Episode 27 – Carrum Health: A new standard for centers of excellence

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SACH JAIN: The butterfly effect is small changes in the current state leads to big rewards, big changes.

STEVE BLUMENFIELD: Nice. Nice.

SACH JAIN: And I think what we are doing at Carrum hopefully will have that butterfly effect in the family model of health care.

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NARRATOR: Welcome to The Cure for the Common Company, a podcast series looking at innovations in the world of employee health and wellbeing. Steve Blumenfield and other experts from Willis Towers Watson's health and benefits practice are talking to entrepreneurs and industry leaders who break ground to meet the needs of today's workforce and deliver benefit solutions that can separate employers from the pack.

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STEVE BLUMENFIELD: Hey, Sach.

SACH JAIN: Hey, Steve.

STEVE BLUMENFIELD: Hi, everyone, and welcome to The Cure for the Common Co. podcast. This is Steve Blumenfield, head of strategy and innovation for Willis Towers Watson's health and benefits North America. And today, I'm joined by Sach Jain, founder and CEO of Carrum Health, a company that is addressing the employer surgical care spin challenge through an innovative, value-based Centers of Excellence solution. Sach Jain, thanks for being here.

SACH JAIN: Glad to be here, Steve.

STEVE BLUMENFIELD: And we're so glad to have you. And I'm also joined, once again, by my trusty colleague and Willis Towers Watson's health care delivery lead, Drew Hodgson. Thanks for joining us, Drew.

DREW HODGSON: Thank you, Steve, for having me again.

STEVE BLUMENFIELD: Excellent. Well, this is going to be a great discussion. Let's get right into it. Sach, if you could start out. Just tell us a little bit about you, and maybe what led you to start Carrum?

SACH JAIN: Sure. So I am a computer scientist and engineer by training. Grew up in India in a small district town in North. The kind of town where you get six hours of electricity and two hours of water in a day.

STEVE BLUMENFIELD: Wow.

SACH JAIN: And I don't think it has changed much in the last 40 years. And for the kids in these small towns, the way out is education. And so that's what I did. After college, I spent some time in high-tech startups and professional services companies in the U.S. and in Singapore. And, frankly, I was just happy to be in first-world country where I don't have to worry about electricity or water.

[LAUGHING]

My calling in health care came over a decade ago when I accepted it all with a hospital recycle company. These are the companies that hospitals hire to maximize their reimbursement against health plans, against patients. And not one single day that will go by when you won't hear a heartbreaking story of a patient being wronged by the health care system or receiving bills of thousands of dollars.

Spending some time in India and Singapore and knowing the health care system, I just felt that the way we pay for health care in the U.S. under PPO fee-for-service models, it's is completely wrong. You cannot pay for health care like buying a car part by part. And one out of five Americans have a medical debt in collection, which is just insane. So we felt there had to be a better way, and that became the inspiration to start Carrum Health.

STEVE BLUMENFIELD: So you ended up creating a Centers of Excellence solution with a motivation to actually help people get better health and find a way to do this by looking holistically at it and considering the price for the entirety of it. That's amazing. I haven't heard a story from that perspective before.

SACH JAIN: Well, thank you. Yeah, the mission behind Carrum is to change how we pay for health care in the U.S. and fix the member experience. When we started Carrum, the question was, where do you start? And so we zoned in on surgical care, which the funny part is that most employers do not understand how big of a problem it is. It is almost half of their total span, and it's a complete Wild West. The way we pay for surgeries in U.S., there are perverse incentives. Almost a quarter of the surgeries are unnecessary. I got one myself, and it's still upsets me.

STEVE BLUMENFIELD: Really? What was that? Do you mind saying what kind of surgery? Don't pry into anything too personal here.

SACH JAIN: It was a lump in my armpit that doctor looked at it and said, "hey, this could be something malignant." And I can tell you, I spent the next few weeks in a total despair of what it might be, and it just turned out to be nothing. And then the doctor was like, "yeah, I knew it was nothing, but just we wanted to double check." And when I relayed that with my understanding of the incentives of providers, it was like, yeah, it was absolutely not necessary.

