Demystifying Value-Based Care with David Snow, CEO of Cedar Gate Technologies

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David Snow
Chairman & CEO
CEDAR GATE TECHNOLOGIES

Frederic Laurier
Managing Director, Digital Health
ALANTRA

Pierre-Alain Rikkers
Managing Director, Fintech
ALANTRA

Episode Highlights

Cedar Gate Technologies

- David Snow founded Cedar Gate Technologies in 2014 to eliminate the inefficiencies and high costs of fragmented point solutions in value-based care (VBC) by creating a comprehensive, end-to-end technology platform for payers and providers
- Today, Cedar Gate's integrated platform serves 60+ million lives, 88,000 employers, 35 regional and national payers, 450,000 providers, and 500 healthcare delivery organizations with its VBC technologies which integrate 50+ different data types from 700+ different data suppliers
- Leveraging generative AI for clinical insights, Cedar Gate predicted with 83% accuracy which of 20,000 members would be diagnosed with diabetes in the next 12 months, enabling earlier intervention to potentially prevent disease onset

Key Takeaways

- The shift from fee-for-service (FFS) to VBC is accelerating as providers adopt risk-sharing models, which provide more upside
- When providers first enter value-based care, they are often risk-averse due to the steep learning curve, but over time, learn how to improve their outcomes
- Sustainable scaling of VBC relies on strong payer-provider alignment, driven by transparent data sharing and structured financial incentives
- Accurate and comprehensive data is the foundation of any VBC model. Refreshing this data with precision is crucial, as it directly impacts the effectiveness of VBC solutions
- End-to-end solutions reduce costs, improve accuracy, and lower HIPAA risk compared to fragmented point solutions used in legacy systems

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Episode Transcript

Frederic Laurier (00:06):
Welcome to another episode of Crossroads by Alantra, where we explore the cutting edge of digital health innovation. In this session, we have the privilege of hosting David Snow – the founder, chairman, and CEO of Cedar Gate Technologies – a provider of technology-powered end-to-end solutions designed to enable customer success in value-based care. David walks us through the current landscape of fee-for-service versus value-based care, the factors shaping its adoption, and the increasing momentum driven by payers and providers. He also discusses the solutions Cedar Gate offers and how the company has empowered payers and providers to thrive within the value-based care model – improving patient care while mitigating financial risk. We conclude this session with David sharing the vision behind building Cedar Gate and how the company continues to drive the transition to value-based care. We hope you find this interview as enlightening and insightful as we did.

(01:00):
Welcome all to another episode of Crossroads by Alantra. We have the pleasure of hosting David Snow, Chairman and CEO of Cedar Gate, which provides technology-driven solutions to value-based care. Previously, David served as Chairman and CEO of Medco Health Solutions where he took the PBM company public and grew its revenue from $30B to $72B over nine years. He also held senior roles at Empire Blue Cross Blue Shield, Oxford Health Plans, and Americhoice. We will be joined in today's podcast by our very own FinTech expert Pierre Rikers. David, Pierre, welcome to our podcast.

David Snow (01:29):
Thank you.

Pierre-Alain Rikkers (01:30):
Thank you.

Frederic Laurier (01:31):
So David, the transition to value-based care or VBC, the acronym widely used, has been slower than anticipated, often due to high upfront costs and providers' aversion to financial risk. Some critics argue that VBC hasn't significantly impacted the cost curve. David, what's your assessment on the current state of VBC?

David Snow (01:59):
Value-based care is growing at an accelerating pace. In healthcare, you never expect things to happen in revolutionary ways. They happen in evolutionary ways. It starts slowly, it builds momentum, and it starts to grow rapidly. And I can tell you that based on our platform, we've got over 60 million lives in various forms of value-based care, from primary care attribution to bundles to capitation of various forms. We're seeing accelerated growth driven primarily by payers, but also, we're seeing it driven by providers who actually want to be in various forms of value-based care. And so, I'm very bullish on the space.

