QUANTIFY HEALTH

Quantify Health Value Proposition

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OVERVIEW

What do we do?	Quantify Health will lower the cost of healthcare for self-funded employers by at least $300 per employee per year ($150+ per member per year) – also works for health plans, stop-loss carriers, captives, and work comp For example, for a company with 5,000 employees, Quantify Health will save over $1.5 million per year Shared savings model where the employer/ payer keeps 70% of the savings we deliver, and we get 30% – no other costs involved and the process takes a few minutes of paperwork to set up with no ongoing effort from your side
Who is it for?	Quantify Health lowers overcharging related to healthcare costs for self-funded employers, health plans, TPAs, stop-loss/ reinsurance carriers, captives, and worker's comp carriers
Our track record?	Last year we delivered total savings of over $140 million (average savings per claim of 23%) Our solution is the underlying engine analyzing high cost claims for one of the top 5 health insurance carriers
How does it work?	High cost claims (hospital claims over $100,000) and medical implants are major categories of healthcare spend, and there is significant overcharging happening by providers (hospitals/ surgery centers) Our proprietary methodology identifies the overcharging and works with your Third-Party Administrator (TPA)/ carrier to lower the amount on a pre-payment basis

QUOTES AND MENTIONS

"Quantify Health addresses one of the biggest cost categories in healthcare spending and does so in an innovative, impactful, and no-risk model. By doing so, it drives major cost savings for employers.
Quantify Health is one of the most innovative solutions in the market today to lower healthcare spend for companies."

- Dr. Mark Hiatt, former Executive Medical Director, Regence Blue Cross Blue Shield

BUSINESS INSIDER

Link to article

...Lowering healthcare costs is critical for companies – the key is to do so in a model that doesn't require capex or other upfront costs, while also not affecting the quality of employee healthcare.

Quantify Health does just that – lowering healthcare and workers' compensation costs for employers ...without any upfront or fixed costs and without negatively affecting healthcare or benefits quality.

QUANTIFY HEALTH

- Quantify Health delivers over $300 in savings per employee per year through our two proprietary solutions:

High cost claims are hospital claims with a total payable of over $100,000 – this is the number one strategic priority for self-funded employers

Medical implants are devices that go into the human body during a surgery – e.g., artificial knees and hips, pacemakers, stents, rods, pins, plates, screws, etc.

- Today, hospitals and surgery centers are significantly overcharging for both high cost claims and medical implants
- Our solution identifies these overcharges after the hospital stay is complete, but before it had been paid, and we work with the TPA/ carrier to ensure that the lower correct amount is paid
- Typical savings for self-funded employers below:

	Typical savings per employee per year	Typical savings per member per year
Quantify High Cost Claims	$200	$100
Quantify Implant Forensics	$100	$50
Total	**$300**	**$150**

