

Vator.tv Podcast 1.1

Transcript

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VatorNews recently invited **Healthmap CEO Eric Reimer** to join them for their podcast series on how technology is changing healthcare. Among the points Eric discussed: How to use advanced data mining and analytics to identify individuals with kidney disease who aren't getting treatment or whose treatment is suboptimal; how to combine best clinical practices with all available information, including pharmacy, claims, lab, and member data, to develop highly individualized care plans; how to connect to the provider ecosystem; and where cost savings occur for payer organizations.



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Welcome to the Vator News podcast. I'm Steven Loeb here with Bambi Francisco Roizen, and we're speaking with Eric Reimer, CEO of Healthmap Solutions, a kidney population health management company. We'll learn about Eric and Healthmap on this podcast. But first, a little bit of background about our goals. Our goals are to understand how technology is radically changing healthcare - the way we screen, treat and measure progress and outcomes; whether technology is helping or hurting our well-being physically and mentally; and whether we're creating productivity that drives economic costs down while improving overall health. Eric, welcome to the show. Thank you so much for being here.



Thanks for having me on.



So, let's start by learning about you. Tell us about your background, your career, and what led you to join Healthmap.



I've been in healthcare for 30 years. I started out as a consultant back in the



very early 90s. I went back and got my MBA at Wharton with a focus on Healthcare Management, then ended up moving into the payer side of things working at Cigna and Prudential Healthcare.

When I was at Cigna, one of my roles was structuring deals with vendors. And I learned how to structure a deal so that a vendor and the actual health insurer could benefit and do well. And that is a real skill, the nuances of how do you get to yes, how do you structure these contracts?

... grew that business in 18 months from a \$40 million revenue business to north of \$400 million, and really expanded the capabilities of the business and the members we served.

From there, I decided I really wanted to be on the payer service side where I saw that even a big company like Cigna needed partners that were really focused on specialized areas of healthcare. So, I took a position running a big behavioral health unit for Magellan Behavioral Health. Where my customers are, we're large Blues plans in the Midwest, southeast and western United States, and I worked for about 18 Blues plans. And what we did was capitated behavioral health. We took full risk, we made sure that outcomes and costs for members went down. And after that, at Magellan – as part of Magellan – I became in charge of M&A and strategy.

We bought another company, National Imaging Associates, which was an advanced imaging company, and really grew that business in 18 months from a \$40 million revenue business to north of \$400 million, and really expanded the capabilities of the business and the members we served. And that was my first taste of real hyper growth. That was in 2006 to 2008. And I was hooked. I just really love the idea of, you know, how you could scale – change your value prop, bring on the right team, and then scale a business so that you could grow five to 15 times over a couple year period. And so that was the first time I had a chance to do that.

I was then asked to take over, in 2008, a business called CareCentrix, backed by Waterstreet, about a \$300 million business, and it was serving health plans again. And what they were really doing is making sure that you were efficiently using home health care – that meant nursing equipment and



infusion therapy – and that you were doing positive things with that great side of service. Now, everyone talks about the home; at the time that wasn't, you know, nearly as popular. This was back in 2008.

We took that business from a few hundred million dollars to a business that was doing a billion dollars of revenue a year, expanded our customer base, but most importantly expanded the functionality that we had. We got into home sleep testing, so we were taking people out of facilities and testing them in the home. We bought a business that was run by my current Chief Growth Officer, Tom Gaffney. We also built an all-cause readmission prevention business, where we would take risk and say, we'll put people in the home post-discharge. We'll come into a home within 48 hours, and we'll make sure that member is stable so they don't go back and forth to the hospital. We'll take full risk on it. So, I really learned about site of service management and the ability to dramatically reduce costs by making sure the member was being treated in the most effective site of service. We tripled that business, like I said to north of a billion dollars.

In 2013, I decided to step back and not run day-to-day health care businesses. I was going to become a chairman and board member of a number of different businesses. I won't go into all of them, but they were all very successful, all with these hyper growth characteristics, in women's health care, one in behavioral health care.

And then one business that I got excited about was Healthmap. I primarily got excited about it, or I should say initially, because one of the stars at CareCentrix started the business along with a co-founder, Joe Vattamattam, and Andrew Wall started this business. I knew Joe for many, many years at CareCentrix; I was excited to work with Joe and support him as the chairman.

We took that business from a few hundred million dollars to a business that was doing a billion dollars of revenue a year, expanded our customer base, but most importantly expanded the functionality that we had.

Did that in 2014. And the business was making progress, had a first customer, started to get data on and understand what it could do in the kidney space. We'll talk more about what we do.



