CAPITAL AND CARE: HOW INVESTORS AND INNOVATORS ARE BUILDING THE FUTURE OF HEALTH CARE

Announcer 00:00:05

Thank you for joining us. Please welcome the panel to the stage.

Tina Reed 00:00:26

Good morning, everyone. Thank you so much for being here today. My name is Tina Reed and I'll be moderating the panel. Today we're going to be talking a lot about—a little bit about one of the biggest forces in the health-care companies that are shaping health care today, and that is venture capital. And so we've got a great panel here today to kind of give us some insights into how they think about what makes a good investment, how they think a company can truly make the biggest impact, and shape health care from the inside. So, I wanted to start with one of the topics that—I'm so sorry, we're probably all sick of talking about already, which is AI. Obviously, AI has been part of health care for a long time, but LLMs have just pushed it into the forefront of the conversation and probably in every conversation we're having here at Milken. So I wanted to start by sort of just talking a little bit about the landscape: where are we right now with AI in health care, and how do you see it really evolving and shaping health care through the companies that you are seeing in your offices today? So, Nancy, I'm going to throw the first one to you.

Nancy Brown 00:01:37

Great, thank you so much for having me. So, I am an investor, mostly tech-enabled services at a company called OAK HC/FT, and I've been a health-care operator for a long time. I'm sure there's a bunch in the audience. This has been a very difficult area. Back when I was running a health plan, a payer-provider, if we had a half a percent margin, we were thrilled, just to be able to cover all of our expenses for our patients and operations. So, we finally, as I say to many people, we've lived long enough to see tech come into our market in a way that it will really make a substantial difference in our ability to deliver services. There are many things it'll do, but I'll focus on the service side. So we're seeing things that many of us have never seen, which is we're going to board meetings and seeing growth in the company with a declining amount of people, which is a very unusual thing in a tech-enabled service company. So, very, very exciting that we're—and these are, when AI started to be buzzy, people were like, well, how will health care figure

out what to do with it? I'm like, our problems are well established. We've had the same problems for a long time. And obviously there's a lot of differences between what's happening in pharma services versus what's happening in care delivery, etc. But those things, there has been plenty of obstacles that are now being moved out of the way, not around clinical decisioning, but more around ops support. The other thing I'll say is, which is a completely different topic, is, I'm sure, like my colleagues here, we are getting endless amounts of pitches from people who are building AI—"native"—AI-native companies. And the one quick story I'll tell as someone who built—I came out of athenahealth as one of the founders. I pride myself in what we built there. I understand it was a long time ago, but people will come to me and say, "We built that whole system in the last two weeks." I'm like, "Great." And it's a little side of me, but I had one recently who, after we didn't invest, said, "Can you come spend some time with me? I want to talk about this. We don't have any idea how to go to market. Like we don't know—meaning we built tech, but we don't really know any of the other things that we need to understand to be able to bring these tools to market." So, and I—and the other thing is if you built it in two weeks, what keeps the next person from building it in a week and a half? So those are two different sides of the question. But yeah, exciting times.

Tina Reed 00:04:00

And that's actually really helpful. I know that I've spoken to several health systems that said, "We're actually already building some of the stuff in-house, too." So then when you're thinking about investing in a company and you're thinking about how do they differentiate themselves and make them necessary for these health systems, how do they position themselves?

Nancy Brown 00:04:15

Yeah, that's such a great question. So in the spectrum of, if I were to show you the list of companies that we're looking at, you have ones that are very specific. We're going to do inventory management for a hospital, right? And then there are platforms. We also spend a lot of time with people like Palantir and others who are, I'll say sort of generically, in hospital systems, as a collaboration platform. And so this is going to become the—this is the age-old question, which is: Is it going to be best of breed individual products or is it going to be platform products? Is Epic just going to deliver everything that people need? What's going to be the ability to distinguish one from the other? What are the data rights? Now, data rights is a hot—it should have always been a hot topic, but it's a very hot topic now. So, we had one company recently that distinguishes itself on being able to keep data rights with the owner as opposed to the LLM developer. So all of these things come into play. And it's, yeah, it's becoming a very difficult time. And people are—that the evolution, I used to say being in health care, it was like watching baseball. You could miss most of the innings and you'd be like, oh, I see where we are in this game. This is not the case—if anyone understands that analogy—this is not the case anymore. It's like things are evolving so fast. So we may, as venture capitalists find the hottest, hottest company in health care using AI. And then they get—there's a leapfrog and it could have come from OpenAI. It could come from an unknown. It could come from an incumbent legacy system, who's bought some of these companies up—whatever. It's a crazy time. Good time for innovation, though, very good time.

Tina Reed 00:06:02

And I should have said at the top of the meeting here today that we also want questions from you. You can use the QR code and send those questions in, and we'll get to some of those by the end. So, feel free to send those questions in as they come up. Sofia, I know some of your research has actually looked into, talked to executives and found financial returns from health AI are concentrated in the back office. Can you talk a little bit about what makes you think about the opportunities outside of the back office?

Sofia Guerra 00:06:35

Absolutely. Thanks for having me. We've seen the early innings of adoption in the back office, traditionally revenue cycle, because it's a lot easier to measure ROI. And the business models and how you implement a lot of these solutions are on the edges, right? You're giving copilots to folks who are doing a lot of these use cases. A lot of the back-office functions sometimes are outsourced, so the go-to-market for a lot of these new companies to come in and provide a service or sell the work has been easier. What we're most excited about, and I think we're going to have a lot of conversation here today, is how do you move that to the front office? We've seen some early adoption of scribes and scheduling, but that opens the door to engagement between the clinician and the patient. And how do you leverage AI to do clinical diagnoses and treatment and augment the existing clinical teams out there? And I think we are going to need a lot of public and private collaboration to enable—how do we regulate, how do we pay, and how do we monitor a lot of these clinical AI solutions. But I think that that's where the biggest potential for the industry lies.

