PRECISION
HEALTHCARE TECHNOLOGIES

STOP NOT KNOWING WHAT YOU DON'T KNOW!

Q Can you give me some local references of who you have helped and what revenue they received?

A We can give you 1,061,000 references of how providers perform in our system directly from CMS/Payers. Their success after that is 100% dependent on them getting out of our way and enabling a system that penalizes them in the background to fix them in the background.

NO UPFRONT OR OUT OF POCKET COST, NO OPERATIONAL CHANGES AND WE LAUNCH IN 72 HOURS. THEY NEVER EVEN SEE IT!

Though I understand where this question comes from, that's not the kind of service we are. We are in the background of the payers regardless and have zero effect on the provider's revenue if they don't empower our partners to provide the services.

One small provider has not enabled any services and today CMS says he's missing $180K whereas when we started it was $135K. This is his fault and not ours as we are only the score reporter and navigator for improvement.

He must first allow us to connect to missed mandated services that better serve his patients. We don't provide these services, but our partners do and at no upfront cost and nothing is owed until after insurance pays, and then the result is a guaranteed profit.

Not only is he missing services, but his reimbursement is going down and he just thinks "that's healthcare." NOT TRUE! Example – for one common code a compliant provider gets $352, and the noncompliant provider would get $179. They never see the cause, but we do, and we can fix it instantly by our AI driven compliance-based patient engagement, care coordination and navigation measures!

This same small provider said he would rather see his patients later himself than pay outside contractors after he is paid. Newsflash! Your patients don't want to wait, shouldn't have to, and clearly, he is NOT getting to these services as his score has fallen even further. It's a horrible use of resources and it costs him dearly.

The bottom line is that moderate risk patients and the follow-up on high-risk patients should be contracted to virtual care under your NPI. That tirages the next steps to care escalation without the wait for the patient, your compliance measures and you don't miss the immediate revenue. Our virtual care and ancillary serivce delivery partners are the trusted source to provide MANY of these very services for hospitals, so they are perfect for any provider too!

I constantly hear that, *"I have already tried CCM and other services, and they didn't work."* The reality is that when medical necessity is identified, the provider must offer the service, track responses, enrollments and declines to be compliant and avoid penalties.

In our system they get paid for making the offer and recording the responses even if the patient declines. But you MUST make the offer for any medically necessary service, track and report results, or face "demerits." Our virtual provider network performs all these services for you under your provider number.

One midsized family practice on the other hand believes he/she is running perfectly yet they are missing $1.438 million in required services based on system-identified medical necessities according to CMS alone. In a 60% capitated model, like their environment, our AI triage, care coordination and navigation would reach those same metrics for only $479,564.

This is the perfect option for ACO/Medicare Advantage and other shared risk programs. But not unless they enable us to navigate and connect in the background.

Providers aren't the only ones in the dark. Most payers don't know what they don't know. Because we started architecting and building these value-based grading systems in 2007, when their rules change our system is updated automatically and they have no idea.

Example – I met with executives of three major insurance companies who wanted to get their Annual Wellness Visits up to 60% from 42%, 40.2% and 38% respectively. I told them that even if they hit 100%, they would still be penalized for failing to act on the medical necessities found within those results. All three of them said, "HUH? We had no idea that even existed," yet we built that into their systems.

Big organizations are just as lost! - This "don't know what you don't know" problem is rampant - One organization with 704 providers spent 200K on data each year, had 70 people doing patient engagement and 20 people working on RAF Scores. Their first 10 providers in alphabetical order were missing an average of $353K EACH! They are failing at great expense because they are chasing a ghost.

The side benefit of streamlined workflow - A provider who said, "I love your program, but I can't possibly see another patient on my schedule," was told that 64% of his patients did not need to be seen by him and should never been on his schedule. They could and should have been triaged to other services, visit types, or personnel, thus freeing his schedule for those who need to see only him.

Only Precision can take the system that penalizes the organization or providers silently in the background and simply flip the switch to help them. But not if they don't take action on connecting to these missed services. Again, Precision does not offer those services, but our partners do. The provider has no idea what services they need until they see their CMS/Payer Report Cared, which only Precision can share. Thank you for your interest!