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But then COVID hit. And when COVID hit the need to round out the team, the group, grew dramatically. The business was scaling at the same time with much more interest, and we really needed to change, in some ways, everything about our business. I wasn't going to come in and do day-to-day management, and I said I would only do it if three things happened. One, it was great people: I had to be surrounded by a team I knew would do a great job executing, would be impressive people, but also people I wanted to work with. And I was able to bring in and build my team there.

The second was, it had to be in a place that just had this chance for massive growth, again, rapid growth; five, six, seven, 10 times where we were. And then last, it had to be work that was going to really make an impact on the population. I did want to see how we were going to help patients' lives, and Healthmap checked all those boxes for me. I was asked by the founders to come in and work with them to scale the business, and I came on board in October 2020 to do that, right in the height of COVID.



All right. Well, that's great. You brought up COVID, so let's talk about that and the impact that COVID had on Healthmap. How did that change? You said that it basically changed everything about the company, so talk about that. How did it change the trajectory of Healthmap? Did it increase interest in your platform? What happened to you over the last two and a half years?



Well, first I'll just talk about what has changed about our offering and operations. I mean, like many companies at the time, we were all office-based, you know. We were based in Tampa, we were sending people out into the field, but everybody was from a home office. All of a sudden, everybody's offices had to close. Providers didn't really want us coming in to their offices, because most providers, many providers, were shut down. And they certainly weren't going to take extraneous people into their offices, members certainly didn't want us coming into their home.

So, we had to think about our offering. We had to get to the point where workers could be virtual, overnight. They needed equipment to allow them to do that. We needed to have all the PHI secure, etc. So, we had to change our systems, our processes, and how we thought about managing care. And we did. We learned how to be effective in a virtual world. We brought our nurses, we allowed them to be virtual, our technologists, etc., and most of our company for a period of time was virtual. And what I will say is it's made us much more scalable now than we would have been without COVID. But it really pushed us to dramatically accelerate a world where we could be more scalable. And so that was what happened in our business, in our operation.



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And it made us really thoughtful about what does need to happen face to face and what can be done virtually, which as you know, can be more efficient. So that was how the operation changed.

As far as the business and the interest in kidney, I would say it wasn't just COVID. I would say there were there were four things that really accelerated the interest in the business, sort of all coming together in a perfect storm right as COVID was giving us the challenges of changing our business. We had these other things, including COVID, that were really accelerating the demand.

The first is COVID does have a differential impact on folks with underlying kidney disease, so it absolutely did highlight the fact that a lot of payers and providers didn't have a great solution for how to manage these folks. So that was the first thing.

Kidney disease certainly is more crippling to people of color. The prevalence is higher and the treatments often are not equal.

Then there was the Cures Act that was passed, that required payers to take responsibility for these members. In the past, they would just go to Medicare fee for service. I won't get too far into the legislation, but that really increased interest.

The third is, everybody is much more cognizant of health equity. Kidney disease certainly is more crippling to people of color. The prevalence is higher and the treatments often are not equal. And so that brought more interest to the space.

And then the last thing I would say is the competitive landscape, because there were a number of competitors coming into the market. We were the first, but competitors coming into the market, that drums up interest. I've been in businesses that I've run like CareCentrix, at the time, we didn't really have a competitor. We had to generate all the interest in the market. In this case. I think the fact that all of us, all of us competitors are knocking on folks' doors and getting them aware of the space and making folks understand the need, I think in some ways lifts the whole industry.



Well, obviously, there are a number of other companies in this space, as you mentioned, and so it would be great to talk about your differentiation. I know that there's DaVita. They recently partnered with Medtronic to develop new



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therapies for patients with kidney failures. Also, Strive Health, Monogram Health, Cricket Health, I'm sure I'm missing some. What is your differentiation from those companies? What's unique about Healthmap?



I would say there's a handful of things. I think first, everything we do is extremely data-driven. We're combining the best clinical practices that are well-documented; we're also combining all this data that we generate. We get pharmacy data, we get claims data, lab data, we get data directly from our members, we're putting that all in our engines. And because we've invested so much in our technology platform, the underpinnings of our company, we're able to run all these algorithms to find folks that aren't getting treated according to best practice or, according to how we see through data, that are not going to have optimal outcomes. So, using all that data, we then are connecting to the provider ecosystem. Our competitors, their first reach out is always to the member. They do partner some with nephrologists and dialysis clinics.

We really want to go upstream. There's stage 3, 4, 5, and then ESRD. The higher the stage, the more severe the disease state; you're getting closer and closer to ESRD. If you end up in ESRD, it's a failure. It will significantly impact your quality of life and your cost for the remainder of your life. The best thing you could do for these folks is to slow down the disease state. The only way to do that is really to engage early, which is the case in a lot of areas of healthcare, right? If you can catch cancer quickly, you can really have an impact. Same thing here. But if you wait to stage five and to ESRD members, you've missed that opportunity. The damage has been done. So, we go much further upstream. By doing that, we can only do that better than our competitors, because we have the technology.

