Quantify Health Value Proposition for Health Plans/ Health insurance carriers

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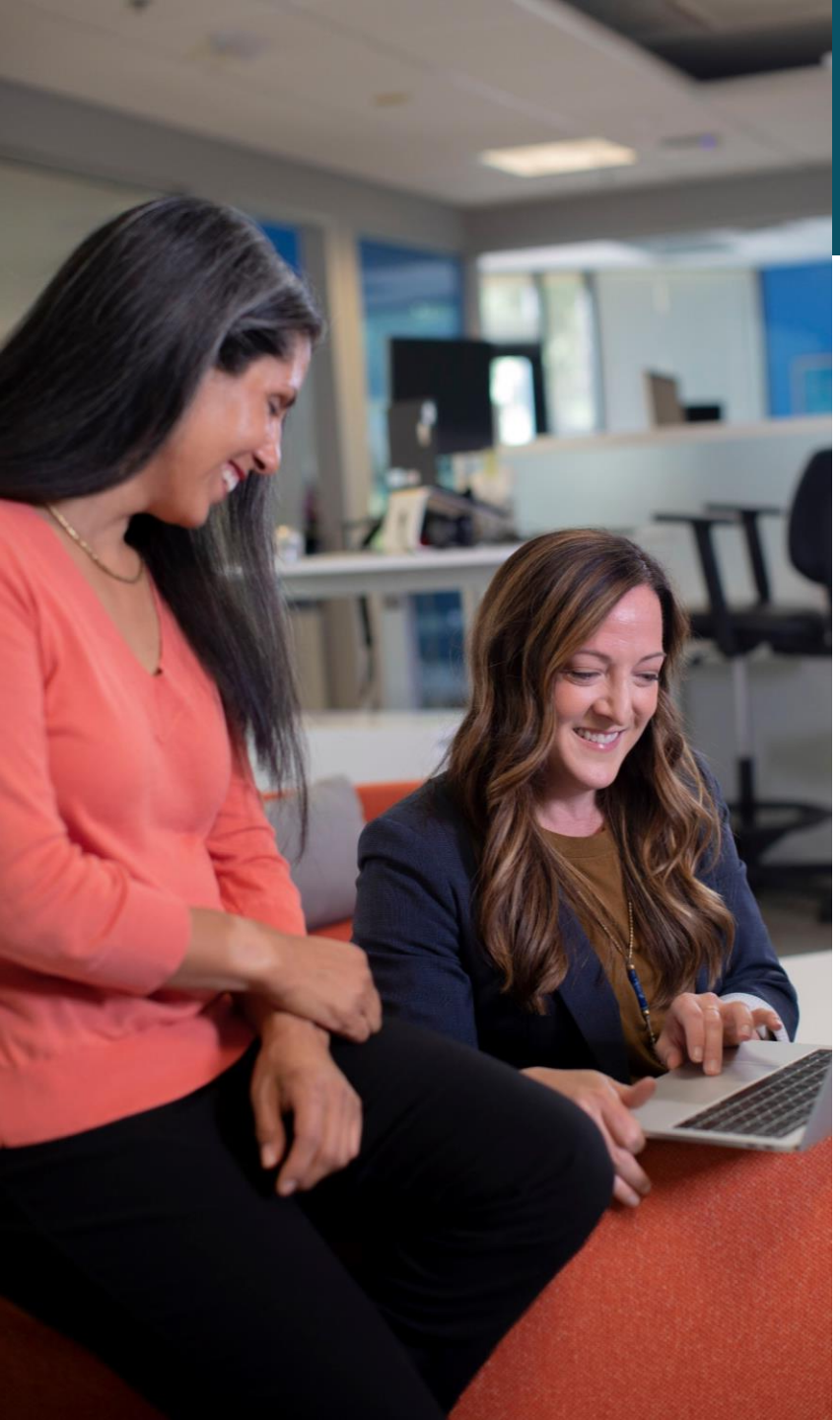
Overview

