing advancement.

So the continued push within the space of new drugs that are coming out, new treatments that are coming out, new interventions that are coming out that require imaging is tremendous.

Also, and you mentioned some of this, the scans that used to take at half an hour, 45 minutes, an hour to take place, now you can do in like seven minutes. Time is no longer a limiting factor in this space. It's the technology and the scans. You used to sit in there, they have the open MRIs, they made a lot of noise. They

were uncomfortable for people, particularly the closed board. But now the technology has advanced such a tremendous amount. How do you continue to work with the patients so that they feel like a patient and not a widget as they're coming through. That becomes a limiting factor on just the throughput of the centers and that side of it by direct correlation to that. Because there aren't any more radiologists and, or technologists that are coming, you know, coming out more technologists, but not really radiologists. It's the things that we talked about earlier. How do you do more remote reading?

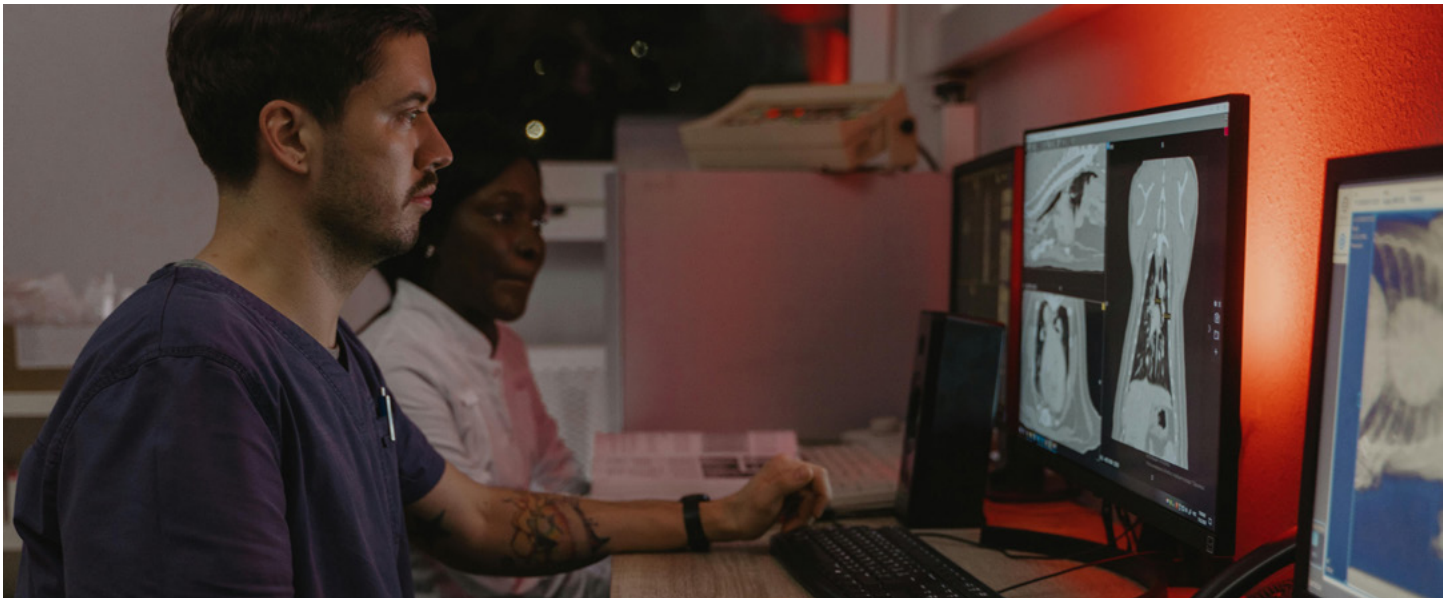
How do you kind of add AI to not replace but to assist the professionals to be able to operate the top of their license to call out specific areas abnormalities over time. Really the leading space in that is mammography where people will hopefully have annual mammography. So you can watch that progression over time. You can look at things from the past to where they are. But even with prostate cancer and other areas to be able to look at that part of it as well. The fourth, which is kind of where we're focused as well with the health system is around becoming much more ambulatory focused and moving things out of the basement of a hospital to an MOB or to a strip mall, where it can be that accessible to go in and get that scan done in a very convenient way. And how do you arm the consumer with the way as much as you possibly can for them to control the scheduling process, the results process, you know, along with their referring physician.

To be able to empower them in a way that they are in every other aspect of their lives.