So, we get all this data on every single member that we are going to treat. Based on their data, based on everything we know about them, we come up with a healthy action plan that is customized for that member. That's so important, because unlike some areas of healthcare, there's so much differentiation between one stage 3 versus another stage 3. Some have hypertension and diabetes, some don't. Some have a very active lifestyle, some don't. Some haven't even detected that they have kidney disease, some are very well aware. So, we've got to have that ability to customize. We can only do that efficiently at scale because of our systems.

The other thing we do that's very different is we go through the providers. As I said before, our competitors are really focused on the nephrologists and the dialysis clinics. We go to the PCPs, the endocrinologists, the cardiologists, and the nephrologists. If you're going to go upstream to stage 3 and 4, you



have to work with the PCPs. If you're going to work with PCPs, there are some challenges. In a market, there's probably 25 times as many PCPs as there are nephrologists, so you've got to engage and connect with so many more doctors to be effective. You also have to realize that the PCPs are seeing maybe one out of every 20 of their members who has kidney disease, so you have to give them different information, you have to work with them in a different way so that it's seamless in their workflow, so that they think of you top of mind on that one-in-20 member.

So, it's working with the docs, going more upstream, being very, very data-driven, and then having the doctors themselves sponsor the program. So, we go to the doctors first, we onboard them, we convince them of the benefits to their members and their practice. Then they go to their members and tout the program. Because of that, we're able to get 65 to 80 percent of the members we identify as having kidney disease to join our program. That's unheard of. As far as engagement in any industry in healthcare, typically you'll get 15 to 25 percent if you're lucky. We're getting a much greater engagement rate by working with the providers first to help tout the program.



Good. Let's talk about kidney disease. I looked at some stats around this, and according to the CDC, there are about 37 million U.S. adults who are estimated to have it. And it's the eighth largest cause of mortality, the 10th largest cause of life lost and the 10th largest cause of disability adjusted life years. It's a really big problem. It sounds like what you're doing is using that data to identify who has kidney disease early and then personalize their care in a way that hasn't been done before. How do you detect that early? What data are you using to make sure that you identify those patients before they get to that point?

In a market, there's probably 25 times as many PCPs as there are nephrologists, so you've got to engage and connect with so many more doctors to be effective.



We get lab data, clinical data from an EMR, we get pharmacy data, we get claims data, and again, we get information directly from the member. We take all that information, run our algorithms, and make sure that we're engaging with folks earlier in the process. And we really tout the fact to our health



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plans that the opportunity is to engage these folks in stage 3 and stage 4 early to slow down the progression. And you may say, well, why wouldn't everyone do that? And why don't you hear more about this? In stage 3 and 4, a lot of these members have diseases that take precedence over kidney in the eyes of the doctors. They've got hypertension, they've got diabetes, and the members are well aware of that. They're treating those diseases, but they're not understanding that there's this underlying kidney disease. Both the doctors and the members often look past it. And what we do is really bring that attention to the forefront. We make sure that the drugs folks are taking are kind on their kidneys, which isn't always the case, even what's prescribed by a doctor. And then we really stress the importance of adherence, because at that point in stage 3 and 4, it may not be a debilitating disease yet and folks may not really understand the importance of adhering. And when I say adherence, I mean you need to take your drugs, you need to see your specialist on schedule, you need to take labs to keep monitoring the progress of your kidney disease, and you need to adhere to the doctor's regimens around nutrition and exercise. Too often at the early stage, it's hard to get their attention because they're dealing with other disease state, and we just lift that up; it's top of mind.



It's interesting that it seems like what you're saying is that doctors don't take kidney disease. I wanted to say as seriously, but it seems like they take other parts of someone's health as more serious than their kidneys. Why would that be? Because it seems like kidney disease – like I said, it's very prevalent and it's a big cause of mortality. So why don't doctors take it more seriously?



I wouldn't say they don't take it seriously. Nephrologists, obviously they're taking it unbelievably seriously. The PCPs, the members coming in often, they've got hypertension or diabetes, and like a lot of things in life, you deal with the most pressing issue at that moment. They don't want to overwhelm the member by bringing in another disease state. And that's not their specialty, the PCPs, it's not their specialty, these are very complex patients. So that's why we really encourage folks early on to see their nephrologist, and again, take these labs, take their drugs, and it's that adherence. We're not by any means trying to manage cost out in that regard. What we've tried to do is get people to adhere more by doing preventative care, seeing their specialist, the labs, the drugs, which results in big-time savings in reduction of inpatient, unplanned inpatient stays.