AGENDA

1) Quantify High Cost Claims

2) Quantify Implant Forensics

THE PROBLEM WITH HIGH COST CLAIMS

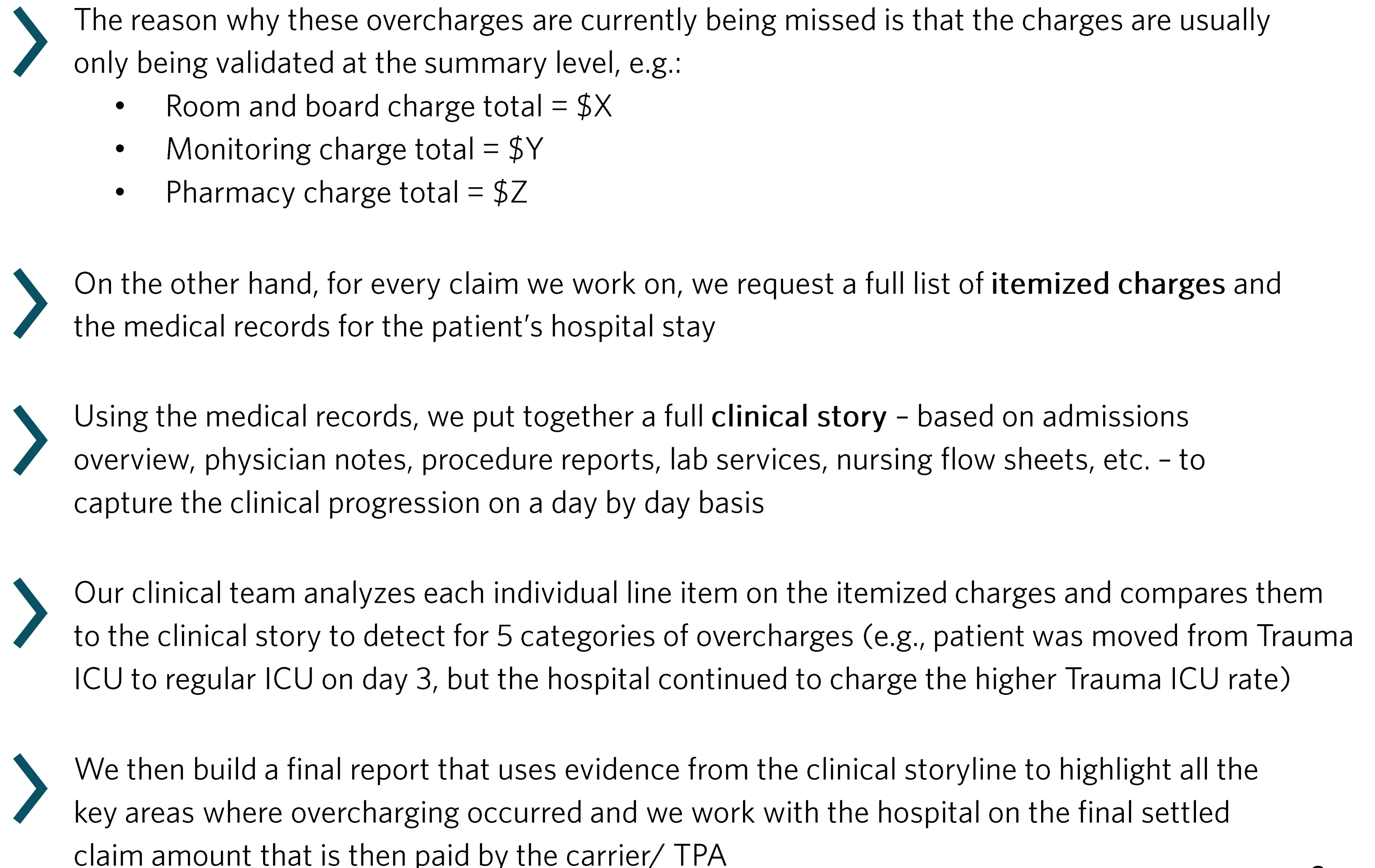
- One of the biggest drivers of healthcare costs are high cost claims (over $100,000)
- The top high-cost claims categories include: cancer, heart disease, renal disease, premature birth, congenital conditions, transplants, and trauma
- Managing high cost claims is the number 1 strategic priority for employers with over 500 employees over the next five years according to a Mercer survey
- 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 (1/1)

- Our proprietary process identifies the overcharges pre-pay (prior to payment but after the hospital stay is complete), and then works with the TPA/ carrier, and the provider to correct it and pay only the appropriate amount, with no member impact
- Our solution works for self-funded employers, health plans, TPAs, stop-loss/ reinsurance carriers, captives, and worker's comp carriers
- Contingent-based shared savings model, where we charge you 30% of the actual realized savings based on the difference between the original allowed amount and repriced amount
- If we do not deliver, then you do not pay us anything
- Last year we delivered total savings of over $140 million (average savings per claim of 23%)
- Our solution is the underlying engine analyzing high cost claims for one of the top 5 insurance carriers
- Simple paperwork to set up from the employer's side, with no additional effort needed whatsoever – we work directly with the TPA/ carrier and providers to correct the overcharges on a pre-pay basis

THE QUANTIFY SOLUTION (2/2)