STEVE BLUMENFIELD: Yeah, I figured there might be something like that behind it, and it's just so valuable. And let's assume the best intentions of the provider. They know that doing everything possible in the most extreme way is ultimately safe. You've checked every box, but that doesn't mean it's the best practice or even good for the patient. But they stayed within the lines, they felt they had to operate. And if you look at the worst incentives, there are also financial incentives. So insightful example.

DREW HODGSON: I would add to that a little bit. We hear regularly that sometimes even higher than 40% of the cost in the United States health care system is waste, whether it be inappropriate care, inefficient care, complications, other pieces of the pie that are just wasted. And some of that's overutilization as well. Surgery avoidance, you've talked about that being such a huge part of your model.

If you just look at the overall cost savings for that individual surgery that's going to happen or not, yeah, you're going to get that bundled payment, you're going to get that discount. But such a huge part of it is that

avoidance of care. Can you tell us a little bit about how it gets at that part of the pie, and how effective that strategy actually can be? Because I think it's a piece that people sometimes ignore.

SACH JAIN: Yeah, and what you said, Drew, is the unfortunate reality of our health care system where under fee-for-service PPO models, providers have little incentive to reduce waste and focus on doing what is right versus doing more. As I mentioned earlier, you have similar metrics that almost a quarter to half of the things we do in health care do not really add much value.

So when we started Carrum Health, the focus was as we are focusing on surgical care, we will not only focus on reducing unit cost, but also eliminating unnecessary surgeries, which is a huge piece of the puzzle that most benefit leaders have little insight into. The thing about surgical care, let's figure out a way to reduce unit cost. But reducing waste through avoiding unnecessary surgeries plus reducing waste through avoiding unnecessary re-admissions and complications is an equal part of the puzzle, if not a bigger one from a cost standpoint.

In Carrum, when we do the quality evaluation, appropriateness is front and center of the process. So it starts with the provider. Figuring out providers that have, both from a quantitative standpoint as well as qualitative standpoint, the right pieces and culture in place to avoid unnecessary surgeries. When we identify those providers, we now make them accountable for the quality of care, and also have an assessment bundle in place so that they can make a surgery decision in an incentive-neutral fashion.

STEVE BLUMENFIELD: So, Sach, let me pick this apart and ask Drew to help with this for folks who might not be as familiar with the COE model that might be listening. So, Drew, if you could just maybe lay out at a high level what a Centers of Excellence model is and what is at play. And then, Sach, you added some layers here about how you do it that I think are somewhat unique. So maybe we can get into that, too. Drew, would you start us off?

DREW HODGSON: Yeah. Yeah, the Center of Excellence model in general is exactly what it sounds. It's how do we get members to high quality, efficient care? Unfortunately, here in the United States, health care quality is all over the board, and it is not correlated with cost. It's been proven over and over again that that correlation is not there.

At a true Center of Excellence, there are certain surgery centers, there are certain physicians, there are certain hospitals out there that truly do excel at certain procedures. And so how do we get them into those areas? So the Center of Excellence concept, whether it be through major carriers with their huge broad network of Centers of Excellence versus a Carrum who is much more selective of who they partner with around the country and looking at those quality metrics, that's how we're trying to get at the problem -- trying to steer those people into those centers. So I think that's really the best way, I would say, Sach, to describe how those operate.

SACH JAIN: Yeah, and just to add to that, Drew, over the last decade, since value-based care model had started to gain traction, the policymakers had hypothesized all along that cost is inversely proportional to quality. The better quality there is, then the lower the cost will be. So far, it has been very difficult to demonstrate.

When we started Carrum Health, the focus was we will front with quality and figure out the providers that excel in the quality outcomes, excel in appropriateness, and doing surgeries when they are necessary. And then in a given group of providers that meet our quality standards, work with those providers that are cost efficient and bring them on the platform, make them accountable for the quality of care. And once you do that, you start to see the impact of these models.

So RAND Corporation, a big think tank, so they did a peer reviewed study that was independently financed. And they found that when employers used a model like Carrum, the unit cost came down by 45%. 30% of the surgeries were avoided. And when the surgeries did happen, the quality outcomes were 80% better in terms of lower re-admissions and complications rate. So if things are done correctly and if you lead with quality, the results can follow. And last thing I will add there is MedPAC, which is Medicare Payment Advisory Commission, they actually used that study to make a recommendation to the Congress from a policymaking standpoint as they think about the future of Medicare.