Eric, my father had kidney problems, which led to all sorts of comorbidities. But I wonder if the cohort, the diabetes and the hypertension, triggered that



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kidney problem, which it sounds like it does. But at the same time, you're saying that underlying a lot of these conditions is a kidney problem. So what comes first, what triggers chronic kidney disease?



Well, what comes first is diabetes and hypertension, and the kidney is at the end. And so again, when you think it's earlier stage, people are more focused on treating their diabetes and hypertension. It's like an automobile, you know. You're pulled over to the side of the road. The first thing you're gonna fix is, you know, make sure that there's gas, make sure that you've got four tires that work, etc.. That doesn't mean that the underlying engine is working perfectly, but at that stage, you're first addressing just getting that car running. And too often, again, we're not getting to the root of the underlying problem that now is going to have a significant impact on that member.



So, it sounds like you're getting to these folks. You know, sometimes even at stage 3, they don't know that they have a kidney problem that's worsening. What are you identifying? And how many years prior to when it really becomes a problem are you saving? And then it sounds like there's a health plan involved, which probably means eat better, exercise and all that. But what is it that you're identifying, to say to the PCP, hey, you need to get this person on some sort of treatment plan.



Yeah, so as I was saying before, the variability among stage 3s and 4s is massive. Some are already seeing a nephrologist. Some of them are seeing an impact on their day-to-day activities and health. Some of those folks are going in and out of a hospital quite frequently. Others are going about their lives; they have no idea. It's as if... I'll go back to another automobile analogy. When your kidneys fail, it's like your car running out of gas. You really don't know it well in advance, it just sort of stops, and you're doing a lot of damage along the way as your kidneys are getting weaker and weaker. Unless you've got a gas gauge, which is telling you how much gas you have in that car. It's the same here. If you're taking the right labs, you can absolutely know the kidney function that you have.

So once we find a member who has kidney disease, the first thing we want to do is stabilize them. We want to keep them from going in and out of facilities. If they are going in and out of inpatient stays, what is causing that, and how can we be helpful? Quite often you find out they're not taking all their meds on time. They're not following the labs, they're not adhering to the doctor's orders. Once in a while, we do find that the doctor's orders are not – now remember, there's a lot of members touching these folks. You could be seeing your PCP, your cardiologist, your endocrinologist, they're all prescribing



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something slightly different for you. And sometimes we find, for example, that people have prescribed nephrotoxic drugs that actually hurt your kidneys, that doctors have prescribed these for members that have underlying kidney disease and again, it's because they are more focused on curing, you know, the most pressing disease without a focus on the whole body.



Well, who's the candidate that you would say you need to, you need to check this person because it sounds like you really want to get them before stage 3. And I'll give you an example. So my brother, he has diabetes, he doesn't know if he has a kidney problem. But of course, we have a history of kidney problems with our father. Would he –as far as I can tell, I don't think anyone's tested him for any kidney problems. But how do you identify who the person is? When is particularly if this is well before any complications?

To monitor your kidney function, you just need to take certain labs, you know, on an as-prescribed, you know, repeatedly to see the trend, the trend line of those lab results. And if somebody has a family history and hypertension and diabetes, they absolutely should start testing.



Yeah, so like most areas of healthcare, you have to do a cost benefit of it. How often do you test? What population are you looking at? I would say, for stage 3 and up, there's no question there's an ROI to intervene on that population, all stage 3, 4 and 5, and ESRD members. When you go back even further, what some plans are starting to do on stage 2 and 3 is say everybody who's got diabetes and hypertension should get a test, and then start monitoring their kidney functions. To monitor your kidney function, you just need to take certain labs, you know, on an as-prescribed, you know, repeatedly to see the trend, the trend line of those lab results. And if somebody has a family history and hypertension and diabetes, they absolutely should start testing. Now, health plans aren't calling for us to do that. They're asking us to get involved at stage 3 and above. At times we're asked to monitor stage 1 and 2 members and just look at whatever data is coming in not to actively engage with them, but just see what we can do. But I do think in the case of your family member, they should absolutely go and talk to their PCP about getting a lab screening.



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So, you're working with PCPs, who already have patients that have stage 3 and stage 4, that's your market now. We talked to a lot of primary care physicians, in fact, we have an annual event focused on the changes of primary care. How many do you have? How many are you working with? And how do you win them over? Because they're pretty under inundated with a lot of new technology, right? They're the gateway to the patients.