(2:47):
But I will say to your point, that when providers start in value-based care, they are risk averse because quite honestly, there's a massive learning curve for them. Fee-for-service is a completely different set of incentives than the various value-based care models out there.

Episode Transcript

(3:10):
What we're seeing is very slow starts, people taking value-based contracts that have quality incentives for upside only, and then we're seeing them become more competent at understanding how they can chart their own destiny. And they're attracted to various forms of downside risk because the rewards are better. We're seeing that evolution occur as we speak, and our clients are moving from risk averse upside only models to various forms of upside downside risk as they become capable and confident in their own competence.

Frederic Laurier (03:51):
It sounds like they start with upside-only, then they get comfortable, and they start taking on some downside risk. I've had a recent discussion with someone in this space, and he told me, “Look, for providers, the hard reality is that they don't control how patients behave, or members behave.” What do you answer to those that say there's too much outside the control of providers for them to bear the downside risk?

David Snow (04:12):
I disagree, completely. I think that what I've seen is when you put a patient inside a prospective bundle or you put a patient inside a capitated environment or even a primary care attribution environment, the incentives change with powerful information. Providers do know when a patient is non-compliant. Providers do have the insight and the intel in terms of who they should reach out to to be proactive, to avoid the acute onset of a chronic problem or even a catastrophic problem. And to the extent you've been prepaid under a value-based care arrangement, you are incented to create that patient-centric model where you are driving better outcomes because you have the information. Those things will never really happen in a fee-for-service model. But in value-based care, the incentives are aligned to actually do those things. Because the models are so different, risk-based versus fee-for-service, without a mandate, it's very comfortable to go back to fee-for-service after you put your toe in the water in a value-based care arrangement. The more we can push—whether it be the federal government, CMS, and or commercial payers, and or self-insured employers—such that there is no turning back, the better off we'll all be.

Frederic Laurier (05:50):
Have you heard from competitors maybe or just in the marketplace in general, people going from VBC back to FFS?

David Snow (05:58):
I've seen a few who have embarked on a value-based care initiative and then stepped back, but it's not the rule, it's the exception. I have also seen more recently when tweaks to the risk model have been made. For example, risk scoring, where it turned value-based care contracts upside down. I've seen providers say, “Okay, then I'm not participating because you've just changed the rules in a way that are fundamentally detrimental to my financial health.” So, implicit in value-based care is partnerships between payers and providers where they work together to drive better outcomes, both in terms of cost and quality.

Frederic Laurier (06:43):
Speaking of financial risk, if you could walk us through, for the layman, how compensation is structured for healthcare professionals under a typical, if there's such a thing as a typical VBC model. And also, if you could touch on who shares the financial risk? Does it rest primarily with the hospital or health system, or is it born by the professional himself or herself?

Episode Transcript

David Snow (07:03):
It depends on the model. There are models of all types. The good news is our end-to-end platform handles all models. And I don't know that if you intend to ask such a big question, but I'll give you a couple of VBC examples. Primary care attribution models are typically between the payer and primary care practitioners. It is the primary care doc who monitors and manages the lower severity, chronic and complex disease, and they do their best to keep a patient. In that case, the risk is borne by the primary care doctor. Now, primary care attribution can be structured so there's upside only, meaning you get paid fee-for-service but there's a bonus payment if you hit these quality scores, close these gaps in care, and you have this level of medical loss ratio.

Frederic Laurier (08:10):
Could you give us an order of magnitude of what the bonus could be percentage wise?

David Snow (08:15):
Yeah, I've seen it upwards of 10-15% of what was paid if in fact... What you're basically doing is saying if outperform the mean of your market, outperforming your peers in your market, we're going to share that with you. Now, when you become very good at this upside only, the opportunities to make more grow if you take downside risk. So, you could go to a risk corridor model where you're going to be at risk for 20% of what was paid, but you have an upside of 20% more than you made if in fact you perform well under specified metrics.

Frederic Laurier (08:57):
So, you would go from upside only call it 10% to two-sided 20-25% upside.