DREW HODGSON: You're definitely preaching to the choir with me that you should absolutely lead with quality. And that's one of the things that I really respect about Carrum.

STEVE BLUMENFIELD: Sach, you've told us that you're trying to accomplish some pretty wonderful things. Let's really encapsulate that. Let's say it's five years from now and you're the cover story on your favorite business periodical. What does that cover story say about Carrum? What's the headline?

SACH JAIN: Oh, boy. I have a lot of respect for companies that have disrupted other industries by making small changes. An example is Amazon that disrupted retail by changing the payment model from brick and mortar to e-commerce. And so I would love a headline like Amazon changed the payment model of retail, Carrum Health has done the same for health care.

STEVE BLUMENFIELD: Nice. So we're all judged by the people we hang out with. I see who you want to hang out with.

[LAUGHING]

DREW HODGSON: My wife owns a brick and mortar shop, so I'm not happy with that.

SACH JAIN: Oh, my god.

[LAUGHING]

SACH JAIN: Well, there's a place for everyone, Drew.

STEVE BLUMENFIELD: Aw, there's a place. So you're maybe the gentler, kinder version of that then. OK.

[LAUGHING]

STEVE BLUMENFIELD: Just on still what it is that an employer buys from this because the way you describe it, it's getting the right doctors and making sure that they have quality, then adding a bunch of tools that they use for you. So you're playing a role back here in network aggregation. And so, essentially, think of you as a carved-out network of high-performing, high-quality providers with tools. You don't own the providers, but you have contracts with them. And that contract is overlaid on the health plan contract. Is that a fairly accurate summary of what the concept is?

SACH JAIN: You are absolutely right, Steve. So that is what it is. We have built a ground of value-based COE platform where providers are selected because they deliver excellent outcomes and they are cost efficient. We put them on our technology platform. And when self-insured employers join that platform, they have access to this best-in-class, value-based COE network that their employees can use as they are going through a surgical care episode.

DREW HODGSON: I'd be interested to understand a little bit more about how you do think about quality because I think one of the problems, also, out there is that a lot of times, Centers of Excellence, they're contracting directly with a health system or a single hospital and grab all the surgeons within that, right? Talk a little bit about your model about how it might be a little bit different with Carrum.

SACH JAIN: So the quality in health care is a big topic. And any approach to solving for everything quality in health care is just a non-starter. So when we thought about quality from a Carrum standpoint, we try to solve for that quality on a procedure-by-procedure basis. So the quality evaluation for a joint replacement is a very different ballgame than a quality evaluation for a cardiovascular procedure.

So for the procedures that we are focused on, we figure out, who are the top experts in that specific space that can guide our quality evaluation process. We use that criteria to, in a given market, figure out which are the providers that are worth speaking with through an outside-in perspective. So we have collected a lot of data both from public and proprietary sources that help us give an insight -- in a given market, these five providers are even just worth speaking with.

When we find those providers, we engage them in almost like an RFI process where they have to give us data ground up on 50-plus metrics based upon the procedure, and that includes their metrics related to appropriateness, et cetera, et cetera. And they have to give us that data both at the facility level and surgeon level. Then we run that through our algorithms and figure out which combinations of hospitals and surgeons deliver excellent outcomes.

And the final step in the process is that once we identify those combinations, we bring them on the platform using prospective bundled payment arrangement and we make them accountable for the quality of care. So every provider on our platform has to give us at least 30 days of re-admission warranty. So that immediately aligns their incentive with delivering better outcomes.

STEVE BLUMENFIELD: Let's just say that again. They've got to, at minimum, provide a 30-day warranty. We expect that. That would be like a bad warranty for many products we bought. Even for massive purchases we make, we expect those warranties to go out for years or a decade. But 30-day warranty for a surgery is actually unbelievably uncommon, so it's worth repeating. You make sure it gets done right.

DREW HODGSON: It's really worth repeating because it's one of those things in health care, right? Why haven't we had warranties in health care, especially on common frequent procedures? I think it makes a lot of sense.