To quantify how big we are, we work with over 125,000 Kidney members, CKD and ESRD. And those in stage 3 and 4 probably are about 100,000 of those 125,000, maybe a little less, maybe 85,000 of the 125,000. But an order of magnitude, it's 85,000 to 100,000 patients. So we do interact with a lot of PCPs. We're in 30 states. And the way we get PCPs excited about the program is a couple of things. We tell them we're an extension of their program, of their office. PCPs, as you know, are overwhelmed with the number of members they have to see; if we can be reaching out to those members and again, checking on adherence, doing patient education around diet and nutrition and exercise, having a nurse help them and check in on them.

One of the things our nurses do a lot of, which again, a PCP wouldn't really be able to do on their own or wouldn't have the time to do on their own, we do a lot of the Social Determinants of Health to find out the barriers to care. Now there are times where the member knows the right thing to do is to take a scrip but they can't afford it. Or they can't get a ride to their doctor, so they don't do it. Or they don't understand that you don't just take the lab if you're not feeling well. If you wake up in the morning and you're feeling better, you're still supposed to take that lab. And it's really that connection we have with a nurse with that member. And that's provided, obviously free of charge to the doctor so it becomes an extension we give to the doctor. Any information we get from the member we feed back to the doctor. So that's one thing we do.

Second, the PCPs, again, are overwhelmed with the amount of work and the complexity of the members that are in front of them every day. [Kidney patients] are among the most complex. So if we can simplify by taking all the information we have about these folks – their drugs, what the cardiologists may have said and prescribed, the endocrinologist may have said and prescribed, and what we're hearing from the members directly – and then we can put it in a seamless way in front of them when that member comes into the office, or contact them even because a member is not coming into the office, we can then make their jobs easier, we can make them more efficient. And we hear all the time that the PCPs find that we give them more leverage over their practice.



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And just really quickly, when you said providers, are you going to sort of health systems and the providers? Or would you work with sort of corporations, and a lot of them have on-site clinics now and providers? So are you going to health plans – or not health plans, but health systems, health providers, or corporations?



All of the above! If we're working with a health insurer, we absolutely go to health systems and we go to multi-specialty practices, we go to single-shingle PCPs, we still do a lot of that work in the doctor's office. If now that COVID has stabilized a bit, we're back in the doctor's office, we are putting our feet on the street. We have people that are working in those 30 markets in the 30 states I mentioned, so we are there. I would also say that health systems now have risks. Right? And, and, and, big, multi-specialty groups hold risk, where that's been downstream to them will also work with those folks and put our kidney program in place and, you know, show them how to reduce costs and improve outcomes.



Listening to what all that you just said, the thing that came to mind was that I go for my annual checkup every year, and I see my primary care physician, and nobody checks my kidneys. I don't think I've ever had anybody ever look at them or tell me anything about them. And it seems like the best way to identify kidney problems early, kidney disease, would be to have it be part of that annual checkup. Do you think that that's something that we should do should be incorporated into that primary care visit?



I would say that again, it depends on the factor of what the member's presenting. I would say if you've got diabetes and hypertension, then absolutely. Should every person in the United States get a screening for kidney? No more than every person should get a screening for, you know, different types of cancer. This system always makes those decisions, you don't get a colonoscopy every month, you get one every X number of years. And it's similar here. I think if you're in a high-risk group, and that's based on your history, your other disease states, etc., then you absolutely should be getting that test.



I have a quick question, how much does that cost? How much – I mean, I know that we spend a ton on redundant testing and a lot of tests that really are unnecessary. But how much does one of those cost?



It's not very expensive. There are companies that – we're not in this space – the are companies now that health plans are encouraging to mail out testing to people in the home. It's not a very expensive test. But I will say it's not very



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helpful if you take it once. Really, the most important thing to look at is to track your kidney scores over time. Right? So, if folks are in a high-risk group, they should be getting lab testing frequently. And you know, it depends on the stage, etc. And it's really looking at the differentials between different lab tests that will make those determinations of how, you know, how your treatment should go from there.



There was another aspect of Healthmap I wanted to bring up, which is your Care Navigation team. I think you mentioned that earlier. And they work with patients and providers to deliver personalized care. So who's on that team? Who are the different members? What kind of expertise do they have?



So first and foremost, we have kidney nurses, so the person that's most likely engaging with the member and on point for that member's care is a kidney nurse. We also have pharmacists, nutritionists, social workers who can help on Social Determinants of Health. Most of the time, the nurse on point will actually ask the pharmacist or nutritionist or the social worker for their advice and they'll stay on point. Once in a while, based on the nuance of the case, we will have the nutritionist talk directly to a member, a pharmacist talk directly to a member etc.