- The reason why these overcharges are currently being missed is that the charges are usually only being validated at the summary level, e.g.:
  - Room and board charge total = $X
  - Monitoring charge total = $Y
  - Pharmacy charge total = $Z
- On the other hand, for every claim we work on, we request a full list of **itemized charges** and the medical records for the patient's hospital stay
- Using the medical records, we put together a full **clinical story** – based on admissions overview, physician notes, procedure reports, lab services, nursing flow sheets, etc. – to capture the clinical progression on a day by day basis
- Our clinical team analyzes each individual line item on the itemized charges and compares them to the clinical story to detect for 5 categories of overcharges (e.g., patient was moved from Trauma ICU to regular ICU on day 3, but the hospital continued to charge the higher Trauma ICU rate)
- We then build a final report that uses evidence from the clinical storyline to highlight all the key areas where overcharging occurred and we work with the hospital on the final settled claim amount that is then paid by the carrier/ TPA

THE QUANTIFY HIGH COST CLAIMS DIFFERENCE

What other vendors do:

Audits are typically being done at the summary view – where all the charges are rolled up on the UB-04

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
174	NEWBORN/CONVERSION		010419	146	1673132.26
203	INTENSIVE CARE - PED		010419	62	477700.08

In the example above, the first line is a single summary charge for $1.67M, the second line is for $477K, etc.
It is not possible to do a full audit at this summary level

What Quantify Health does:

...Whereas we review the full list of detailed itemized charges...

Svc Date	Rev Code	Description	Qty	Amount
01/05/20	0173	TC NEONATAL INTERMEDIATE	1	7,777.00
01/05/20	0250	PIPERACILLIN/TAZOBACTAM 60 MG/ML INJ	1	39.09
01/05/20	0250	VANCOMYCIN 5 MG/ML INJ	1	36.88
01/05/20	0250	SUCROSE 0.24 G/ML SOLN 1 ML VIAL	1	15.51
01/05/20	0250	INFANT CENTRAL TPN	1	2,051.78
⋮				

+ *Hundreds of itemized charges that make up the $1.67M summary charge*

We analyze every single itemized charge that makes up the $1.67M summary (could be tens of thousands of lines)

...and supplement with a full clinical story built based on the medical records

Time	Event
1550	Anesthesia Start Physical exam of patient unchanged since pre-op evaluation.
1616	Start Data Collection Machine, drugs, equipment checked.
1710	Stop Data Collection
1726	Anesthesia Stop

We compare that to the full clinical story we built to chart the patient journey on an hour by hour basis every day

This is what differentiates us: we dive deep into each individual itemized charge and review against the clinical story based on the patient's medical records to detect for billing errors, unbundling, mismatches, experimental or investigational usage, and hospital-acquired conditions

EVIDENCE-DRIVEN SETTLEMENT PROCESS

- After our clinical team analyzes the itemized charges and the clinical story, we then build a report that covers each overcharge line item by line item and provides evidence to prove it

- In the example below, the hospital charged for 2 heart valves, even though the clinical records indicate that only one was used (we would usually include the physician's notes here showing that only 1 heart valve was used, but cannot show that here due to confidentiality)