SACH JAIN: You go and buy a scissor in a market for 5 bucks, and you will get warranty on that scissor that you can return it if you don't like it. I think something is broken, you can go and return it. On a joint replacement procedure, you are spending probably 30 grand. And if anything goes wrong, you'll go back to the hospital, and they will make more money for fixing it.

STEVE BLUMENFIELD: Crazy. It's just such a mixed incentive. But to be clear, you're not suggesting that we replace our joints with scissors, right?

[LAUGHING]

DREW HODGSON: That's funny. Can I steer the conversation a little bit in another direction? Because I love what you do, right? I love the concept that you've come to market with. I do think the quality is there. I've evaluated it myself looking at some of the quality of the systems that you partner with. But I'm noticing as more and more of this business is being removed from the major carriers, you think about what you do and others like you. I think about some of the carved-out network solutions out there.

Not going to mention names, but there's a few of them out there that are pulling business slowly away. I know we'll talk about this later about how you're getting into oncology, too. I love what you're doing around bundled payments in oncology. So what do you think the major carriers are going to do in the next three to five years? They're going to react, right?

SACH JAIN: Absolutely. Look, there is a general shift in the market to move from these monolithic health plan products to unbundle best-of-breed solutions. And it is happening for a long time in primary care and chronic care, and just started to happen surgical care now. And from a peer standpoint, look, they are not at the forefront of innovations, but they do know when a category becomes indispensable and a solution that employers are asking.

And at that point, they react. And the reaction is typically either partnering with a best-in-class solution or building something of their own. And we have started to see that happening now in our space in surgical care. And, frankly, the mission in Carrum Health was to move the system away from fee-for-service to a value-based care model. And if health plans get there, that's very much in line with what we wanted to do. And they can get us there faster if they decide to get behind it. So from our point of view, if we are pushing them in that direction, that is absolutely part of the mission.

STEVE BLUMENFIELD: That's great. It's worth talking for a moment about the challenges for a health plan in doing this, right? They want to get the best care for their people, no question. But in this country, we have such a strong push toward choice that they also have to have very broad networks so that employers who want to provide choice for their people will select their plan because they've got great discounts available

everywhere with every doctor people have. Nobody can argue whether or not that's the right approach. And there's certainly a lot of innovations happening on every piece of that.

But if your premise is basically that you need to have a broad network, then at some point, as you try to create a narrow network on top of that of excellent providers, you have to say "no" to some very influential people in your network that they can't be in that top network. But they also may be a dominant provider in a certain geography that says, well, if I'm not in your top network and rated top, then I'm not going to be in your broad network. And so there's this unfortunate conflict of trying to be both things. It makes it very hard for a major health plan to do that.

DREW HODGSON: They also have relationships in Medicare and Medicaid that they might squeeze right into the balloon. They can't beat them up too much because they're going to go into the negotiations on the other end, which is another big problem for them.

SACH JAIN: If you are dealing with a large health system where your members are going for an array of health care services, you cannot say that, give me a discount on your chargemaster on a visit, or an X-ray, or this and that. But for some of these more expensive procedures, like joint replacement, you are not in my network. That doesn't work.

And the second challenge is for a provider that is Centers of Excellence worthy, they know how much volume they get from an existing health plan for those kind of procedures. And a health plan then goes back to them and say, hey, we want to include you as part of this COE program, but you'll have to give us 45% discount on top of this. And then it's like, why will I do this? And that's the challenge.

And saying these health plans are still a whole lot of leverage in the system. And I can talk all day why it is difficult for health plans to get on board, but the system will move much faster if health plans get on board. And whether they partner or build something on their own, it's good for the system overall.

DREW HODGSON: Yeah, I noticed that a recent survey we did suggests with a lot of employers that the administrative complexities, competing priorities, bandwidth, all those things, are major roadblocks from implementing solutions like COEs and any HCD solution, healthcare delivery-type solution to be honest with you. What's your response to that? How do you fit into that ecosystem when you have to obviously play ball a little bit with the major carriers for the exchange of the metrics and whatever you need to do. So how are you addressing that? And how's that working?

SACH JAIN: And you're right. I'm doing this for seven, eight years, and I've yet to meet an overstaffed benefits team that has spare bandwidth to do something new. And just given the proliferation of gazillions of digital health solution, it is very challenging for benefit leaders to figure out where to spend time on and where not.