David Snow (09:04):
Yeah, it's negotiable. Payers all have different models and approaches, and providers have different levels of risk tolerance, but the concept underneath is risk and reward. The more risk, the bigger opportunity, if in fact you're managing well, and you have the tools to manage that risk. You can't do it blindly. You have to have good insight relative to your patient population to do well. There's another model called prospective bundles that we at Cedar Gate do a ton with and that's basically creating episodes of care around a specialty. We do orthopedics, cardiovascular, transplants, women's health, gastro and basically what you do is you just say, here's the episode of care definition. Here's the trigger point start. Here's the trigger point end of that case. Here are the inclusions. Here are the exclusions. You're responsible. Here's a single price for surgery, the anesthesiologist, the facility, the whole nine yards. That is attractive to specialists. And there are two kinds of prospective bundles, one that are professional only, meaning it's just the doctors around the case, not the facility. And then there are other prospective bundles that also include the facility. This is the real opportunity for specialists to participate in value-based care, and really it's the physicians who control the risk and the reward.

Frederic Laurier (10:45):
Who acts as the arbiter, David? Are you Cedar Gate in the middle of it?

David Snow (10:50):
We are. We have a highly specialized prospective bundles claim engine that basically can administer a bundle. We do the single billing up to the payer. We receive the payment. We do the downstream distributions to the providers.

Episode Transcript

Frederic Laurier (11:08):
And what about the negotiation of the contract itself? How it's going to work, the different flavors. Are you, Cedar Gate, in, with that selection as well? Please walk us through it.

David Snow (11:18):
Yes, we help put together the payer contracts. We have a 3,000-physician group of cardiovascular surgeons and related physicians in Texas. We do all of that. We negotiate the payer contracts, administer their bundles. We work for them. We're basically the MSO in this case, and they do incredibly well. They're who I would want to go to if I had a cardiovascular problem. They really pay attention to the numbers and to the quality scores, and they're very much in favor of continuous quality improvement.

Frederic Laurier (11:50):
So they're very much quality driven?

David Snow (11:52):
They are. Those are the exciting stories. Those are what are possible when we get people aligned properly.

Frederic Laurier (12:02):
Let me turn it over to Pierre. Maybe Pierre bring a fintech perspective or payments perspective to the discussion, Pierre.

Pierre-Alain Rikkers (12:08):
Thanks Fred and great to connect again David. So, I'll jump right in and I'll raise my hand to say if there's a layman on this call about healthcare and healthcare tech, I'm this guy. I'm fascinated by the space where Cedar Gate seems to be playing a central role as a platform that manages, ingests, and process so much data. And just to try to maybe draw a few analogies, if I may with offset to FinTech, in terms of data management, I think you have 150 automated data scrubs and like 40+ APIs. I wonder to what extent these data capabilities are really central to your offering and maybe a key barrier to entry?

David Snow (12:48):
Pierre, I think it's foundational. Without data, you're blind. Accurate data that's comprehensive is foundational to any form of value-based care. We are good at it. We do all the work for our clients. We have 82,000 employers on our platform. We have 35 regional and national payers. We have 450,000 providers, including over 500 big health systems using our technologies. And we refresh this data at a cadence needed for their use cases. We do it across over 50 types of data, and we do it at enormous scale with great precision. And that's key because the precision underneath drives all of the outputs across our platform, whether it be value-based care analytics or with care management technologies. We also have payment technologies for all forms of prospective bundles. We also have forms of capitation – primary care capitation, specialist capitation, and global capitation.

Episode Transcript

Pierre-Alain Rikkers (13:58):
Let me think about what you do from a transaction processing perspective where you have a lot of declines and chargebacks. In healthcare, there's errors or denials and all that are a persistent challenge, particularly in the fee-for-service model. Given what I would consider maybe the added level of complexity with VBC payment, how significant are these issues and do the underlying cause differs from the FFS model?

David Snow (14:23):
Even in the payer contracted prospective bundle model, we still do pre-certification, but we do it on behalf of our clients. It's one case, one episode, one payment, and the details underneath we take care of with the provider community. So, it's actually fairly attractive to a payer as well because they don't have to deal with all of that. All the doctors are not billing the payer. They're sending the bills to us. We do the aggregation around the case, and it's one bill to the payer.