Tina Reed 00:07:57

Can you talk a little bit about the risks of that shift into clinical care, though, because obviously it's not without risk. And I think that's why a lot of companies obviously have focused first on that administrative side, because there is less risk on that side. How do you sort of de-risk or see if a company can kind of scale an idea as it moves closer to clinical care?

Sofia Guerra 00:08:17

Yeah. Our initial thesis then—by the way, this is all happening real time—and I think that we've never seen so much of, like, government and CMS and CMMI and FDA. The state's really trying to figure this out. Because I think it's an imperative for our system, and honestly, globally, to figure out how do we enable AI-first care. I think what we see, where the risks fall, is, one, patient safety, and where does liability fall in a lot of these decisions? That's still something that falls on the clinician, right? And so our initial thesis of the things that we're really interested in investing is this ability to be the harness and have a clinician on the loop as some of these tools are leveraged to provide care. It could be particular use cases like a wellness visit or triage at the beginning, but having the clinician judgment as part of that is so critical. Because I think that there are two big differences. There's the intelligence and what these systems can really do. I think when you kicked off the panel, we were talking about AI has been around for a long time, but really the capabilities in improvements in the last five years have been tremendous. But capability of intelligence is very different than clinical judgment. And how do we fill that gap? I think that we still have a ways to go, and having a clinician on the loop is the best way to achieve that.

Tina Reed 00:09:52

Open question for the panel. How far are we from having autonomous AI in health care?

Navid Farzad 00:10:03

It depends on what you mean by that. We've got a ways to go. But my definition of autonomous AI is, like, real autonomous AI, truly doing the work of a licensed provider today. Technically, we're probably not that far off. But it's health care. And so that—the technology is one thing, and then there's the getting it to the right people and the right places and distribution, which then includes things that everyone's mentioned already: the policy around it, the regulatory, the liability, the safety, the trust, like changing care and the way care is delivered. There's: How do we pay for it? The workflows, the change management—there's a lot there to—but with that said, whether it's in some of these sandboxes, we're in the baby pool. But there are things happening, and you can see some signs of it. There's the FDA, at least today, is trying to figure it out. And there's been some FDA clearance of some solutions that are autonomous. But even those

solutions in the wild are heavily harnessed. And, you know, right now, just to be really cautious and safe. Because you can do real harm, obviously. And a couple of cases and the headline risk and—and then, you know, then we take five steps back. And so I think that that'll be counterproductive. As much as all of us on—I won't speak for you guys, but I will. Our clock goes really fast. Venture is not the most patient, generally. But I think in this case we need to be, and think longer term, and think about durability, and think about sustainability, which means, in the case of autonomous clinical AI, not cutting corners.

Erin Harkless Moore 00:12:12

And there's still so much that is, from a data perspective, where it's just wrong. Right? And particularly, about 30 to 40 percent of Americans are using AI to access answers and solutions around their health. But the leading models, when it relates to women's health questions, have a 60 percent error rate. So I think when you think about some of these tensions, and as I was saying, we have a ways to go, right? We still have to have humans in the loop to be a part of this system. But if the data and the datasets are not robust and as accurate, we can't count on that information to drive great outcomes for patients.

Sofia Guerra 00:12:52

What I'll add is, I do—I am super bullish about the potential and really thinking about these pillars that Navid was bringing up. But consumers are full-on, like, using these models. They, more than ever, have access to more data: wearables, bringing in your health-care records. So as clinicians, I have deep respect. I'm not a clinician myself and have deep respect for the profession and years of training. And I believe that we're—AI doctors are not going to replace doctors, but the doctors need to leverage AI in the next year, two years, three years, and in the short term, to really change the way that we approach this, because consumers are expecting it as well.

Navid Farzad 00:13:38

It's a really good point. The other thing that I—we think about is: How do we—how do we implement these amazing tools with the existing—meaning we don't disintermediate the existing providers. As we all know, health care is plenty siloed. We don't need more of that. We need less of that. And the data liquidity—and just if we just go down these different paths, we're going to fragment it even further. So, that's not an easy thing to do, but I think that's, in my opinion, the best path. And, ultimately, get to a place where we're truly empowering the providers. As we all know, there's a huge shortage and we're not going to make that up with just more humans.

Nancy Brown 00:14:26

I guess the only thing I would add—one is just, I know we're talking about clinical autonomy, but there's a ton of nonclinical autonomy, which is fine. So it's—and having been through many of these cycles, obviously this is a different cycle. But I remember when first clinical decision support came and electronic medical records, like, it was—the privacy folks were crazy. Like, what is this? Who's doing what? Who's seeing what? Who's making decisions? And what we did, for those of us who were the early pioneers in that, we were really just automating the very thing that the physicians or clinicians were trying to do. So what is your intention? My intention is to diagnose. Okay, good. How do you do that? Okay. And then your intention is to order tests and read the tests and make sure that actually someone sees them and follows up on them. So, a lot of the things that we—you know, the way that I think about it is just making sure that the things that are supposed to happen, happen. And that the information comes out the other end with—right?—with the—and there's been all these examples. We used to have call centers with these, you know, phone trees. Is the patient—you know, you've all dealt with them probably either on the side of delivering them or on the side of getting one of them on the phone. A lot of this work is really taking those

things and just replacing the human with an agent. And so I would say that there's a lot that can be done before we have independent autonomous diagnosis. Just a lot of decision support and a lot of, like, looking through this also impossible—as you all know, we've been talking about this for 20 years—looking through an entire medical record, even if it is—even if the data is collected, and finding that one piece of information that's actually critical. Which most providers miss because they're still using, as I say, their fingers or their fingers to find these things, but they have to correlate them all in their head. So, a lot of improvement before we get to anything really wild and space age.

Tina Reed 00:16:19

I'm curious, when you've got these start-up founders coming in and talking about the incredible things that their companies can do, how do you separate just the crazy hype from something that's truly going to make a meaningful impact on patients?