And when we started Carrum Health, we actually interviewed a lot of employers to understand, as the thing about the COE programs, what are the challenges? And the challenges we heard were that, hey, for three or four procedures that could be part of these programs, this is a heavy lift to put in place because it requires a lot of work. An employer like Walmart, or a Boeing, or a United Airlines could do it because they have scale. But for the vast majority of employers, it's a bridge too far.

So at Carrum Health, we solve the problem in two ways. One, from day one, we were focused on scaling this model using technology. We spent our first three years building out this model ground app configuring all different pieces of the solution in a fashion that could make these programs plug and play. We have done national rollout of this program in less than a month, which speaks to how easy we have made these programs to adopt.

And on the other side, these here programs initially were limited to two or three procedures -- joint, spine kind of thing. We offer now 100 plus procedures, which include the entire gamut of MSK, bariatrics, cardiovascular, and oncology. So you combine those two factors, and it becomes very easy decision for an employer to think about with an easy activation that Carrum has made it possible with, and with the huge impact it can have on the surgical care span. It starts to change the conversation.

DREW HODGSON: And you are finding that the major carriers are playing in the sandbox better than they were? Because I know in the past it was like, oh, I got to go to a TPA. And I still hear that sometimes where employers they've got to go away. And it does feel like that's softening a little bit.

SACH JAIN: Absolutely. I think we are now working with every single major carrier, as well as regional health plans. We are also working with almost every single popular digital health solution in expert medical opinion space, navigation, chronic care management, digital landscape. And just given how we have built the platform using technology, a lot of this integration happened through API to make it a seamless experience for the member. We had this partnership with Hinge Health recently where it's a seamless experience for the member, and employers can activate it with a simple amendment and because the products are integrated in the background.

DREW HODGSON: That's great.

STEVE BLUMENFIELD: So for those who might not be aware, Hinge is remote physical therapy and related treatments. And obviously, if you're providing a sense of excellence for musculoskeletal, you can see how a member might go back and forth across those other post-surgical therapy or doing therapy before they escalate into surgery, and making sure that there's the need there.

But let's double click down on that member experience just for Carrum for a moment because we've been talking about how the model works and whether it works with health plans. But let's say a member is working for a company that makes Carrum available. What happens? How do they know that they should go to Carrum? What does it look like? Do they ever experience Carrum, or is it happening behind the scenes?

SACH JAIN: Yeah. So, as I said, the reason we started Carrum was primarily to fix the member experience. And the member experience today under PPO networks is you need a surgery and you're like, where should I go? And you will learn your uncle went to this doc was great, and you should go there. And that's pretty much it. You have no idea about the cost. You have no idea about the process, and you just hope for the best.

Compare that with the model that Carrum Health has built where every single provider, every single surgeon on our platform has been rigorously evaluated for their proficiency in that specific kind of procedure so you do not have to worry about the quality. You do not have to worry about the cost because everything is covered by the employer. Members typically never see any medical bill, let alone any surprise bill. And we give them a concierge person and an apps. Whether you're using an iPhone or an Android, you have an app to help you manage the entire episode of care.

STEVE BLUMENFIELD: When you're getting into that, Sach, just make it really, really clear. I'm a member, and my primary care physician tells me I need to get surgery, or get an X-ray, or maybe I think I do because I fell down and I went to urgent care, or I don't know what to do next. How does Carrum know to be involved? How does a member to go to a Carrum app? How does it start?

SACH JAIN: The process actually starts way, way before because a lot of these surgeries do not happen in a vacuum. There is a trail that happens. If you are going through a hip replacement, you probably have seen a physical therapist, or you have used a hingle solution, or you have seen an orthopaed. And that trail exists in the claims data that Carrum Health uses to predict which members are on a path to a surgery.

We receive that stream of data, and we have built models using AI that can predict almost up to two years out in a given population who will be getting a surgery. So we engage those members proactively throughout the process through all different channels so that if a member progresses towards a surgery, they know a benefit like Carrum Health exists and they should take advantage of.

STEVE BLUMENFIELD: So that might be, I get an email that references a bill that I had, or that references a visit I had to a specialist or an MRI I took, and makes you available-- that you've got available this benefit, or call here if you believe you might need surgery, that type of thing?