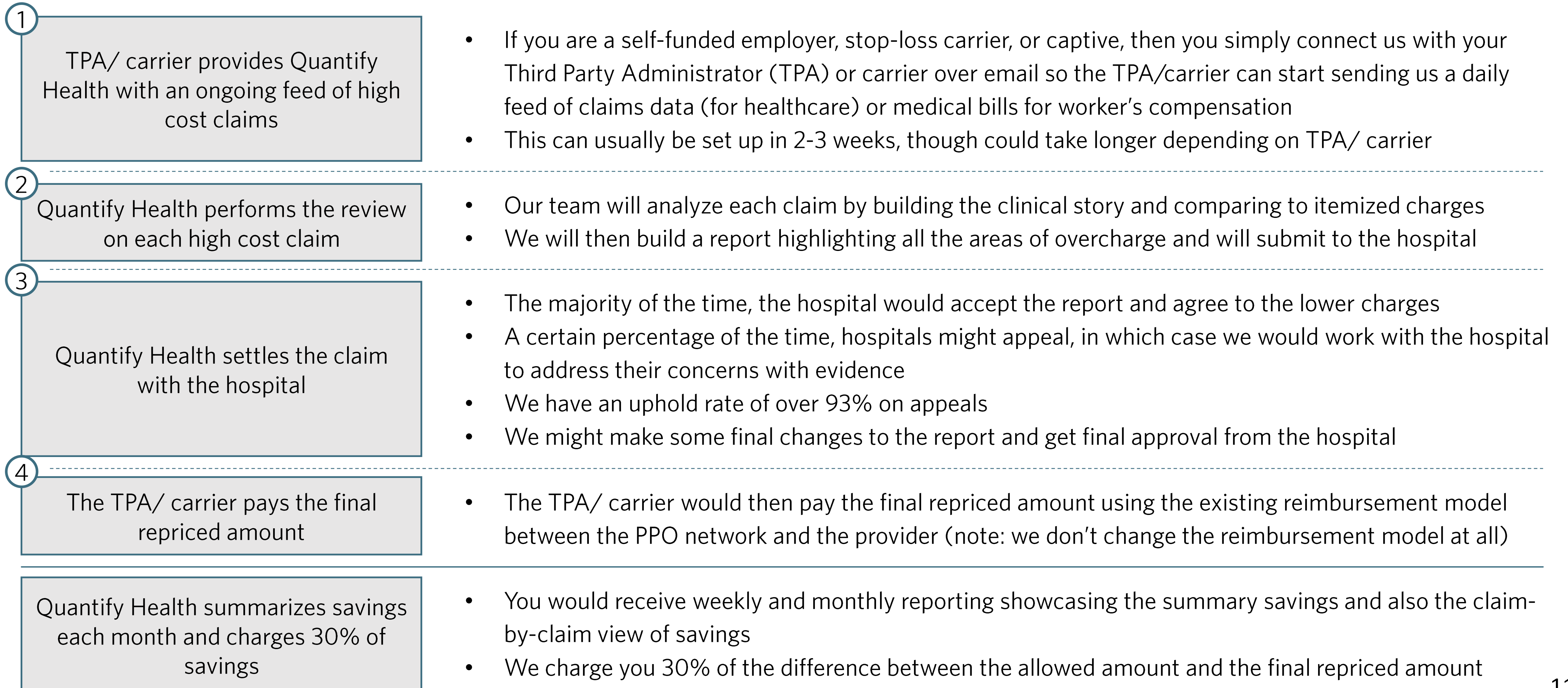
Charge Adjustment Detail						
Description	Supplies Billed In Error	Nursing Services Billed In Error	Billing Errors	Non-Covered Services	Total	UB-04 Revenue Code
EDWARDS LIFESCIENCES SAPIEN 3 UTLRA TRANSCATHETER HEART VALVE			$89,375.00		$89,375.00	278

Billing Errors

For date of service 05/13/2020, the charge of EDWARDS LIFESCIENCES SAPIEN 3 ULTRA TRANSCATHETER HEART VALVE for 2 units in the amount of $178,750.00 has been deemed a billing error. We have allowed this charge for 1 unit in the amount of $89,375.00 for this date of service. Per the clinical record, one valve was explanted during surgery and is therefore considered a non-payable item.

- This detailed evidence-driven report is used to settle the claim with the hospital to remove the overcharges on a pre-payment basis

THE QUANTIFY HIGH COST CLAIMS PROCESS



FINANCIAL IMPACT

- We charge 30% of the difference between the TPA/ carrier's allowed amount and our final repriced amount – we never compare our performance to the billed amount

- Example of a claim below:
  - Billed amount: $400,000
  - Allowed amount by TPA/ carrier: $200,000
  - Final repriced amount by Quantify Health: $100,000
  - We would charge 30% * ($200,000 - $100,000) = $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 or ongoing fixed fees

- You would receive weekly and monthly reporting showcasing the summary savings and also the claim-by-claim view of savings

- At the end of each month we would send an invoice for 30% of the saved amount – there are two options for payment for an employer:
  - **ACH transfer**: Pay us through a direct ACH transfer through our billing system
  - **Claim**: Have the TPA/ carrier pay us through a claim the same way they pay providers today – in this option, we would be paid out of the same account in which we delivered the savings (essentially paying us using the savings we have already delivered)

COMPARISON TO REFERENCE BASED PRICING

A common question we get is how we differ from Reference Based Pricing (RBP) – **we are very different from RBP**

Reference-Based Pricing (RBP)