Nancy Brown 00:16:35

Well, at the end of the day, someone has to buy these tools, right? So we probably all lived through the times when health systems and insurance companies and other like to do pilots and try out new technology and try out new things. I think those days don't exist right now. So everyone's really worried about the bottom line and how things will have an immediate impact on, actually, the CFO's office and the medical director's office, both of those things. A lot of our companies that would be considered to be clinical tools, autonomous—not autonomous, but agents, I would say, working collaboratively with doctors, are being bought by both parties: the CMO and the finance people together. Because you have to have that level of things hitting the bottom line. So I don't see people dabbling in things anymore or saying, "We'll look at this in four years and see if there's a return on investment." They need to see it right away. And even with that, some of them can't even afford to experiment with the tools because they don't have the budget to do it.

Navid Farzad 00:17:44

My response to that would be, I think we have it's an opportunity that's completely unprecedented. Where historically, I would say we've innovated or improved things around the edges, whereas now we have the tools and technology to really go to the core of the problem. Because at the end of the day, we've got such a shaky chassis in health care, in terms of our infrastructure. It's unbelievably antiquated, put it up against any other industry, probably. And that's something that I tend to like in a founder is—you know, they're going—first of all, they appreciate how hard it is, but they're also not afraid of hard. And they're going for the root of the problem that then, if they can pull that off, will be more durable and sustainable. Easy for me to sit here and say that, but that's why we love our entrepreneurs.

Tina Reed 00:18:43

I'd love to hear more about what you all have to say about picking founders that you think are going to be winners as well as understanding the underlying data that they're basing their whole algorithm on. Could you go a little bit deeper on that?

Erin Harkless Moore 00:18:56

Yeah, no, I was just going to build on Navid's point around, you know, we spend a lot of time thinking about that founder-market fit and what they're building, and particularly in health care. And a lot of our work at Pivotal, we're investing in particularly women's health, and also in care coordination, care economy—huge opportunities where often the founders themselves are the ones that have struggled with a misdiagnosis, a poor caregiving experience, trying to get help for their families. And so with that, I think it's easy to sort of see and to kind of have that real lived experience drive what you're building. But

without—the question ultimately, and this is what we were talking about, is who's going to pay for it, right? And you can have a great idea or see a gap in the market. But if there isn't a clear pathway to someone sort of purchasing that product or service or solution, there's no scalability. But I think some of the best founders in our portfolio—one example, a patient-centered sort of doula maternal health platform called Millie—the founder herself, a tremendous operator in the health-care space, almost lost her life. And the data has shown that doula-centered care improves outcomes, reduces C-sections, time in the hospital, all of those things. But it's not the care model that we focus on in this country to deliver. So she set out to build a platform and partnering with health systems, starting on the West Coast to do that. And so I think that technical background, but also the lived experience as a patient, honestly, were real drivers of her seeing that gap and building something that there—but at the end of the day, there had to be clear kind of buyers, clear users of this product. And she was able to build those partnerships and relationships with larger health systems.

Tina Reed 00:20:43

And then how did she convince you about the data that she was basing her product?

Erin Harkless Moore 00:20:46

Yeah. Well, I think in that instance, the data was pretty clear, in terms of the poor outcomes that we're seeing, at least from maternal health in this country, and particularly for women of color, right? It's some of the worst metrics in the world. And so I think that grounding it in the clinical outcomes was really essential to sort of seeing a care model that was going to set up a better form of delivery. So the data was foundational to sort of what she was building and identifying that problem and gap.

Navid Farzad 00:21:14

Nancy, you said it's not hard to find a problem in health care to solve. They're everywhere. And—but the appreciation, and I could see how this is tricky because people that are building in health care, entrepreneurs, are looking at people building outside of health care, and they're getting to revenue and they're getting to a product, first of all, to revenue. There's scaling so fast. Now, how sustainable is that? We'll see. Health care just doesn't scale that way. You know, you've got 18-month sales cycles, maybe on a good day. So it requires patience. It's just different. And so, there has to be this intensity: I'm going to die on the hill building this, but also I'm going to be patient and keep pushing when it's really hard.

Sofia Guerra 00:22:04

There's a—

Nancy Brown 00:22:05

Sorry, go ahead.

Sofia Guerra 00:22:06

I was just going to say, not for the faint of heart. I am always kind of trying to change how we look at founders, and especially in this environment. I think, Nancy, you made the point that you can build a lot of these things very quickly, right? So what prevents someone else coming in? I think that distribution has always been key to enable understanding how do you build a business model and align the incentives and how you're going to go to market. It is very critical to hit start, Navid, to your point. And technology and what you can build today is a lot easier than you did before. But that doesn't diminish the importance of teams that are really building at the edge and really understanding the capabilities of technology today, because you need to be so much flexible and adapt so much quickly today. So the moats that we thought existed before in the software era are getting totally diminished, but the teams that are evolving and doing product development incredibly quickly and always building at the edge and understand the capabilities of

these models are the ones that I'm the most attracted to today. Of course, paired with that health-care expertise and understanding of the distribution.

Tina Reed 00:23:18

What are the areas right now where AI has the most potential to really impact a health-care business or a portion of the industry? I'm thinking, for instance, caregiving is something that's come up in our conversations or women's health. Can one of you kick us off with an example of where AI can have the most impact?