Pierre-Alain Rikkers (15:00):
It's like you're simplifying as opposed to making it more complex, which is maybe counterintuitive.

David Snow (15:02):
What's nice is in a prospective bundle, there's a lot less hassle for the delivery system, number one. And number two, because they're seeing the financials end-to-end, how every dollar is spent. It's amazing how they say, “Well, wait a minute. I didn't need to do this in that inpatient setting. I can do this in my office, or I can do this in a freestanding ambulatory surgical center.” They're seeing how they spend the money in making changes that improve both costs and quality and because they're motivated.

Frederic Laurier (15:37):
Because they have the insights, David. They can drill down and really understand where you can extract cost savings, I would imagine.

David Snow (15:45):
Absolutely, absolutely. And at the same time, improve quality. You can do both.

Pierre-Alain Rikkers (15:50):
Are there cases in the prospective bundle payments where there could be payment adjustments after the fact?

David Snow (15:57):
One thing that happens occasionally, the providers inside our network bill a payer directly versus us. The payer pays the bill directly, and we have to reconcile with the payers around that. So, we work very hard to make sure the office staff know how to handle the cases so that there isn't a double payment.

Frederic Laurier (16:23):
I would imagine that occurs, David, when they do the switch to the VBC model or when they start working with you, but after a certain period of time, that goes away, right?

Episode Transcript

David Snow (16:33):
That's exactly right.

Pierre-Alain Rikkers (16:35):
Right, because it's more of an error of directing the payment to the wrong party as opposed to entering in an amount or anything like that.

David Snow (16:45):
Yeah, it's a problem that through education and experience goes away. However, physician office staff turnover and the new person coming in makes a new mistake and you've got to constantly keep up with it. That's part of the job.

Frederic Laurier (16:58):
If we could talk about the vision you had for your technology initially, David, and how it has evolved over time. Because if we look at it today, your platform does integrate several modules from population health risk analysis to contract management. How different are the two pictures from the one that you painted initially when you founded Cedar Gate and now what it has become today?

David Snow (17:19):
The idea I had in my head in 2014 when I created Cedar Gate is exactly what we built. I started the company in April 2014. I partnered with GTCR, my private equity firm, in August of 2014. I laid out to GTCR the assets I wanted to build and buy. We reached agreement. We immediately began building value-based care analytics while we shopped for the bundles capabilities, the capitation capabilities, the population health analytics, the care management capabilities. Very precise about what we wanted to build out this end-to-end value-based care capability. The reason we were precise and we stuck to plan is we wanted, when we created the company, to solve a problem in healthcare.

(18:11):
Let me be clear about what that problem was. When I created Cedar Gate, the world was littered with these point solutions. This company did care management. This company did value-based care analytics. This company had the capitation engine. It wasn't unusual to find participants in the value-based care space who had four, five, six different point solutions. That includes providers, payers, and self-insured employers. They were using multiple capabilities because they needed this complete picture to manage the risk and manage the business. So, what's the value prop of having end-to-end versus four, five, six point solutions? Number one, it's ridiculously expensive. You're paying each one of those point solutions, onboard, homogenize, enrich, and store your data. Same data four, five, six times. What a complete waste! Number two, after you finish onboarding the data, you go ask those four, five, six point solutions the same question on the same data. You get different answers because it's organized differently. It's enriched differently. It's categorized differently.

(19:32):
On an end-to-end platform over a single source of truth, everything ticks and ties across the applications. And then the third big piece of the value prop for end-to-end, you exponentially increase your HIPAA risk when you give your proprietary data to multiple point solutions. We wanted to dramatically reduce that HIPAA risk by single source of truth. And by the way, it is resonating in the market. We're seeing very positive responses to it.

Episode Transcript

Frederic Laurier (20:02):
So, M&A was part of the initial playbook?

David Snow (20:06):
Absolutely.