SACH JAIN: So the way a lot of these outreaches happen, they happen in a fashion which are very HIPAA compliant. You'll receive a general email based upon some of the indicators we have seen that highlight you

may be on a path to a surgery. And it may be one month out, it may be a year out. And we use those indicators to engage those members.

Obviously, you cannot go to the member and say, hey, we know you visited a physical therapist because that just becomes controversial. So our models help figure out a given set of population that has high propensity towards getting a surgery in a given time frame, and we apply the same consumer marketing tools that other industries are using for a long period of time to engage those members. And when the time is right, they know a solution like this exists.

STEVE BLUMENFIELD: OK, so they're already familiar with this exchange they're having with someone who they've been invited to participate with. And when it gets close, you're teeing up the next piece of information, and maybe you're providing an app that says, go here to learn more or to pre-register or something.

SACH JAIN: Exactly. So pre-register. You learn about if you're going through any pain, learn about the knee pain, what the options are for you to feel better. Our focus is to get member to full health and get them health from a solution standpoint. We do not engage with the member until they actually have a recommendation for a surgery.

So the first question they have to answer is, do you have a recommendation for the surgery? And if you don't, we will guide you more towards the education part of it. And if you do, then you go through a path where we evaluate the surgery necessary by putting you through the process of evaluation through the COE surgeon who will ensure you need a surgery, and then it goes for the process.

One thing I'll highlight here, it's a process that employers cannot take on by themselves because putting a COE program is one thing. Getting members to use the program is completely different. And so you need someone else with experience in that space who has expertise in that space, and that's where we take a lot of that burden off on employer shoulders.

DREW HODGSON: Pivot a little bit here into some of your bundled payment solutions and what you work through. For pretty much every client, and Steve's probably going to agree, 90% of clients, the two top spend items are musculoskeletal, oncology, right? Those are the two big line items. Musculoskeletal is very well established as far as the COE is concerned. You've done a lot of work in that space. You started in that space. And there are plenty of different competitors out there, if you like, out there for you in that space.

Oncology is a little bit different, right? I'm aware, obviously, that you've branched into bundled payments in the oncology space-- surgical bundles around things like thyroid cancer, breast cancer. And I believe you're looking at others as well, which I find really interesting about how you do that. And I think you've certainly led the way in that.

Can you talk a little bit about that process? Because that is a little bit different. It's a lot more challenging to be diagnosed with breast cancer and going for a surgery than it is, oh, I'm a runner I need a knee replacement.

SACH JAIN: You are absolutely right, Drew. That initial set of programs in this space were hyperfocused on musculoskeletal procedures because they are highly episodic, very well-established. The procedures are fairly standard. And so that's where we ourselves got our start.

But, as I said, the mission behind Carrum is to bring the model of bundled payments to the entire surgical care span, and not just specific service lines. And so as we started to work with employers and they started to realize the benefit of these programs for musculoskeletal, they were like, why are you not doing it for bariatrics? We've got bariatrics saying, why are you not doing it for cardiac? We brought cardiac in. And those were, I will say, were also in some ways not very distinct from musculoskeletal, and they were relatively easy for us to expand into.

Oncology is a different beast, both from diagnosis standpoint as well as treatment standpoint. It's a different beast. And it's not very episodic where in a month, everything will be done and you can close the case. So it

required really rolling up the sleeves to figure out, what are the different cancer pathways? What are different type of cancers that are low hanging fruit for us to take on?

And so we focus on those. And a big chunk of that starts with the initial diagnosis where if you get the treatment plan right, that is where a huge win is because going to a facility like Memorial Sloan-Kettering in New York and having a treatment plan created by them is very different than your neighborhood oncologist. So we focus on that.

And then once the treatment plan is established and among different options of surgery, chemotherapy, radiation, you are prescribed for certain combination of those. Then there is a bundle that is associated with that treatment plan. And the best part is that given we wanted to make sure, irrespective of what bundle we focus on, providers are accountable for the quality of care. So for our oncology bundles, they come with a two year warranty, which is unheard of in health care.