Nancy Brown 00:23:40

Well, I mean, I would just—I'll give you a—it's, I can't imagine that I would bring it down to, like, GI, like GI is going to be the area, or women's health. It's really all of these service companies that—where there is real work that has to be done to see patients, treat patients, provide care, whatever, all of that. That labor component is something we all live, you know, live and die on, which is what's the unit economics? I would say this is a very simple business. You've got to sell a service, meaning you have to be able to go to Medicare and say, "We're going to take care of your patients and we're going to achieve this goal," and they're going to pay you a certain amount to do that. And then it should cost you less to do it, or there's no margin. Like basic stuff. Basic. I don't care if it's called value-based care. I don't care what it's called. Like, that's the basic stuff. And it's very, very hard to do it because there is—as much as you—we've been very efficient and effective, there's still human components, and that makes something expensive. So for each of our companies that are these big process companies, meaning we find a patient, we enroll a patient, we see a patient, we engage a patient, those are all steps that involve work. And a lot of those work steps now can be automated through agents. And this is absolutely amazing because the companies have always known what they needed to do. Like, we need to have this touchpoint. We need to do these four things with patients to make sure that the end-of-life experience is what it should be, or women's health. And so that's what we're seeing. It's an incredible ability. The other area, which is a completely different area than any of us have talked about, but we're doing a tremendous amount of investing in, is pharma services. So I've never—you know, I think I'm too old to be an intern, but if I could get someone in the pharma side to bring me in—the evolution of both discovery—I don't know here who's been a bench scientist. I was for about five minutes, just long enough to know I didn't want to do it much longer. And just thinking about the unbelievable progression of trying to discover something, and then clinical trials. Like, it very quickly—it's become—it looks cruel the way that we were doing things before between the animals and the people. And now it's just absolutely amazing. So in that case, it's different than just ops. It is actually the ability to model what's going to happen. And we just did an investment in a company that creates tissue, right? So, as someone who also had to use animals as a proxy, those—like, all of this stuff is changing. So it's a little different question than you asked—

Tina Reed 00:26:13

No, I love that.

Nancy Brown 00:26:14

But it is wild in the best possible way.

Sofia Guerra 00:26:18

I'll add to that, because I believe we're in the golden age of biology, and not because we're going to cure all disease in the next five years, 10 years, but because we're going to put so many resources and leverage this technology, large language models, AI, to develop new drugs, to Nancy's point. But how do you take all of the steps in the value chain and reduce the amount of time and the capital that goes into that? And I

think that we've made huge strides on the preclinical side, and this is where the models are having the biggest impact today. But we're going to have 10 times, 20 times the number of programs that need to be going into clinical trials. But that's the difficulty of running a clinical trial: the number of teams involved. How do you find these patients? How do you engage them? That all falls back to, I guess, the old health-care industry, right? So how do we enable these stakeholders, providers, clinical trial sites with sponsors, to really bring in the patients and really think about accelerating a lot of these complex operational problems that we have in health care to realize that vision? And obviously, then after that, you get a drug approved. How are you going to distribute it? How are we going to pay for it? So, I really love the biggest opportunities in health care that fall between the interstitial tissue between providers and payers, providers and pharma, pharma and payers. How are we going to pay for these drugs? I think those are the ones that we really need to reimagine to enable this future.

Navid Farzad 00:27:44

Yeah, it's very interesting to think about drug development. Totally agree. I think it's going to be better, faster, cheaper, and substantially faster.

Nancy Brown 00:27:53

Yes.

Navid Farzad 00:27:53

And, but it'll be better, faster, and cheaper to develop. Now the question is, will it be—will the actual medications once they're approved and commercial, will they be cheaper? Because how are we going to, you know, that payment is not a trivial thing. For humanity, it's incredible. Right? The new therapies curing disease. I think the next 10 years, I hope, are going to be unbelievable. And we've got to try to get ahead of that, in my opinion, on how we're going to pay for these things, how managed care comes in, and how does that all work together so that we can ultimately get it to the right person at the right time.

Nancy Brown 00:28:33

But what's really exciting, as though that's not all really exciting, is go-to-market's completely changing for pharma. So the days of having—I worked in a staff-model HMO. We did not let people come in and detail our docs. We had very strong opinions about what the medication should be and what the outcome should be. But most of the world runs through detailing of pharma reps. And because these are all becoming so specialized and because the data is so available, they'll be able to really, in the point of service, while I'm being diagnosed and treated, you'll have the exact drug that should be the treatment protocol come forward. It won't be the shotgun of, “Let me try to influence all of you, and then hopefully you'll remember my drug when I'm doing it.” So all of the—I don't know, I don't think I'd want to be an ad agency right now in this world. And I think—I love to see—we're probably all dealing with this: patients, loved ones, friends that have had terminal diagnoses who are now what they call—I just heard this term—like on a lily pad, where they've slowed their disease down. And they're like, “You can just wait. In two weeks, we could have another new drug.” That was not the experience of this world before.

Navid Farzad 00:29:39

On the ads. Can I make a request? I have a dog that when they see a dog on television, he goes crazy. And so can we just, fewer dogs in pharma ads. [Laughter]

Nancy Brown 00:29:50

Your dog goes crazy with dogs?

Navid Farzad 00:29:50

Crazy, crazy. So, like there's a dog in every, I mean, maybe like half.

Nancy Brown 00:29:56

Maybe he needs a friend, or she needs a friend.

Navid Farzad 00:29:58

Maybe, but it's disruptive.

Sofia Guerra 00:30:03

The one other area I'll add that I'm really excited—and I was listening to the plenary at the beginning here—it talked about screening and diagnoses and identifying signals from patients before they get stage 2 cancer, right? How to identify a lot of these things early? And I think that we can really do that, like surveillance, understanding kind of a person and their risk factors and trying to identify or prevent further disease. I think we can really do that today with the tools we have and in figuring out how to obviously increase efficacy and accuracy of a lot of these potential models and pay for it.