When you say a kidney nurse – I've never heard that term before. Are there nurses that specifically specialize in kidney care?



Someone with experience working with kidney patients, so they would have worked with nephrologists in the past etc. They're RNs.



How come you don't have nephrologists on staff?



We want to be very pure about our mission. First of all, we're not trying to take away members from the nephrologists they're already seeing. So when we go into a health system or a health insurance company, they already have nephrologists that are in the network. We use those nephrologists. We refer into those nephrologist, we don't put them on staff, because what that really does is you're seeing your nephrologist, and our nephrologist then is just giving a second opinion, and oftentimes that will create a barrier and we'll get the current nephrologist that's really the practicing nephrologist up in arms that you're now competing somehow for that member. We don't do that. We also want to make the nephrologist that they're in the market already better and more efficient, more effective. I would also say that about dialysis.



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We partner with the DaVitas in the world. We're not building dialysis clinics. There's more than enough dialysis clinics in America. There should be less because people should be getting dialysis in the home. We work with whoever the dialysis provider is that the member happens to be using. And we actually make sure that the member is getting dialysis and adhering to their schedule as prescribed. That's probably one of the most important things we can do.



So from what I'm hearing, and to use a software terminology, it sounds like you're kind of middleware, right? You're coming in, and you're providing the support system, or at least the go-between between the PCP and the nephrologist, the specialists and the dialysis treatment centers, and you're really providing the support layer with the nutritionist and the social worker and the nurses. So that sounds like you're adding a layer of cost, but at the same time, you're probably shaving a lot of costs. Where are you shaving the cost? Because they're gonna have to pay for your service now.

...most of our savings come from eliminating facility inpatient stays that are unplanned.



Yeah, when we get involved, you will see that doctor visits will stay the same or actually increase, so the doctor visits will go up in cost, the number of labs and the lab costs will go up and the cost of the pharmaceuticals. The savings that offset that many, many times over is on unplanned inpatient visits. So it's for folks who aren't staying in front of their disease state and then needing to show up at an ER. Or they're having acute issues and then, all of a sudden, they're going to the inpatient stay. So, in this particular disease state, there's underutilization of preventative services and maintenance services. And there's an overutilization, unfortunately, of these acute episodes. So most of our savings come from eliminating facility inpatient stays that are unplanned.



And you have studies that already show that they've been able to collect that data?



Absolutely, absolutely. We typically measure our results across all the eligible population, which is very different from some of our competitors. Once we



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work with a health plan, we identify all their stage 3, 4, 5, and ESRD members. And let's say it's 20,000 members, we basically will show all of our results on that 20,000. That's our job, to control the cost of those 20,000. As I said before, we may engage 65 to 80 percent. We've got to save enough and improve the outcomes enough on the 65 to 80 percent that we engage to make a difference, but what we find is across that fully engaged population, we can reduce those facility costs by 25 percent or more. And you know, that's the kind of cost people want to eliminate. I mean, frankly, no one wants an unplanned inpatient stay because they haven't kept up with their meds or they're having an urgent issue that could have been dealt with by just, you know, adhering to their own treatment and maintaining good health.



So let's talk about your business model a little bit. How do you actually get paid?



I mentioned before that we look at all the eligible people, not just those that we get engaged. Some of our competitors will engage 15 to 25 percent of the folks and they'll talk about how they move the needle on those folks. By definition, there's some selection bias in doing it that way – you know, the folks that are most interested in their healthcare and willing to make changes are the people that put their hands up. Again, we're looking at that 65 to 80 percent.

And so we get paid on all the eligible members, once we define that eligibility. So sometimes it's stage 3 all the way up to ESRD. Sometimes it's stage 3 members that have hypertension and diabetes all the way up to ESRD. We get paid a fee on all those members; we put 100 percent of those fees at risk for achieving savings that more than offset our fees. And then once we save even more than that, we begin to share in the upside that we create. And typically, you know, this is pretty significant. Just to give you a sense, if you're a Medicare plan, we would typically care for about ten percent of your members. And those ten percent of members result in about 20 percent of the total cost for that Medicare plan. If we can bring down the cost by ten percent net of our fees, that's improving the medical costs by two percent. That may not sound like a lot, but remember, health plans are targeting three to five percent margins in the business. So if you go to a health plan that's got a four percent margin in the business, and you can take a significant portion of their spend, save enough that you could then raise their profitability from, say, four to six percent, that's a 50 percent lift in their profitability. That gets their attention, to say the least.



Eric Reimer, CEO, Healthmap Solutions



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So is there a value-based component attached?