Pierre-Alain Rikkers (20:07):
When you create a platform and you manage and process a lot of data, there's always the question of how do you keep your solutions and your offering up to date. How often and how do you update your, let me call them your algorithms, to adapt to emerging trends? And what are the specific challenges or successes that you could share in that respect?

David Snow (20:28):
That's the secret, isn't it, Pierre? [laughs]

(20:31):
It's a good question. First of all, when we bought the companies that we bought and put them together, we spent enormous development time not only integrating the capabilities, so they worked as one, even though they're composable. We also took out the tech debt. We bought the easy cap suite of products. We had more than one care management capability after those acquisitions because multiple companies had care management. We had to rebuild everything, take best of breed and then innovate on top of that. We're doing some innovations around prospective bundles where we're lifting all of the logic for prospective bundles to the cloud such that a payer can use our technology and administer their own prospective bundles using their claim engines. Those kinds of innovations. We listen to the market. We respond to the market.

(21:20):
We're also doing a lot with generative AI, and there are two key areas we're focused on. One of them is leveraging clinical insight using generative AI as part of our algorithms so that clinicians have further and deeper insights around what they might do. The other area is administrative efficiency, lots and lots of automated data onboarding. And there's always room to be better, more precise, higher quality relative to data. So, we've done a lot with AI to help us scale in that regard. Now on the clinical insights example, inside our database, we looked at 20,000 commercial members. And we posed the question: how many of these members currently have not been diagnosed with diabetes, but with the data we have end-to-end, are likely to be diagnosed in the next 12 months? We ran the algorithm, trained the algorithm. We were 83% accurate in terms of who would be in the next 12 months diagnosed. So, what does that mean to healthcare and the quality of care to a patient? It means you intervene 12 months earlier and maybe stem the tide such that they're never diagnosed with diabetes because you do the right things up front to avoid that onset.

(22:55):
We've got examples in cardiovascular. We've got examples in women's health. The opportunities are enormous. By the way, the generative AI is not diagnosing patients. It's showing the tracks such that clinicians can make better decisions.

Episode Transcript

Frederic Laurier (23:15):
And in a non-FFS world, it makes a world of a difference to the provider.

David Snow (23:19):
Right, in a fee-for-service world, the provider doesn't get the information. By the way, payers will not share their data with you as a provider if you're not in a risk-based arrangement. What's the purpose? What's the point? The provider isn't incented to be proactive.

Frederic Laurier (23:36):
David, thank you so much.

David Snow (23:38):
Thanks guys.

Pierre-Alain Rikkers (23:40):
Thank you so much.