Erin Harkless Moore 00:30:42

And to bring it to, I think, a wider swath of the populations, too, that have often been ignored, haven't been included in clinical trials and other datasets. And so that, you know, just plus one to everything my fellow panelists have said. It feels like we're really at the precipice of this unprecedented moment. But the question is, who benefits and over what time horizon? And I think that's really where the tension lies, of how we can harness AI, whether it's in pharma trials, all these things, and just the care delivery, as we've talked about too. I mean, that's a big focus of where we spend a lot of our time investing in the care economy, specifically, which my favorite stat, it's a $648 billion market, actually bigger than the pharmaceutical industry. But, you know, the caregiving—caregiving itself is an inherently human job, right? But I think, Nancy, you were touching on this. Like, there's so many different ways. And we've seen this in our portfolio and some of our companies of where you can free up capacity or time or improve training, improve different ways for the caregiver experience. Which again, will—again, hopefully—lower costs and improve access to care, improve care outcomes for a variety of folks across our country.

Tina Reed 00:31:54

Well, I'd like to shift to a little bit more current news and talk a little bit about the recent midterms. Obviously, we're not too far away from those. Trying to understand what signals you may be watching or how you may be helping your founders navigate any changes in the environment as we see this shift happening politically right now. Nancy, I'm sorry. I'll pick on you again. Governors were on the ballot in 30 states that—I know you work with a lot of companies that care for Medicaid patients. We've got a lot of states that, all the states have to put up Medicaid work requirements. So what are you watching right now at the state level in light of the midterms? And could it change—could anything change where you tell a founder to expand right now?

Nancy Brown 00:32:45

I know all the answers. No, I don't know. Yeah, so it's very interesting. You know, I transitioned from being an operator of companies to investing 12 years ago, and we've seen a lot of change in the political environment. And I think what I would say is, you can't always tell where innovation is going to come from. We've had some tremendous innovation coming from both sides, depending on sort of their level of interest. And there's a lot of misunderstandings. And I think, as we talked about when we were preparing for this, and all of us are like this, we're not—we don't invest in anything that has stroke-of-the-pen risk,

meaning there's this great new code that's coming out through CMS. And, you know, if you find all the doctors who aren't coding this right, you're going to make money, appropriate, fine doctors. You know, that's not what I don't think any of us are doing. We're all really trying to fundamentally improve health care. I think we talked about—I've been an investor in a company called Unite Us, which is a social determinant of health company. It's always been about bringing together supply and demand. So, in the world of—there's a lot of money going into the Medicaid population to support them, but it's very, very hard to access this information. And that's what they—that's what they do. The way that that's talked about in this administration is not SDOH.

Nancy Brown 00:34:08

I'm going to generally speak; I'm probably not going to be perfectly right. But that's not really the way that people like to talk about it; they like to talk about sustainability. So can we get the citizens of the United States that are dependent on the government subsidies to become independent? And so we're tying together—well, if you don't have—if you have substance abuse problem, if you have a disease state, if you don't have a home, if you're a mother who's about to give birth while you're opioid addicted—all of these things, we have to go after each one of them to get people to be able to have a life that they can sustain on their own. So that's a long way of saying that we're really just correlating the outcome to whatever the political environment wants to hear. If you don't want to just help people because it's a great thing to do, but you only care about the budgets, then we can sort of align it. But I would suggest that we haven't changed much. The other thing I'll say is that the current administration has, as the head of Medicaid and what was the former head of Medicare, but now he's got a new role, they're both former venture-backed CEOs. This is very unusual. I never thought, like, that would be a career path for me, who was a venture-backed CEO. But what it is, it kind of reminds me of the job of, like, governors. I like the governor's position a lot in political positions because they're doers. They're managing something. So the decision was made to put these two people in who really—one who really understands what the lack of infrastructure and modernization of the technology that exists within states is doing to our ability to help our citizens, and another one doing that more on the federal level. So, to me, instead of going pure policy, which is, "Let's try to think tank our way through this," they're actually going in and saying, "We've lived in the market and these state variations that are not the good ones, they're like just artifact." And so I'm getting—anyway, it's a very interesting thing to say if you're handed, if you know, if you're handed all of the big departments, like, where do you begin? And what do you do when it's like, just like running any company? They go in and they really try to analyze: What are we trying to do and what's getting in our way? And what they're mostly doing is pointing out just waste, just artifact waste. So I'm encouraged. I'm not worried that these things will look like things we shouldn't do, as we turn blue.

Tina Reed 00:36:42

Okay. Navid, say a founder calls you right now, says, "The midterms are behind us. Should I change anything about my growth plans for the next year?" Which founder in your portfolio would you have the most to say to and what would you tell them?

Navid Farzad 00:36:56

If a state regulator—ask that again, sorry.

Tina Reed 00:36:59

If one of your founders said, "What should I change about my growth plans for the next year?" Which founder in your portfolio would you have the most to say to and what would you tell them?

Navid Farzad 00:37:09

As it relates to state regs, one thing that we have to really keep an eye on, it's going to be interesting, is with AI as well. And you've got these sandboxes that are starting to pop up, and some states have gone—are leading the pack on AI regulation. Others, just—and if we have 50 different states with 50 different regs, it's going to be prohibitive to getting some of these solutions out to do what they can do to improve our health-care industry. As it relates to, we—I'm in the boat with Nancy—I mean, we take a really long-term view when it comes to policy, whether it's federal or state. Because it's just unreliable. It's going to take a long time to develop. And then, also, it will change on you. And so we take, you know, a seven- to 10-year view. And then really just, like, a core principles view, too. And you could call it whatever, call it the triple aim, quadruple aim, just higher quality, lower cost, a better experience. Again, it's very easy for me to say that; it's very hard to do all those things at one time. But if you do, then we believe that that endures, agnostic of policy. Now, I'm not naive, you know, policy will push you around. But that in the long run, you'll be okay if you can hit on those marks. Which, I would say that to all my CEOs, probably.

Tina Reed 00:38:49

Very diplomatic.

Sofia Guerra 00:38:50

And I'll probably add, too. I mean, you've heard this message: the problems are not new in health care, right? And those problems endure administrations. So do the investments that we and the plans that these companies are putting together. So we're always really thinking about: Okay, what's the big goal 10 years from now? How do you envision that world and kind of adjusting on the edges, but not largely?