STEVE BLUMENFIELD: It is unheard of. And just to be clear, by bundle, what you're basically saying is a price for getting the whole thing done as opposed to a separate charge when this person comes in to do this test on you, and a separate charge when we're using this facility, a separate charge for this. It's just, this is the payment. It's just like getting a price for a car, the entire car, as opposed to individual parts and a warranty on it.

SACH JAIN: That's exactly right. And it just gives the peace of mind to a member that there is no surprise bill coming my way that will put me in really financial crazy situation.

DREW HODGSON: That's the last thing anyone needs when they're diagnosed with cancer, right?

SACH JAIN: Exactly. Your health you are already stressed about. And you add on top of all the financial uncertainty, and it's catastrophic. And also, it aligns the incentive of the providers that if someone doesn't need radiation, they just need chemotherapy, just focus on chemotherapy only. You don't need to just do radiation just for the sake of doing it. And so just having a set payment starts to align those incentives that start to show the value both from a cost standpoint as well as quality standpoint.

STEVE BLUMENFIELD: It is amazing where we are in health care today that that's a novel thing, right? I think of all the surprise billing legislation that's out there and all of the travesty, people going bankrupt just trying to pay for their medical bills, for goodness sake, if they're especially unlucky enough to not have a good insurance. And everything else you purchase, this is already assumed. So kudos for bringing this to the market.

SACH JAIN: I'm sure you've heard of the statistic that one out of five American has a medical debt in collection. How insane is that?

STEVE BLUMENFIELD: Oh, it's unbelievable.

DREW HODGSON: It is. So what's next? I've heard rumors. I've talked to some of your colleagues, obviously, around maternity, substance abuse. What's the medium hanging fruit that you're going after next?

SACH JAIN: We are in discussions with employers every day to understand what the other burning items are in their benefit span, both from cost standpoint as well as quality standpoint. Obviously, mental health is a huge topic nowadays, and a lot of great companies are doing a lot of great work in making it more accessible and virtualizing it.

But still, there are treatments over there that in the facility component, it adds to it and which is where Carrum Health specializes in. How do you bring these expensive infertility treatments as part of our model, put a bundle around them, and make everyone accountable for the quality of care? So that is our focus on behavioral health.

Same with pregnancy. It's a specialty for employers with relatively younger population. In addition to musculoskeletal and oncology, women's health is the biggest spend area. And pregnancy lends itself very

well to bundling because it's, by definition, just highly episodic. And there is a huge gray area of what should be a natural delivery versus c-section just to start with. And there are a lot of low hanging fruit over there. We actually published a research study on that in partnership with UCSF that how a bundling approach could be brought to pregnancy. And you'll be hearing more on that topic from Carrum in the coming months and years.

STEVE BLUMENFIELD: Can you share with us a little bit about what it takes for an employer to make this work and how they pay for it?

SACH JAIN: Yes. So from an employer standpoint, as I said, the focus has been to make these programs essentially plug and play. We work with them. Everything is pre-configured. They have the choice to decide which procedures they want to offer to their employees, in which markets, and with which COEs. So they have the opportunity to configure as much as they want, but the reality is that almost every employee we work with, they take every single COE and every single procedure we offer.

The rollout, even for national employers, is almost a four weeks exercise where they make the introduction for Carrum to their other ecosystem partners, the health plans, the other solution they are using, and Carrum takes it from there. Employers can implement it at any point in that year. It doesn't have to be aligned with their benefit cycle. And especially at the moment when a lot of surgeries that are on a backlog and employers are worried about this span that is going to come their way, there's a lot of interest in rolling out a solution like Carrum in the off-cycle fashion.

STEVE BLUMENFIELD: So what I think I'm hearing is once that's all done, you're taking care of the billing to the payer-- in this case, the employer. And then any kind of balance that's going to the employee, you're working through all of their plan design and you're meshing that up with your bundled payment approach with the provider.

SACH JAIN: That is exactly right. And, as I said earlier, we are already working with most of the major carriers and most of the other digital health solutions, so it becomes just turning the light on on a new account for a new employer. And from a payment standpoint, there is no cost to implement Carrum. And the only fees employers pay directly to us is in the form of the platform fees to join the platform. And after that, they pay on an ongoing basis based upon the utilization of the solution. So if an employee goes through a procedure and they have a transaction done through Carrum, we bill the employer directly, and they make that payment.

