There's some where large integrated systems are starting to take risk, or are being giving risk underneath traditional insurers. That's one side of the spectrum. The other side of the spectrum, which is where we are working, is working directly with primary care physicians because we think they have the greatest leverage in the system. They have the most amount of influence with at least amount to lose, in a fact, they have the most amount to gain if they are successful in managing cost and quality appropriately.

They're many, many models. There are some folks who are acquiring practices in order to teach providers and themselves how to take risk. Our model has been to work with the primary care physicians. We don't know how to cure people. They don't know how to do risk management. We think it's a great partnership of bringing out skills and their skills together in - and I guess you would call it a joint venture, because we work with them, and typically partner with the primary care physicians on the ultimate outcomes.

One size fits all doesn't work, as some of the primary care physician groups are very well organized, do understand risk management, and some are really in the first inning of understanding this. So, we have a pretty flexible offering, where we can meet, as I say meet the groups where they are. Now, of course we have some things that we do with everybody. So it's not a free for all. We have medical management skills. We have risk management skills. Everybody has to do compliance. Everyone has to do financial reporting. So we bring a lot of those skills to the primary care group so that they understand not only how to take risks, but how to interface with either the government or other providers-- or excuse me, other payers.

On the ground, primary care physicians have found it very difficult in the new world to be independent.

we think that if primary care physicians organize properly and have access to help that we can give them, as an MSO, we think they're in a great spot in the health care delivery continuum to really influence cost and quality. What we've been able to convince, I think legitimately, many
primary care groups to do, is to work with us instead of, for example, selling to the local hospital or going and selling to a consolidator.

Leadership. One absolute but for in working with primary groups is leadership. Because the behavior change required to do this is very difficult. Not all physicians are wanting to do this and I understand why they wouldn't, if they decide not to. But I think the smarter of them - and particularly the younger - understand that the world is changing. In the SGR fix bill, there is a lot about primary care physicians and a lot about payment for quality in Medicare, and what we are trying to do is capture all that into one place so that the physician groups can do it, but without good leadership who can change the culture, it doesn't work.

Technology is an enabler. It doesn't-- It's helpful. It's very helpful. I don't want to minimize it. I would rather have the first leadership with culture than technology because these folks know what they are doing. They know-- intuitively understand how to work in the system, but what we do is we give a lot of data to them to help them figure out where to focus their time and energy. Who is come in, and how is it coming for their annual wellness visit, what gaps in care are still existing. The interesting thing is that all of the new government programs have quality in Medicare. What we are doing is helping these groups learn how to deal with quality going forward, and technology is very helpful.

everybody is looking for-- legitimately looking for ways to improve the cost quality matrix in healthcare. I think that what you need to do in order to understand if they are serious or not, is to understand ultimately how they get paid and whether they are really serious about reducing cost. And, you know our belief is that the primary care emphasis puts us in a very straightforward place to do that.