What do we do?	Quantify Health offers a forensic review of high cost claims (claims with a payable of over $100,000) for health plans/ insurance carriers and have historically delivered average savings of 23% per claim Shared savings model where the client keeps 70% of the savings we deliver, and we get 30% – no other costs involved The typical impact of our process is in lowering the cost of healthcare for health insurance carriers/ health plans by at least $100+ per member per year – this works for health plans in the commercial, Medicare, and Medicaid space For example, for a health plan with 1 million members, Quantify Health will save over $100 million per year
Our track record?	Last year we delivered total savings of over $160 million (average savings per claim of 23%) Our clients include one of the top 5 US health insurance carriers, two major health plans with 1M+ lives each, five of the top 25 reinsurers, two top 20 stop loss carriers, and a top 3 health insurance captive We are a preferred vendor with Association of Community Affiliated Plans (ACAP) – an association of 75+ health plans
How does it work?	High cost claims (hospital claims over $100,000) represent about 15-30% of healthcare spend, and there is significant overcharging happening by hospitals Our team of US-based physicians and nurse practitioners performs a forensic analysis of both the itemized charges and the medical records (which can take tens of hours), which delivers average savings of 23% For health plans, our review can be performed on either a pre-pay or a post-pay basis and comes in as the final review step after any internal reviews performed by the health plan

5 key differentiators

1. We deliver average savings of 23% (vs. adjudicated amount/ contract payable)
2. Forensic review includes a deep analysis of medical records, which takes tens of hours
3. Reviews are performed by our US-based team of physicians (with expertise in specific areas such as oncology, neonatal, transplants, etc.) and nurse practitioners
4. We build an incredibly detailed 10-30 page report with strong supporting medical evidence
5. Once the claim is paid, we proactively reach out to hospitals to address pushback/ appeals



Quantify Health – key strategic partners and clients

Key strategic partners

HOLMES MURPHY

Virgin Pulse

ACAP
Association for Community Affiliated Plans

Preferred vendor with ACAP

Key clients include:

- Top 5 health insurance carrier
- Two major regional health plans with 1M+ lives each
- TPA with 500K+ lives
- Five of the top 25 reinsurers
- Two top 20 stop loss carriers
- Top 3 health insurance captive
- Top 10 auto insurer
- …

The problem with high cost claims

- One of the biggest drivers of healthcare costs are high cost claims (over $100,000)
- The top high-cost claims categories include: cancer, heart disease, renal disease, premature birth, congenital conditions, transplants, and trauma
- High cost claims are usually either the #1 or #2 spend category, and can represent 15-30% of the total healthcare spend
- There is a significant amount of overcharging by hospitals on high cost claims in 5 key categories:

1. **Billing errors**: E.g., the hospital bills for 48 hours of ventilator usage in a 24 hour period
2. **Charge unbundling:** E.g., the hospital bills separately for patient monitoring, even though the cost is actually included in the cost of room and board
3. **Mismatch of service and billing**: E.g., even after a patient has been moved from trauma ICU to regular ICU, the hospital continues to bill at the higher trauma ICU rate
4. **Experimental and investigational**: E.g., the hospital bills for treatments that are not covered under the health plan and might be more expensive than other treatments
5. **Hospital-acquired conditions**: E.g. the hospital makes an error during a surgery and so has to take the patient back into the OR, but bills separately for both surgeries

The Quantify Solution

- Our proprietary approach involves a forensic analysis of both itemized charges and medical records by our clinical team (which can take tens of hours)
- This analysis is performed by our US-based clinical team of physicians (including specialists in areas such as oncology, neonatal, transplants, etc.) and nurse practitioners
- There is no way to automate this – any solution involving software or algorithms is simply doing a high-level review of the UB-04 and itemized charges (which delivers minimal savings)
- Performing a forensic review comparing the itemized charges (what was billed) vs. medical records (what was actually done) takes tens of hours and requires a very strong level of medical expertise
- We write up our findings in an incredibly detailed evidence-based 10-30 page report, which maximizes our savings, and minimizes pushback from the hospitals
- This is what enables us to deliver 23% savings on average (vs. payable amount) and why we delivered a total of over $160 Million in savings last year

How we're different

What other vendors do

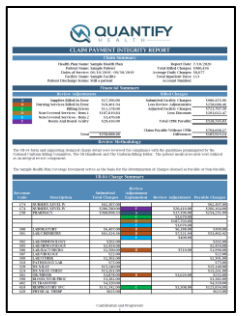
- Other cost containment companies focus on automation through software and algorithms to deliver quick savings
- This method can involve a quick review of the UB-04 and itemized charges, but does not involve an analysis of medical records
- Since medical records can be hundreds or thousands of pages long and are incredibly complex, the only way to review them is manually, by physicians with strong expertise
- Without a forensic review of medical records, savings are only in the low single digits

What Quantify Health does

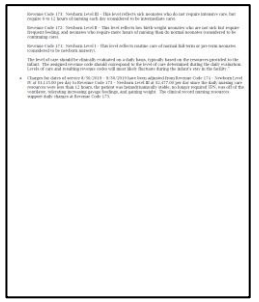
- A forensic review of a claim requires a deep analysis of both itemized charges and medical records
- That is impossible to do with software, and requires deep medical expertise
- That's why our reviews are performed by our US-based team of physicians and nurse practitioners, and require tens of hours to complete
- This enables us to deliver 23% savings on average vs. adjudicated amount/ contract payable