DREW HODGSON: Pivot again here a little bit. You recently did announce your strategic agreement with Vizient. First of all, I think it would be great for the listeners to understand who Vizient is, number one. And you partnered with them to help to accelerate your growth, right? And number one I wanted to understand, I think and listeners would like to know is then, how that's going to work. But also, Carrum I think has been very selective about who they partner with, right? And how are you going to balance that, that you're emphasizing quality, but yet want to grow geographically? Where is that balance going to be?

SACH JAIN: Absolutely. So Vizient is the largest group purchasing organization for providers in the US. So more than half of the provider organizations in the US, more than 95% of academic medical centers in the US, are Vizient members. In addition to that, they also have, perhaps, the biggest clinical database in the industry. We have member organizations share their EHR data.

So when we started to have this discussion with Vizient, the idea was that for us to grow our COE network rapidly, we need to overcome two bottlenecks. One is the contracting process, which takes a long time with providers. And second is quality evaluation process. Given the amount of data that we ask for the providers, it takes them a while to put that together. And in some cases, it take months.

So through our Vizient partnerships, both of those bottlenecks are removed because providers are already contributing a lot of those metrics to Vizient, and we have a master service agreement in place with Vizient that members can use. So it cuts down the timing of bringing a new COE on our platform by almost 80%. And for an employer that is looking for certain COEs in certain market, it gives us almost an ability to bring them on the platform on-demand basis.

To your point about quality, the quality evaluation process does not change. Whether we are working with a COE directly or through Vizient, they have to meet exactly the same quality standards. But just the logistics of bringing them on the platform accelerates significantly because of this partnership.

DREW HODGSON: Yeah, so you're not changing the evaluation, you're just making it quicker to be able to evaluate the person.

SACH JAIN: Exactly. You'll be surprised how long it takes to complete this quality evaluation process with the provider. In some cases, months because in some cases, they have not tracked those data sets. And so we push them to figure out a way to get those data sets. And a relationship like Vizient, where a lot of this data already exist and they can formulate that data in a fashion that Carrum can accept easily, it just accelerates the whole thing.

STEVE BLUMENFIELD: You're essentially expanding from a data pool to a data lake, right? So rather than thinking of it as going from the top 10% to the top 20%, you're not doing that. Instead, you're going to the top 10% in a pool where there's data of a multiple of the current pool you've got. So you're just finding more of those top 10% because the current pool is so shallow that you're needing a bigger pool to test.

SACH JAIN: That is absolutely right. And the challenge in COE programs have been that if you acquire a COE one by one, it just takes very long to meet the demand side of the platform. So Vizient is really unique in that way to help us accelerate the model. And just very excited about this partnership.

STEVE BLUMENFIELD: Let's say Carrum were an animal. What would Carrum be?

SACH JAIN: How about a butterfly, which symbolizes transformation. The butterfly effect is small changes in the current state leads to big rewards, big changes.

STEVE BLUMENFIELD: Nice. Nice.

SACH JAIN: And I think what we are doing at Carrum hopefully will have that butterfly effect in the payment model of health care.

STEVE BLUMENFIELD: Wow.

DREW HODGSON: Steve, I think that may are the best answers to that question I've ever heard.

STEVE BLUMENFIELD: I think it might be. In fact, I think that we may hear that at the start of this pod as well. What a great way to close the podcast. Our listeners learned so much. I learned so much. Drew may have known it all already, but totally learned an amazing amount about Centers of Excellence and, in particular, about the great things you built at Carrum. Thanks so much for the time with us today.

SACH JAIN: Well, thank you, Steve and Drew, for having me here. And I really enjoyed the conversation. It was so much fun. And thank you again for inviting us.

STEVE BLUMENFIELD: My pleasure. Drew, it's awesome any time I get to see you. Thanks so much for joining us on this pod again today.

DREW HODGSON: Thanks, Steve. Good to see you, too.

STEVE BLUMENFIELD: And Thanks mostly to you, our listeners, of the Cure for the Common Co. podcast. We appreciate you listening. If you like it, don't forget to rate us and make some comments, subscribe, tell your friends. Thanks, everybody. Have a great day.

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