- In RBP, the provider is offered a certain percentage of what Medicare will pay for the procedure – e.g., 140% of Medicare
- The problem is that this often negates the existing reimbursement models that exist between the PPO network and the provider

Quantify High Cost Claims

- On the other hand, 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
- "Percentage off billed" is a common reimbursement model with hospitals – 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
- The payment of charges would be done by the TPA/ carrier under the current reimbursement model

CASE STUDY (1/2)

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 (2/2)

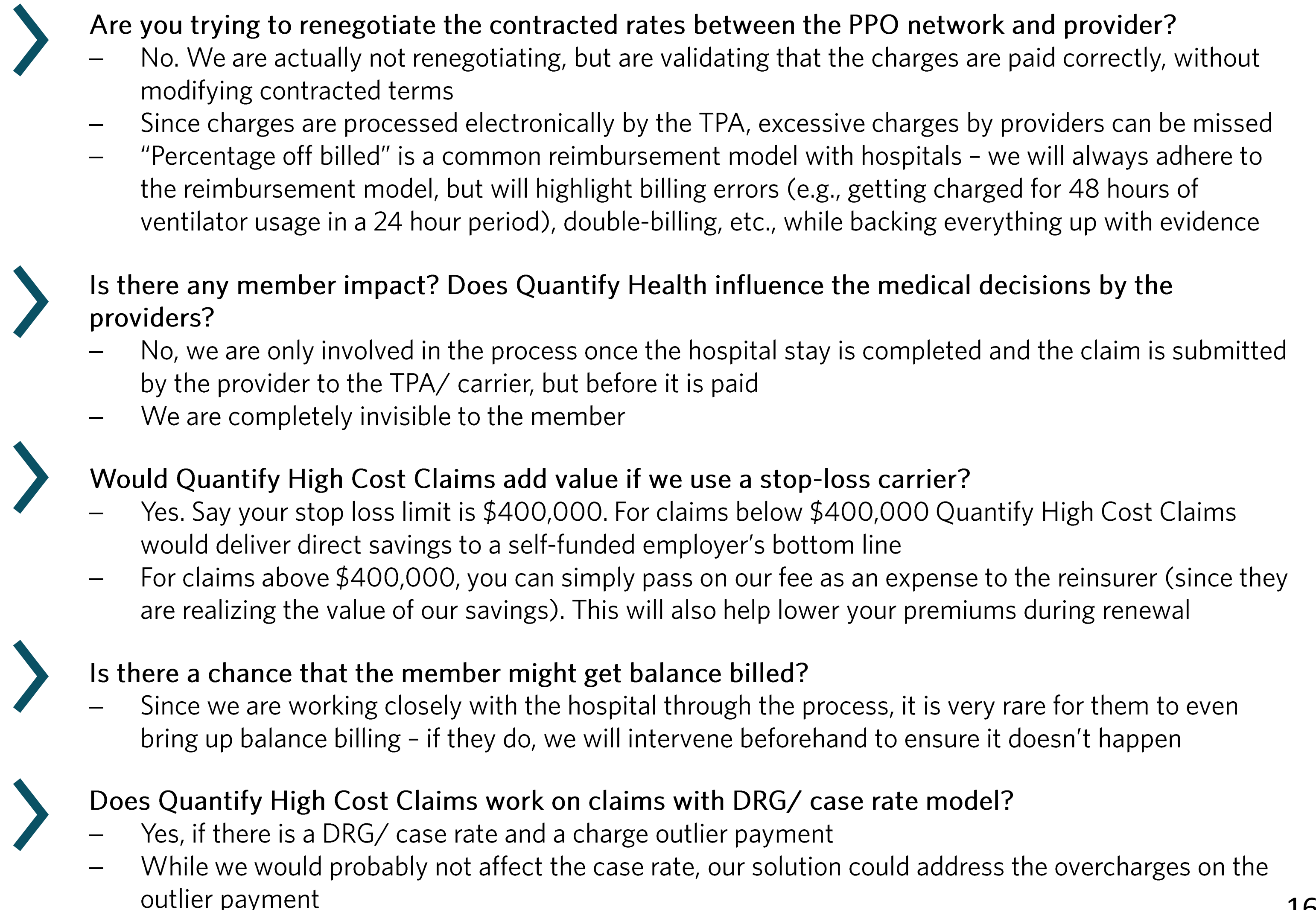
Claim payable without Quantify:	$344,177
Claim payable with Quantify:	$253,761
Savings by Quantify:	**$90,416 (26.2%)**

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



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
- Since charges are processed electronically by the TPA, excessive charges by providers can be missed
- “Percentage off billed” is a common reimbursement model with hospitals – 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

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 TPA/ carrier, but before it is paid
- We are completely invisible to the member

Would Quantify High Cost Claims add value if we use a stop-loss carrier?