Well, I would say first, everything we do is value-based in the sense that we get no fees, and we get no payment unless we're improving the cost and improving outcomes. We always have outcome checks that we've got to do things like reduce facility costs, make sure that there's less inpatient utilization, less crashes into dialysis, meaning a member that doesn't even know that they had any kidney disease often crashes into the hospital, and if they're not prepared, they don't know the dialysis options in front of them, etc. By going upstream, we make sure that they're prepared for their options, and that dialysis starts in a controlled way. So we go at risk for the percentage of starts of dialysis that happened in the home or in a clinic. We go at risk for transplant education and getting members ready for transplant. So there's always a quality component. Ultimately, there's certainly a cost component, and we don't get any fee, unless we pay more for ourselves.

...the first thing is you want to make it as easy on their lifestyle as possible. If you have home dialysis, you can do the dialysis even at night while you sleep. So, you can have a job, you can have a social life, you can tend to your day,...



So you mentioned a couple of times doing dialysis in the home, what's the benefit of that?



A couple things. First, put cost aside for a second, let's just talk about a member's life. There are very few things in healthcare that affect a member on an ongoing basis as much as being on dialysis in the clinic. That means essentially three times a week, for multiple hours a week, you're going to have to go in for dialysis. If a member has to come almost an hour a day each way for dialysis treatment, that means they're on the road for six hours a week to get their dialysis. Oftentimes, you can bet that means they don't adhere to their regimen. And that leads to inpatient crashes and inpatient admissions.



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So, the first thing is you want to make it as easy on their lifestyle as possible. If you have home dialysis, you can do the dialysis even at night while you sleep. So, you can have a job, you can have a social life, you can tend to your day, whereas if you're in a clinic, it becomes overwhelming to everything about your life. So it's a huge quality of life issue.

Then you get to the cost side of the equation, and a couple things. One, you certainly find like I said that adherence is much greater, because it's in your home. You're going to have as much dialysis as you need, as opposed to saying, I got a flat tire or I was running late or I didn't want to drive two hours, I wasn't feeling up to driving two hours. So, people adhere to the regimen much more in the home than they do in a clinic. And then we do find that just because of that, there are a lot less inpatient stays that folks need, related to complying and in keeping their health and maintaining good health. Members are just more stable in the home. So it's really about eliminating those facility costs by preventing these events that nobody in the health care system would say is a positive event.



Yeah, we've definitely seen over the last couple of years a real move toward digital care, virtual care, in home care, thanks to the pandemic, obviously, because people couldn't actually go to a clinic or to a doctor, because those were shut down for whatever, you know, number of months, during 2020. And so that was a big shift. Do you find that more people are willing to take that kind of care, the dialysis and kidney care, in the home now than they were pre pandemic?



The needle is moving, but our country has a long, long way to go. Right now, about 13 percent of all dialysis happens in the home. There are many other countries where that number is north of 50 percent. And so you know, we need to get that number closer towards 50 percent. And there's goals that are even bigger than that, that have been set by the US government. I would say the members are more open to it. I would also say that the nephrologists are more open to it. I think folks like ourselves have really stressed the importance of it. They've educated the members. I think the nephrologists understand that, in many cases, it is the right treatment for their patients. And so, we're seeing that move the needle. There's a real movement towards home dialysis, and I think it's just going to pick up momentum.



Okay, so the doctor wants this, the patient wants this. The third component obviously is the insurance companies. Is that who's kind of standing in the way of getting that number to 50 percent?



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The insurance companies love it. They are pushing the dynamic towards moving folks into the home. So, you say well, what's keeping it? It's like a lot of things in life, you know, there's these dialysis clinics that have been set up. There's a lot of infrastructure around that. That's what a lot of the nephrologists are used to using, those clinics.

It's not every nephrologist that's comfortable with seeing folks in the home. A lot of the nephrologists would say when folks are in the home, I don't feel like I have as many touch points with them, and I don't know enough about what's going on with those members. Again, that's where we come in, where we say we can be that extension; we'll be talking to your member several times in a week. We'll let you know if anything's changing about those folks.

So, I think that the docs understand that it's a great solution for members in the right environment with the right suite of services around it, the wraparound services. And again, I think we provide a lot of those services.



And as you said before, when you do that in home care, and even heard this about doctors doing telemedicine appointments, even a video, they can see into the home, obviously being actually in the home would be better than, you know, seeing whatever you're seeing in the background of a zoom call. But even though that was for doctors, they would say I could get a better view into their life and what's going on with them just by seeing what their home life is like.

Right now, about 13 percent of all dialysis happens in the home (in the U.S.). There are many other countries where that number is north of 50 percent.