Evidence-driven reporting process

- After our team of physicians and nurse practitioners have completed the review, we write up an incredibly detailed 10-30 page report with all the evidence to support our findings
- This is a true differentiating factor – the detailed medical depth enables us to maximize our savings and minimize pushback from hospitals
- We share this 10-30 page report with the hospital once the claim is paid at the lower, correct amount – that way we proactively address any potential pushback from the hospital









Financial impact

- We charge 30% of the difference between the health plan's allowed amount and our final repriced amount – we never compare our performance to the billed amount
- Example of a claim below:
  - Billed amount: $500,000
  - Allowed amount by carrier/ health plan: $300,000
  - Final repriced amount by Quantify Health: $200,000
  - Therefore, savings delivered by Quantify Health: $100,000
  - We would charge 30% of the savings: $30,000
- Proving our savings is very straightforward – and is based on the allowed amount and the final repriced amount – if we don't deliver any savings on that claim then we don't charge anything
- There are no other upfront fees/ ongoing fees/ implementation fees
- Our solution works for fully-insured health plans (commercial, Medicare Advantage, Medicaid), TPAs, self-funded employers, stop-loss/ reinsurance carriers, and captives
- Our clients include one of the top 5 health insurance carriers
- Last year we delivered total savings of over $160 million (average savings per claim of 23%)

Option 1) Pre-pay review of high cost claims

1 Carrier/ health plan pends High Cost Claims (post-adjudication and pre-pay) and sends claim to Quantify Health	• The carrier/ health plan would pend high cost claims (in-patient hospital claims with payable of over $100,000) after any internal reviews by the health plan • The carrier/ health plan would send the UB-04 and adjudicated amount over secure email/ secure FTP (no IT implementation needed)
2 Quantify Health requests itemized charges and medical records from hospital	• If the carrier/ health plan already has the itemized charges and medical records, they can be sent directly to Quantify Health • If not, we're happy to reach out to the hospital ourselves to request the information
3 Quantify Health performs the review on each high cost claim	• Our clinical team of physicians and nurse practitioners then performs the full forensic analysis • We build a 10-30 page report highlighting the areas of overcharge and submit it to carrier/ health plan
4 The carrier/ health plan pays the final repriced amount	• The carrier/ health plan would then pay the final repriced amount using the existing reimbursement model between the PPO network and the provider (note: we don't change the reimbursement model)
5 Quantify Health addresses any questions or appeals from the hospital	• Once the claim is paid, we proactively send the report to the hospital and address any questions or concerns • If the hospital appeals, we handle the entire appeals process on an end-to-end basis • We have an uphold rate of over 93% on appeals; if there is a successful appeal on an overcharge item based on evidence, then a supplemental payment would be issued to the hospital

Option 2) Post-pay review of high cost claims

1 Carrier/ health plan sends a list of paid high cost claims to Quantify Health	• The carrier/ health plan would send Quantify Health a list of paid claims over $100,000 after any internal reviews • The carrier/ health plan would send the UB-04 and adjudicated amount over secure email/ secure FTP (no IT implementation needed)
2 Quantify Health requests itemized charges and medical records from hospital	• If the carrier/ health plan already has the itemized charges and medical records, they can be sent directly to Quantify Health • If not, we're happy to reach out to the hospital ourselves to request the information
3 Quantify Health performs the review on each high cost claim	• Our clinical team of physicians and nurse practitioners then performs the full forensic analysis • We build a 10-30 page report highlighting the areas of overcharge and submit it to carrier/ health plan
4 The carrier/ health plan offsets future payments to the hospital	• The carrier/ health plan would then offset future payments to the hospital based on the findings of the Quantify Health report
5 Quantify Health addresses any questions or appeals from the hospital	• Once the claim is offset, we proactively send the report to the hospital and address any questions or concerns • If the hospital appeals, we handle the entire appeals process on an end-to-end basis • We have an uphold rate of over 93% on appeals; if there is a successful appeal on an overcharge item based on evidence, then a supplemental payment would be issued to the hospital

Impact on contracted rates

- A common question we get is how does Quantify Health affect contracted rates between the health plan and the provider
- Our solution works well across commercial, Medicare, and Medicaid plans without affecting the existing contractual relationship between the health plan and the provider