Erin Harkless Moore 00:39:18

But there's a storytelling piece to this, too. And I think sometimes investors maybe underestimate the role that we can play in communicating what's good about these models and what we're building, and not being shy about sharing that with—whether that's at the state or at the federal level. And I think we have a model at Pivotal where we pull all of those levers in our work, right? We're investors, we do some policy work, and we also do philanthropy. And I think that gives us some of the resources and access to rooms that can be beneficial to our founders. Not that—I think I agree with what everyone has said, right? Like we're investing for the next decade plus, right? We also invest in funds ourselves. That's a 12-, 15-year life, right? So the decisions that you're making are going to be here at this administration, the next one, and the one after that. But it's really a question of, like, how can you demonstrate what's good about this, how we're going to reduce costs and improve outcomes at the end of the day? And it might have a different label. Maybe it's fraud reduction today that people care more about than a prior administration. But the consistent theme of reducing costs and improving outcomes is there regardless.

Navid Farzad 00:40:30

Yeah. I think we also have an opportunity with—like, the Rural Health Transformation Program is probably a good example of finite dollars that are distributed to the states. They have agency to make decisions to a large degree. And if you believe that they'll make good decisions, that's a great way to catalyze this public-private. If those things are benefiting the private sector, like, in the front end, we've seen some states approach it this way on the front end, saying, “Hey, we're going to help subsidize or fund this solution that's going to improve health care in our state.” But the idea is that there's going to be an ROI for the private sector, and that you're going to ultimately pay for this, whether it's through Medicaid RFPs or

however they do that. There are levers to infuse that and do that. And then it just makes the public funding so much more efficient if you can pull that off.

Tina Reed 00:41:29

I wanted to move to some, to our audience questions. One of our questions is: “What guidance do you have for early-stage tech-enabled care delivery startups that are struggling to reach scale that's seemingly required now to attract funding in a world where AI-only or AI-mostly focused companies are attracting so much of that early risk capital and driving up return expectations?”

Navid Farzad 00:41:51

Oh boy. You want to take that one?

Erin Harkless Moore 00:41:52

That's a good one. That's a very good question.

Nancy Brown 00:41:54

What I would say is, yeah, so we're in this world right now where we have a new shiny object. And there's a reason it shines, but also it doesn't. It shouldn't blind—whatever the analogy is—like, blind to everything else. It's—so what I love and what I hope I represented years ago, when I joined athenahealth, which was really a very innovative tech platform way back when, was my health-care experience. So these founders who have come up—so each of our tech-enabled service companies that we all invest in have a point of view about a population, whether it's the GI population. This is a group of people, we know exactly what kind of outcomes, clinical outcomes we want, and here's how we're going to do it. That is not expertise that an AI engineer just happens to know. So I would say the obvious thing is to actually marry yourself to some of the generic AI companies and help them understand that that level of experience, of that process, of that go-to-market, of that interaction with the patients—things that are—you can't observe health care. It's not obvious. Like, it's not. It's not like you're looking at—you're like, “Oh, I get it now.” It's not like that. It's very, very, very complicated and often very confusing. So I would say, just make sure you understand and position yourself with the expertise that you have. That should be very valuable. Some of these companies also end up being more valuable for the source of data. All of a sudden, people are like, “Yeah, we don't care about your clients. Can we have your data? You know, we need that data to train our models.” So they just have to get in the game.

Sofia Guerra 00:43:31

I'll add, I certainly don't have the decades of experience that everyone on this panel, but I've been a student of businesses. So I went back six years ago and looked at all the tech-enabled services that had scaled in our industry and understanding those business models. And it was a lot of people and some tech. And I think with AI, you turn that around. So my encouragement to the founders in the audience that are building AI-enabled services, right? Like, you can do a lot more with technology today than what you could have done three years, five years ago. And you should be leveraging that because it's only going to improve the core business model of delivering care. Obviously not losing sight of patient outcomes, the experience, and quality, right? But technology is like—it's a toolbox, and you need to leverage that to deliver the best care and build the most successful businesses that will scale. And I am so bullish that that will have a massive impact in how we scale tech-enabled services.

Navid Farzad 00:44:32

I think it's a great, great, great question and we feel it. The shiny object is like very, very shiny right now. But the other thing that I would say to that question is, affectionately, we oftentimes have multiple-sided markets in health care. And we used to be really two payer-provider for the most part in our experience.

Now you've got pharma that's much closer, as we talked about. So if you can really demonstrate value to those stakeholders, deep value to those stakeholders and more than just one, then that just makes you more irreplaceable in the ecosystem. That's another kind of vantage point to that.

Tina Reed 00:45:16

And I guess another way to ask that question too, and maybe Erin, we'll have you take this one. What's a health-care business that sounds boring at a dinner party, but you would write a check for?

Erin Harkless Moore 00:45:27

Oh. I mean, I think—so a couple of things we've been looking at recently, say, in the community health worker space. How they're able to better deliver and work with care. I mean, that's kind of something that's not particularly sexy. I think, to Sofia's point, where AI is coming into that and allowing that to be just much more efficient feels like a really interesting model. I think there's so many different nodes of care kind of giving, whether we've backed a kind of company in the neurodegenerative care space. I've spoken a lot about maternal health, menopause care. I mean, I think none of these are super novel or exciting things, but every woman—I mean, we're half the people in here. Women are all going to have go through menopause, right? So it's like, why are we not investing in these opportunities in these markets that are going to impact half of the population? So to me, that's some of the stuff that doesn't sound quite so sexy or exciting, but I think is really interesting.

Tina Reed 00:46:34

And what makes you want to write a check? I'm curious. What's the thing that makes you say, “I'm maybe interested,” to “Okay, let's sit down and talk”?