Frederic Laurier (23:41):
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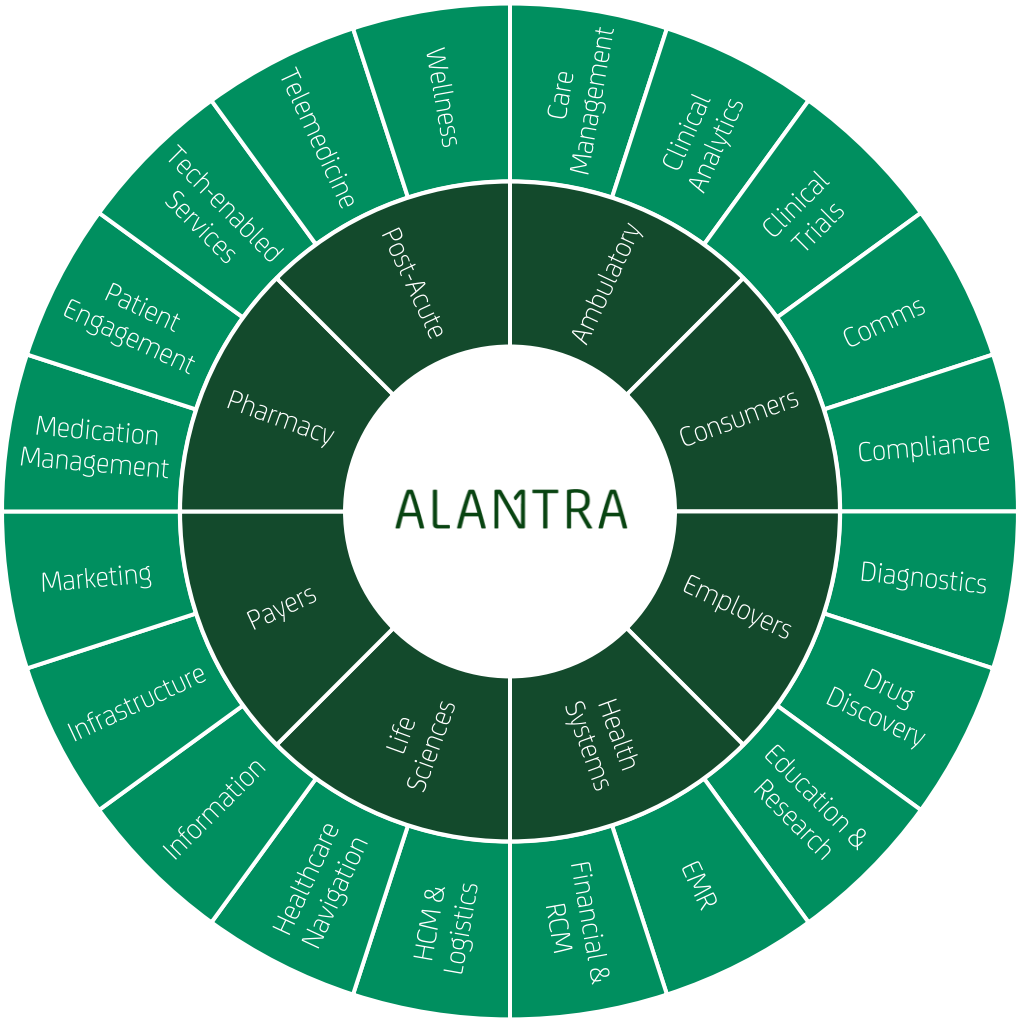

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Alantra – Global Senior Healthcare Team

Alantra benefits from a global senior Healthcare team with deep local presence, able to reach global strategics and investors

Rusty Ray
Managing Partner
rusty.ray@alantra.com

Frederic Laurier
Managing Director
frederic.laurier@alantra.com

Matthew Wiseman
Partner
matthew.wiseman@alantra.com

Justin Crowther
Partner
justin.crowther@alantra.com

Fabrice Scheer
Managing Director
fabrice.scheer@alantra.com

Franck Noat
Managing Director
franck.noat@alantra.com

Michael Maag
Managing Partner
michael.maag@alantra.com

Jonas Bauréus
Managing Director
jonas.baureus@alantra.com

Gianni Casanova
Partner
gianni.casanova@alantra.com

Saad Ashraf
Managing Director
saad.ashraf@alantra.com

Guillermo Arbolí
Managing Director
guillermo.arboli@alantra.com

Pedro Serrano
Director
pedro.serrano@alantra.com

Alantra – Global Senior Technology Team

Alantra benefits from a global senior Technology team with deep local presence, able to reach global strategics and investors

Renee Shaening
Managing Director
renee.shaening@alantra.com

Michael Lenoce
Managing Director
michael.lenoce@alantra.com

Pierre-Alain Rikkers
Managing Director
pierre-alain.rikkers@alantra.com

Oliver Parker
Partner
oliver.parker@alantra.com

Oriane Durvye
Managing Partner
oriane.durvye@alantra.com

Franck Portais
Managing Partner
franck.portais@alantra.com

Nicolas Senlis
Managing Partner
nicolas.senlis@alantra.com

Christopher Jobst
Managing Director
christopher.jobst@alantra.com

Daniel Lilliehöök
Partner
daniel.lilliehook@alantra.com

Lodewijk Sodderland
Managing Director
lodewijk.sodderland@alantra.com

Julio Cardenal
Managing Partner
julio.cardenal@alantra.com

Richard Zhu
Managing Director
richard.zhu@alantra.com

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