Absolutely. Again, as a reminder, before this business, you know, I ran the largest home health business in the country. And many of my team came from that company. And so, we believe in home health. It's just got to be used in the right situations, like everything I talked about today. It requires a lot of customization around the situation. If you send everybody into the home, it's just too costly a service. And it's also burdensome, as much as people want to get treated in a home. In some cases, because of COVID, a lot of folks don't want somebody coming into their home that's just seen 15 members. And so there's a balance.



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Steven Loeb, *Vator News*



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We think that when post discharge, we're used to being in a home. We think that when someone's getting home dialysis, there's value in that, but you have to use it selectively. And, to your point, though, you can see a lot through a camera. There are some things you can't, right; it's very helpful to see the whole house and see what the staircase looks like and are there loose rugs and, you know, walk me over to the medicine cabinet and let me see all the medicine that you're actually taking on a daily basis. You know, we're used to that, because that's the business we just came from. And you get a lot of value from being there. But again, it's got to be selective in use or you won't get the members to welcome you in.



Yeah, I would imagine that patients don't want doctors coming into their house all the time. Like, it's like having company constantly, right, you have to, I imagine that it's almost like that would become too much of a burden as well. So like you said, you have to find that balance between the two.



Yeah, and most often, it's not going to be a doctor, it's going to be a nurse that's used to going into the home. But again, it is expensive. It is a burden, so to speak, unless you're going to do something there that really requires you to be in that home. I mean, most home nurse visits in the US are really folks coming in to either change a wound or hook up an intravenous – they need to touch the patient for some reason. In this case, it's much more about member education.



Yeah, absolutely. All right. Well, this is fantastic. It's a great conversation. Before we go, let's look into the crystal ball. Let's make you into a little bit of a prognosticator. You know, obviously, a lot has happened in healthcare over the last couple of years. A lot of things have accelerated. As we talked about, things are changing very rapidly, it seems. So what is healthcare going to look like a few years from now? What's your vision for what that's going to be and where's health not going to fit into that?



Hopefully, COVID is going to stabilize some things. And I think that there'll be some things that stay forever. I think that folks have realized that behavioral health visits, for example, should be on telehealth. It's just more convenient. Maybe once every certain number of times you go face to face, but there are certain things that have proven to just be very efficient, that came out of necessity.

On the other hand, I do think you're going to see a rebound where a lot of folks, you know, want to be fully examined by their doctors, and there'll be going back into the offices. I think that's certainly going to take place.



I think you're going to continually see more innovation around devices and equipment, and you know, the amount of information that you're going to be able to get about a member is going to go up significantly – exponentially.

So, you know, between remote patient monitoring, between apps that allow members to give you feedback, hourly or daily, on how they're feeling about their own condition, etc., we're going to have all this information coming at us. That could be good, but you need to know what to do with that information. And you have to know what's important, what's not, otherwise you're overwhelming an already-taxed system. So, I think folks like us, we'll be experts in saying what are the priority data? What should we do with this? How is it actionable? We make that actionable for the docs, I think that positions us well.

...we've grown more than 500 percent over the last year. Our employee base has grown 700 percent. I'm really focused on the kidney, but I do think that over the next couple of years, you'll see companies like ours getting into other disease states.

I do think a couple things we'll see, particularly in our company, I think we will go more at full risk. We'll do a more traditional capitated model. I'm used to that from behavioral health and advanced imaging, and I think it will look more like value-based bundles in some cases. And so, you're going to see a movement towards more capitation in our space. And then I will say, again, when we manage somebody, we manage the full patient. We manage their hypertension and diabetes as well as kidney disease.

We've learned that a lot of what we're doing with nurses and using data proactively and coming up with customized care plans is applicable to other disease states besides the kidney, and right now, there's so much opportunity in the kidney space itself. You know, we've grown more than 500 percent over the last year. Our employee base has grown 700 percent. I'm really focused on the kidney, but I do think that over the next couple of years, you'll see companies like ours getting into other disease states. We have the team and the infrastructure, and the model we think will lend itself to doing that.



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Okay, so it sounds like kidney is just the beginning for Healthmap.



It's a big beginning because it's so big and it's so important. And it's really still at the very beginning of a marathon. You know, there's less than ten percent of the market being penetrated and served, so I think we and our competitors all have a lot of room to grow. But I do think that it makes a lot of sense over time to think about a service that can be cross-sold, and data can be shared across different disease states that are of a high prevalence and overlap with kidney disease.



All right, perfect. Well, Eric, thank you so much for joining us.



My pleasure. Thank you for having me and inviting me to the podcast. I really appreciate it.



I'm Steven Loeb here with Bambi Francisco Roisin. We've been speaking with Eric Reimer, CEO of Healthmap solutions. You've been listening to the Vator news podcast.