And we all have these, you know, if not one, we got multiple of them that we're carrying around today. So how do you use those in a way to empower the consumer to be able to do so? So that's sort of on those pieces as I think about it on. It's interesting as I joined this industry specifically how kind of antiquated it was on the payer side though, it really is a fee for service environment. There's virtually no value based care play in imaging whatsoever. The only sort of play within it is between trying to get people out of the hospital based setting because of the higher reimbursement into a freestanding setting. And that's kind of it. No real focusing on quality, no real focus on anything else. I reached out to some of my former board members at Sound Physicians, which are part of Optum, and asked them about it and they were like, no, really, it's not something we think about. Which is kind of crazy to me. When you think about what the technology can detect in a patient population and the difference between detecting a potential cancerous issue with breast cancer at an early phase versus a late phase. Not just the benefit for the patient - of course, the mortality rates, etc. – but also the cost benefit that's associated with that. So you hear about full body scans, you hear about some of that, and there's kind of debates on that, whether that's really the best way to approach or not. But certainly if you take a look at a specific demographic based upon their family history, based upon some of the genetic aspects of information that's out there. And we're also partnering, started a pilot with a couple of companies that do that type of testing in addition to ours to better identify potential risk patients and proactively work with that patient group and bring them in. I think there's tremendous value for the overall health of the individual as well as the overall cost for the larger healthcare community writ large to be able to identify those things. And if you combine that with the equipment that can now detect in a much easier way, creating a much easier access point with an ambulatory, retail oriented environment and kind of pushing that out there, I think that there's ways for us in imaging to become much more upstream as it relates to value based care. I added a board member just who started then back in my last board meeting in September. And I wanted to have somebody with that experience in other industries because I want to position us to take that proactive approach. So anyway, those are a lot of the areas that I feel like the industry is going and quite honestly where I want MedQuest to drive.

Why is it still so hard for a patient when they ask for their imaging to get something other than a CD?

Yeah, it's. I'm glad you mentioned that. So, once again, coming into it fresh and I started to realize how much we spend on burning CDs. And I was thinking back to almost my college days. I can't explain exactly why. I think it's just one of those things that people have got comfortable with in this space. But as you have disruptors that are coming into it, there are now new PACS platforms and new things that are just becoming more progressive and leveraging technology in other ways. So I agree with you and I think that you're going to see a significant amount of change with that approach. RadNet, which is clearly the leader in this space on the technical imaging side, is definitely the one that's at the forefront of it. And I think, just like everything else, once people have seen it - nobody carries the Walkman anymore, so I think the same thing is going to happen. And again, I mentioned this earlier, to put it in the palm of somebody's hand, in their provider's hand as well. There's no reason that can't be done. The technology exists in other industries.



Not only that, like, just yesterday my wife had an ultrasound. I asked for a copy of the imaging. They looked at me like I had a third eye.

Yeah.

And secondly, you carry a CD into your other doctor or like an orthopedic office and they'll tell you we don't even have a CD reader anymore.

Yeah, no, I agree with you. It is an area where we've selected and are partnering with a new PACS vendor now. We've rolled it out to a few of our sites in North Carolina and South Carolina that we're working with our radiologists, and that's what going to allow us to do is to digitally.

You mentioned the complexities when Sound Physicians entered into anesthesia and the limited resources you had for a lot of your recruitment and back office. We do a lot of work in radiology. How concerned are you as you look to expand in capacity and the availability of radiologists to read your images?

Those in my mind are the two biggest professions that have a shortage right now. At least in the case of anesthesiologists, you have CRNAs and anesthesiologist assistants and things like that to supplement them. You don't have that in radiology. So to me, that's where AI will ultimately come in. And it has to come in and is coming in on that side of it. With that being said, the predicted demand into the future far exceeds that supply. So there's a great level of concern on our side and I think on the industry side, which is why we're looking to define ways to augment it as much as we can with alternatives, once again led by AI. And this is, you know, I have to say this in all these, in case somebody takes a snippet and carries away with it. It's never to replace the professional decision-making ability of the radiologist that is incumbent. It's to augment it and to help them so that we can move through it quicker, call their attention to specific areas, that type of stuff. The second piece, and you look at this in all spaces, where are there just needless work that radiologists are doing today that can be farmed out to assistance and things like that, so that they are truly just focusing in on the top of their license side of it. But certainly maybe something you and I can follow up on as well. We're always looking for options and alternatives, from remote aspects to international aspects to on site aspects to be able to, you know, to be able to.