- Yes. Say your stop loss limit is $400,000. For claims below $400,000 Quantify High Cost Claims would deliver direct savings to a self-funded employer’s bottom line
- For claims above $400,000, you can simply pass on our fee as an expense to the reinsurer (since they are realizing the value of our savings). This will also help lower your premiums during renewal

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

Does Quantify High Cost Claims work on claims with DRG/ case rate model?

- Yes, if there is a DRG/ case rate and a charge outlier payment
- While we would probably not affect the case rate, our solution could address the overcharges on the outlier payment

GETTING STARTED

Step 1: Opportunity Analysis

- As a first step, we would like to do an opportunity analysis – for which we would need last 12 months of claims data (we have a standard format with no PHI needed)
- We will then come back to you with an analysis of how much you were overcharged over the last year – we cannot claw that back since we don't work retroactively, but it's a strong indicator of how much you can expect to save next year

Step 2: Getting started with Quantify Health

- We would both 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)
- If you are an employer, you would then connect us to your TPA/ carrier, who would set us up with a daily feed of claims and/or billing data – this usually takes 2-3 weeks to setup
- Fully seamless process for you from here on – we work directly with the TPA/ carrier and providers and will soon start delivering savings

AGENDA

1) Quantify High Cost Claims

2) Quantify Implant Forensics

QUANTIFY IMPLANT FORENSICS (1/2)

- Quantify Implant Forensics addresses a different problem – hospitals and surgery centers overcharging for medical implants – but addresses it in a similar way as Quantify High Cost Claims
- Medical implants are devices that go into the human body in a surgery – pacemakers, stents, artificial knees, hips, plates, screws, rods, pins, etc. – they are involved in 70% of all surgeries
- The cost of an implant represents on average 30-80% of the insurer's payment for a surgery
- Implants rarely have a fixed DRG/ case rate price in the contract between PPO network and providers – implants are usually reimbursed under "percentage off billed" or "cost plus pricing"
- Given the lack of fixed pricing, we find that implants are getting overcharged over half the time by hospitals and surgery centers – below are three of the most common techniques they use:

1. A common form of pricing for implants is the "cost plus" model where providers are reimbursed for implants based on the actual cost plus a % for overhead (e.g. 25%);
   While providers are required to supply an original manufacturers invoice, they often instead provide an internally generated charge sheet, or a doctored invoice with inflated pricing
2. Providers sometimes bill for more implants than they use – e.g., they will sometimes bill for 2-3 implants for a surgery even though they only used one
3. Sometimes an implant warranty covers the cost of the implant modification (e.g., with a pacemaker), however providers will sometimes bill for the cost of a new implant

QUANTIFY IMPLANT FORENSICS (2/2)

- Our solution identifies the overcharges pre-pay (prior to payment but after the surgery is complete) and works with the TPA/carrier to correct it and pay only the appropriate amount, with no member impact
- Our proprietary process is based on a combination of:
  - A massive dataset of millions of invoices of medical implants of all types across all major manufacturers, supplemented by FDA data, warranty information, etc.
  - Sophisticated algorithms to identify potentially inflated implant charges
  - A team of analysts with decades of experience in the medical implant ecosystem
- Contingent-based shared savings mode, where we charge you 30% of the actual realized savings based on the difference between the original allowed amount and repriced amount
- The Quantify Implant Forensics solution is similar to Quantify High Cost Claims in terms of the overall process and approach
- Similar to Quantify High Cost Claims, to get started we would need the last 12 months of claims data to run an opportunity analysis, and then get started once we sign a BAA and MSA
- The below deck is a deep-dive into the Quantify Implant Forensics value proposition

Link to full Quantify Implant Forensics deck

Thank you!

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