Sofia Guerra 00:46:45

I'll take that. I mean, if I find it boring, I'm not going to invest. So the job of an entrepreneur is to get me excited about an opportunity. And that will be your unique insight on why you're approaching that problem and why that problem is big and needs to be solved by you. And I think that there's plenty of examples where something looks niche, but it's not so niche with the trained eye. Or it looks competitive, but the way that you're thinking about it and you position yourself in the market gives you an edge. So I'm not giving you a specific answer.

Tina Reed 00:47:18

I was going to say, do you have a specific example?

Sofia Guerra 00:47:20

An example of a company we invested in called SmarterDx, right? It seemed boring at the time, like another revenue cycle company. This was five years, four years ago. How do you leverage kind of ML and new kind of large language models to really understand all of the data that's coming through the health system and understanding, like, the audit of the bill? And everyone's like, “Oh, this is like this one niche problem that you're solving.” But what we didn't—what we understood was you're empowering the clinical decision and the clinical auditing of all of the things that go from, like, giving care to getting paid for this gray area of clinical judgment to kind of provide an understanding. And obviously, it wasn't just a point

solution. It was a big enough market, right? That company was acquired for $1 billion three years ago. So, as an example.

Tina Reed 00:48:15
Navid, do you have an example of where somebody, at first you were like, I don't know if I like this idea? And then they really caught your attention, made you sit down.

Navid Farzad 00:48:23
Yeah, I think it's going to be similar. I think it's, yes, you have to get us excited. Also, just, I said this earlier, but acknowledge that it's going to be hard. And that, but that it's going to be hard. You're being deliberate about going for the really hard thing and you're excited about it because you have to be. But also that you acknowledge that it's, you're not going to transform that overnight. And that—the combination of those things get us excited because that typically means that the market opportunity, if you can figure it out, will be really, really big. And if you're persevere enough that the reward could be great.

Tina Reed 00:49:09

I've got a really big question here. “Can we solve the huge issue of complexity, of navigating insurance coverage and access?” Who wants to solve this? Does anybody have an answer? You said yes. How?

Navid Farzad 00:49:28
Insurance coverage and access.

Tina Reed 00:49:29
Access. Yes.

Navid Farzad 00:49:31
Access. We just can create supply with the technology that we have. So we can, number one, when we're doing this already is taking down the admin burden, which then there's the admin burden that just has the admin ROI. But that also impacts the care delivery in so many ways. So we can just get more capacity with the providers we have. So, yes.

Sofia Guerra 00:49:58

I'll add to that. I think we haven't talked about the front door of care, right? And how do we think about coverage of—we started the conversation today on kind of AI-enabled care. So how do we pay for a—how do you engage with a lot of these algorithms to start your clinical journey? And when do you do that handoff to a clinician? And then really thinking about, you know, AI-enabled care as the front door of the first engagement with the system. And then how do patients discover care, and how do we access or get accessibility to a lot of the specialties that today have long wait lists? So I think that that will have a big impact in the space.

Nancy Brown 00:50:44
And I'll take the question as a different question. Because that was a—I'll take it as access to insurance. Because obviously, in this administration, it was a big hit to access to insurance. And I think that'll—at least what I'm hearing, you know, in all the same sources you hear on CNN and other things—is that it's going to be one of the first things that gets fixed. But just to bring it back to our world, we do a lot of managed Medicaid, and redetermination has been—I guess the good news was it was really good when Medicaid was expanded, and then further through COVID. A lot more people had access to care. But then it's been rolled back in an awkward way for those—for those of us who deliver care, which means we'll be in the middle of delivering care of, let's say, a treatment course, and suddenly they will no longer be. They'll show

up as not being eligible anymore. So something that we used to just do basic eligibility around insurance. Now we're working very—and there's whole companies being built to do nothing more than go in and evaluate the Medicaid patients, determine things like work requirements, look through the databases, and get them back on the ranks if they should be there as quickly as possible. So there's a whole bunch of work that many, many payers and venture-backed companies are doing to make sure that people have access to what they need. There's also these Rural Health dollars. I mean, every—I don't know, I'm going to exaggerate—we used to have—it was used to all be for Medicaid. It was all around managed Medicaid, for the states that have managed Medicaid, and for my companies that mostly got funded through managed Medicaid, almost all of those are now being funded through rural dollars. Like, it's meaning we sometimes have to figure out which source of money there is to take care of the patients that we're taking care of. So…

Navid Farzad 00:52:34

Yeah, we also shouldn't take for granted the access to these LLM tools, like, as a consumer. Like, all of us in this room have probably four of them on our phone. But there's a huge part of our country that is way behind in that same kind of access. And we have an opportunity—I think Sofia said this—to really provide more agency to the patient member with a health plan lens for them to take control of their health in a way that's never been possible. But they have to be able to trust it and access the tools as well.

Tina Reed 00:53:13

This is actually a side question, but how much do you have to consider the environmental impact of the LLMs that your companies are using and thinking about the risk of adoption moving forward? This just seems to be coming up more and more when I'm hearing people talk about AI. And I wasn't expecting it to be as big of a deal as it is. Is it a factor at all? It may not be, but I'm curious.

Navid Farzad 00:53:35

My boss is the global chair of the Nature Conservancy, so I'm going to skip that question. I won't get it right.

Tina Reed 00:53:44

I guess, is that a factor, though? Is that something that you have to consider as you're talking to companies that are using AI?

Erin Harkless Moore 00:53:50

I mean, I think you have to understand from a cost perspective just how it's going to impact their ability to scale, right? And if this is something that, you know, again, it's going to be very resource-intensive. I think it has implications for, again, additional capital that they're going to have to be raising. How is that going to be leveraged and used? And so it's definitely, I think, a something that we—you know, is it the focus of the underwriting and the diligence? No. But is it a question and something to interrogate? Yes.

Tina Reed 00:54:21

So sorry. My—the iPad is not cooperating. That's okay.