Commercial plans

- We are not changing the reimbursement model between the PPO network and the provider
- We are simply validating that the charges are paid correctly by using our evidence-based approach, without modifying contracted terms
- In "Percentage off billed" models (which are common with commercial plans) – we will always adhere to the reimbursement model, but will highlight billing errors (e.g., getting charged for 48 hours of ventilator usage in a 24 hour period), double-billing, etc., while backing everything up with ample evidence

Medicare and Medicaid plans

- DRG/ case rate models are common with Medicare/ Medicaid plans
- While low-cost claims usually only have a fixed DRG rate, high-cost claims (with a payable of over $100,000) usually involve a base rate and significant outlier charges
- While we can't change the base rate – however the outlier charges are billed on a "percentage off billed" model, and we can address the potentially significant overcharging that might be happening through our forensic reviews

Case studies

Case study 1

Claim payable without Quantify:	$1,578,649
Claim payable with Quantify:	$1,028,046
Savings by Quantify:	**$550,602 (34.9%)**

Claim Review Summary

Health Plan Name:	Sample Health Plan	Report Date:	1/16/2020
Patient Name:	Sample Patient	Total Billed Charges:	$2,870,272
Dates of Service:	3/14/2019 - 6/14/2019	Average Daily Charges:	$31,199
Facility Name:	Sample Facility	Total Inpatient Days:	92
Patient Discharge Status:		Account Number:	

Financial Summary

	Review Adjustments		Billed Charges	
A	Supplies Billed In Error	$55,527.57	Submitted Facility Charges:	$2,870,271.94
B	Nursing Services Billed In Error	$194,227.00	Less Review Adjustments:	$1,001,095.53
C	Billing Errors	$165,866.96	Adjusted Facility Charges:	$1,869,176.41
D	Non-Covered Services - Item 1	$268,982.00	Less Discount:	$841,128.93
E	Non-Covered Services - Item 2	$62,917.00		
F	Room And Board Acuity	$253,575.00	Total CPIR Payable:	$1,028,047.48
			Claim Payable Without CPIR:	$1,578,649.02
	Total	$1,001,095.53	Difference:	$550,601.54

Case study 2

Claim payable without Quantify:	$344,177
Claim payable with Quantify:	$253,761
Savings by Quantify:	**$90,416 (26.2%)**

Claim Review Summary

Health Plan Name:	Sample Health Plan	Report Date:	4/21/2020
Patient Name:	Sample Patient	Total Billed Charges:	$647,399
Dates of Service:	9/3/2019 - 9/30/2019	Average Daily Charges:	$23,121
Facility Name:	Sample Facility	Total Inpatient Days:	28
Patient Discharge Status:	Still a patient	Account Number:	

Financial Summary

	Review Adjustments		Billed Charges	
A	Supplies Billed In Error	$28,803.91	Submitted Facility Charges:	$647,398.69
B	Nursing Services Billed In Error	$14,102.00	Less Review Adjustments:	$170,072.99
C	Non-Covered Services - Item 1	$33,834.16	Adjusted Facility Charges:	$477,325.70
D	Non-Covered Services - Item 2	$54,409.92	Less Discount:	$223,564.76
E	Room And Board Acuity	$38,923.00		
F			Total CPIR Payable:	$253,760.94
			Claim Payable Without CPIR:	$344,176.94
	Total	$170,072.99	Difference:	$90,416.00