Sofia Guerra 00:54:25

The one thing I'll add is, I mean, we often at Bessemer think that we're—obviously this can—AI and intelligence can be the next industrial revolution, right? And, like, we're really at stage one. Like, we've—they identify oil, but we not yet have the airplanes and the trains and all of the innovation that came from that. And thinking about what is required in terms of resources today, and obviously a lot of the capital

that's going into building all of these data centers. I am an optimist that there's going to be also innovation in the requirements to enable that future. So I think, to your point, like, thinking about resources and how do you access this, but also, like, all the little improvements that will happen in the system to enable this revolution. And I think health care will occur a lot of that impact more than any other industry.

Tina Reed 00:55:21
I wanted to shift to a question. I always like to end these panel discussions on one fun thing. I think they're really fun and illuminating. What is one health-care company idea that you would just love to have as a patient, but you would hate to invest in?

Nancy Brown 00:55:40
Oh.

Tina Reed 00:55:41
Any ideas?

Nancy Brown 00:55:41
I have to be the consumer of it?

Tina Reed 00:55:43
Yes, you are the consumer. What would you love to see in health care? It just wouldn't make any money. Or alternatively, what's an idea you're pretty sure would make money, but you'd hate to see?

Nancy Brown 00:55:53
I'm fully satisfied with all the health care I have access to. No, I'm only kidding.

Tina Reed 00:55:56
Sure.

Nancy Brown 00:55:56
I don't know. I was going to talk about a different population where we can't. But that's not fair about Medicaid moms, but I. That's a good question. I have to think about that one for me.

Navid Farzad 00:56:10
I think the point solutions as a, like the clinical point solutions, they're just, they're siloed again. And so I would love to invest in it. I haven't seen the right thing, but it's a huge problem that needs to be solved.

Tina Reed 00:56:26
Of bringing the point solutions together?

Navid Farzad 00:56:28
Totally. Yeah. So that, you know, if I've got these chronic conditions, whatever those digital solutions are in the case of that are all in one place and speaking to one another.

Tina Reed 00:56:39
I know as a patient. Yeah, sometimes it can feel like a mess, but, and then you can have a benefit one year and then the next year it's gone. And it's, yeah, it feels like a little bit of a mess. Are there any in particular that you think would be a particularly good point solution? I guess like a service.

Navid Farzad 00:56:56

We love all the point solutions. They're all good. But they do—I mean, point solutions gotten this like negative connotation. And many of them do really good work in what they do, they just need to be coordinated.

Sofia Guerra 00:57:12

I'll answer your question in a different way. Or, like your original question, I guess, like, what do I want to say? [Crosstalk] I have trouble investing in consumer, direct-to-consumer businesses. And, like, so many things that I, like, wish existed as a consumer, when I look at those businesses, distribution is so hard. So how do you nail reaching many consumers with a net new care model direct to consumer or, you know, like a doctor in your pocket? How do you enable that future? It's hard as an independent company to scale that, obviously. You need to build a brand and invest a lot of marketing, and, like, what gives you a differentiated advantage? So I want to see more of that and net new ways in which you can hack your way to engaging consumers.

Erin Harkless Moore 00:58:01

Yeah, yeah, I really—that was great. I was going to—so that—you said it so well. Plus one to Sofia's point. I mean, I think we've seen a lot, and this is more in the care economy frame than the health-care frame, but a lot of—as, like, a mom myself, like, the things, the coordination of all of the household tasks, right? Like, how do I get my kid from soccer and my other kid's at ballet and all of that stuff? I think there's some of these—it's like a great sort of maybe tech, but is it accessible? And then it has elements of a consumer-facing business as well. So it's something sometimes that I think that would be helpful to me, but should I just have my kids do less activities? And then I won't need this platform to, like, coordinate all of this stuff. So I don't know. And we've seen a lot of those models. And this is not so much in health care; it's more in the kind of—I think of the care economy, like household optimization and support side. But it's like a lot of interesting stuff there. I just don't know really how it scales and who it's serving the most.

Nancy Brown 00:59:01

I want to take two.

Tina Reed 00:59:02

Okay.

Nancy Brown 00:59:02

I didn't like my answer. No, I thought of something. Well, I think women's health, but not where a lot of investors, but it's almost all reproductive health or menopause. And I don't even remember menopause. That's how long ago it was. But there's not enough of an emphasis. But I have had other things where they're like, oh, you might have had this because of the, your IVF treatments. You could have had this because of this or that exposure. And there's just not enough focus on sort of things that are non-menopause. I'm happy for the menopause focus. Believe me. But beyond that, you know, aging and women.

Tina Reed 00:59:41

Really quickly, if you could ban one phrase from every health-care pitch deck, what would it be? Erin, I'm going to go to you first.

Erin Harkless Moore 00:59:49

Oh, geez. I don't know. I'm going to pass and think for one second.

Tina Reed 00:59:56
Sorry to put you on the spot there. Any other takers?

Nancy Brown 01:00:00
AI native.

Tina Reed 01:00:02
AI native.

Erin Harkless Moore 01:00:03
Yeah. And AI-enabled, I don't know. Yeah. Anything with AI.

Nancy Brown 01:00:07
AI adjacent.

Sofia Guerra 01:00:08
Just saying agentic AI doesn't mean anything.

Erin Harkless Moore 01:00:10
Yeah. Yeah.

Tina Reed 01:00:11
Yeah. All right, we've got—

Erin Harkless Moore 01:00:12
It's a business that's like did you just put AI in this deck because, to our earlier comments, you think that's going to differentiate you? Then, no.

Tina Reed 01:00:19
Yeah. That tracks. Well, thank you everybody. I really appreciate this awesome discussion. And thank you everybody for your questions.

Nancy Brown 01:00:25
Thank you.

Announcer 01:00:31
We hope you enjoyed the discussion. Be sure to utilize the mobile app to stay up to date on the latest programming changes. As you exit the room, please remember to bring your belongings with you.

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