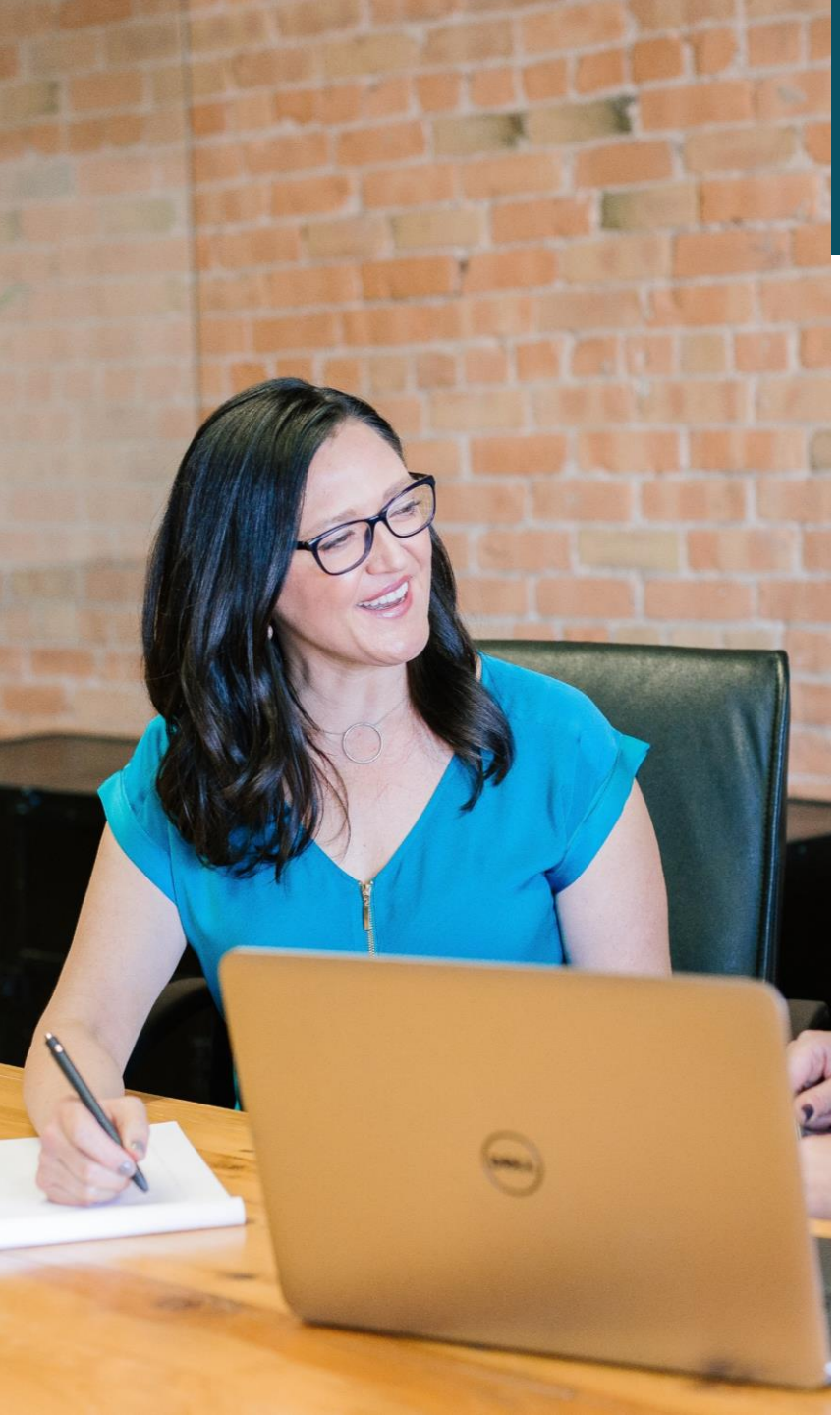
Getting started

We can start on either a pre-pay or post-pay basis:

- **Pre-pay**: We first start with free preliminary analysis of 1-3 pended live claims:
  - We need the UB-04, adjudicated amount, itemized charges
  - We come back with a report on key areas of savings, and if you want to proceed, then we run the full forensic analysis
- **Post-pay**: We first start with free preliminary analysis of 1-3 paid claims:
  - We need the UB-04, adjudicated amount, itemized charges
  - We come back with a report on key areas of savings, and if you want to proceed, then we run the full forensic analysis using which you can offset future claim spend

Next steps:

- We would sign a BAA (happy to sign your format once we review it) and our contract (which can be canceled at any time with a 30-day notice)



FAQs

Are you trying to renegotiate the contracted rates between the PPO network and provider?

- No. We are actually not renegotiating, but are validating that the charges are paid correctly, without modifying contracted terms
- "Percentage off billed" is a common reimbursement model with hospitals especially on the commercial side – we will always adhere to the reimbursement model, but will highlight billing errors (e.g., getting charged for 48 hours of ventilator usage in a 24 hour period), double-billing, etc., while backing everything up with evidence

Does Quantify High Cost Claims work on claims with DRG/ case rate model (which is common in Medicare/ Medicaid plans)?

- Yes; high cost claims with a payable of over $100,000 will usually involve a DRG base rate along with outlier charges
- While the base rate is a fixed amount and can't be changed, the outlier charges are billed on a percentage off billed basis – and there is significant potential for overcharging
- We have strong impact in addressing the potential overcharging on the outlier charges

Is there any member impact? Does Quantify Health influence the medical decisions by the providers?

- No, we are only involved in the process once the hospital stay is completed and the claim is submitted by the provider to the carrier/ health plan, but before it is paid
- We are completely invisible to the member

Is there a chance that the member might get balance billed?

- Since we are working closely with the hospital through the process, it is very rare for them to even bring up balance billing – if they do, we will intervene beforehand to ensure it doesn't happen