Merger Life

Practice-to-Practice Deals Deliver Big Benefits

WHITEPAPER

By Ron Jackson,
National VP Radiology Division,
Zotec Partners

Business to Consumer
Starts With Zotec.

Your Success is Our Focus.

ZOTEC PARTNERS®

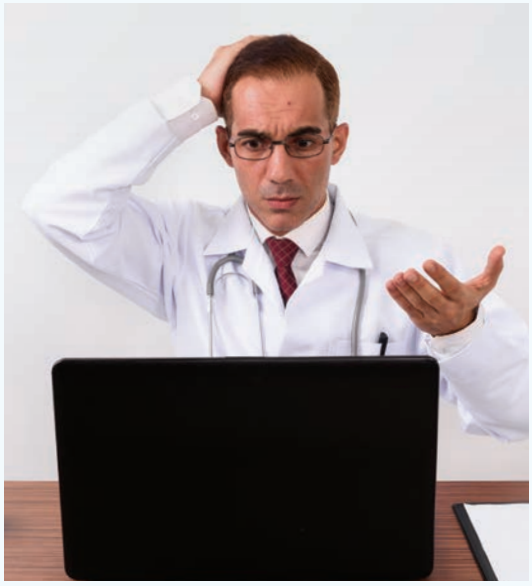
Hospital interest in acquiring independent radiology practices has cooled off, while large national practices continue to pursue smaller groups…but mergers between independent imaging groups continue to gain favor as another viable option to consider. In fact, newly merged entities are seeking to expand geographic reach and improve coordination with allied health systems and reduce costs.

Today's practice-to-practice deals increasingly are being structured as strategic mergers that allow the combined organizations to retain a relatively high degree of autonomy. The approach can save time and money when compared to traditional asset transfers and also help preserve an exit strategy if the alignment doesn't work out. In fact, Inc.com recently cited that "culture clash" is the one thing that can kill any merger or acquisition in any industry, and radiology is no exception, especially as it relates to work-life balance, vacation time, and other elements where groups may be misaligned.

Groups should identify tangible, long-term benefits that suggest a merger is a good fit.

Regardless of the type of merger pursued, groups need to have a sound strategic rationale for seeking a union and should also be sure that the organizations are culturally compatible before pulling the trigger.

For instance, if the idea is to get big just for the sake of being big, then that's not the right reason to do a merger. Groups should identify tangible, long-term benefits that suggest it is a good fit, such as expanded geographic or health system coverage, increased sub-specialty expertise, 24/7/365 service, and shared clinical best practices, as examples. If the reasons are not there, it is probably not going to work.



Rethinking Radiology Merger Strategies

Hospital and health system radiology acquisitions that followed implementation of the Patient Protection and Affordable Care Act have diminished considerably over the last several years, in part due to a realization that radiologist productivity tends to fall off, sometimes dramatically, once the physicians become employed. Many hospitals may not really understand what they were getting into. Before, they were paying significant premiums for independent practices, but when productivity declined, they had to hire additional staff to do what the independent groups had previously done alone.

Having had a good deal of success rolling up anesthesiology and emergency physicians into big, national single specialty provider organizations with many having built-in operational expertise, private equity has decided that radiology also provides similar opportunities, showing much growth in acquisition activity over the years.

Practice-to-practice mergers continue to thrive amidst all of this, however. With the right partners, and with a well-designed merger, the benefits can be significant:

- Improved geographic coverage to better serve a hospital or health system
- Shared management expense
- Increased capacity with subspecialty coverage
- Reduced malpractice risks
- Enhanced negotiating leverage
- Decreased materials and information technology costs
- Expanded offering of more reads around the clock
- Shared clinical best practices

Being able to offer 24/7 reads by sub-specialty is a huge value for the hospital, as well. If the radiology practice can develop the bandwidth to do it, it decreases the likelihood that the hospital will go out and look at viable competitors to provide after-hours coverage, because it allows the hospital and health system to have one single point of contact for all contracting. In turn, the radiology group has the ability to report across the entire health system, versus giving one silo that shows hospital coverage with views for one single practice.

Unified Front

Organizations are embracing the strategic merger concept while eschewing traditional asset transfer deals. The goal is to reduce the cost and complexity of a transaction while preserving the benefits of independence, which allows each individual practice of the merged entity to still "eat what they kill" and be financially rewarded for their hard work.

Sometimes referred to as a "merger lite," the strategic merger allows practices to collectively contract and bill under a new, single tax ID number. At the same time, collections are tracked back to the specific group that provided the service and reported under that organization's original tax ID. **This approach enables the merged organization to function as a single entity in many respects, particularly in the areas of negotiations and cost-sharing.**

Because strategically merged groups can present a united front to hospitals, health systems, and payers, procedural and operational touch points are reduced, contracting is streamlined and quality reporting and care continuity can be made more consistent. Equally important, the potential for conflicts surrounding lifestyle and workload differences between newly combined practices is reduced when groups remain solely responsible for their own productivity and income.

A full merger gives the anesthesiology practice the most control, but it is also the most time-consuming and expensive to complete and it can be pretty difficult to unwind if any of the parties want out. **One of the best things about a strategic merger is that groups can leave if they want because they've not given up their own taxpayer ID.**

Big Picture Views

Making sure a proposed merger supports a larger strategic vision is an essential first step in deciding whether to move forward. An expanded footprint to better serve hospital and health system facilities is among the most frequent reasons that groups combine. Groups should consequently spend time understanding their hospital relationship and work to identify the ways in which a deal could benefit the hospital. They should also try to make sure that no hidden issues surround a would-be partner's hospital contract. Is it perpetual in nature, or does it come up from grabs all the time? Asking those questions may prevent groups from inheriting someone else's problems.

Assuming the post-merger potential for benefits like cost reduction and expanded specialist capacity exists, the next step is to assess whether the organizations are culturally like-minded. **One of the toughest issues with mergers is when deals bring together physicians with sharply differing views on lifestyle and workload expectations.** Many radiologists work relentlessly and pride themselves on high productivity, while others are more focused on a work-life balance that allows for shorter days and more time off.

While there is no right or wrong answer, it is important to be clear about what everyone's expectations are going in. Strategic mergers can help mitigate lifestyle-work challenges, since physicians continue to be responsible for their own income and productivity.

Beyond working to ensure a good cultural fit, attention should be paid to how the organization will be managed and by whom. Too often, practices assume that the processes and personnel that worked for a small practice will be just as effective for a larger organization. In fact, the challenges can be very different and the management workload may be exponentially greater. It is important, therefore, to **think hard about the practice management expertise the new entity will need** and clearly identify the most capable leadership before executing the merger.

One of the biggest challenges with a traditional merger is putting an appropriate value on the acquired practice. Formulas that take into account asset value, cash flow, A/R and other variables can produce an equitable number, but it is still important to enlist the services of a neutral, outside consultant. Culture also plays a part in these as well, with a secondary concern regarding how all the partners will be paid when taking into consideration that the individual practices may have varying vacation levels. If one practice has 10 weeks off and another has 14 weeks off, for example, the merger might fail or never happen due to cultural differences in work-life balance.

Hypothetically Speaking

Done correctly, radiology mergers can have a dramatic and positive impact on operations. As one hypothetical example, let's say eight previously independent radiology groups band together to better serve a single regional health system in a major metropolitan area. The deal, which is structured as a strategic merger, could generate multiple improvements for the groups, including six-to-seven figures on malpractice insurance alone. **With a deal of this size, groups can negotiate managed care agreements that are among the best in the industry, and move ahead rapidly with clinical integration, evidence-based medicine and aggregate quality reporting.**

Let's talk.

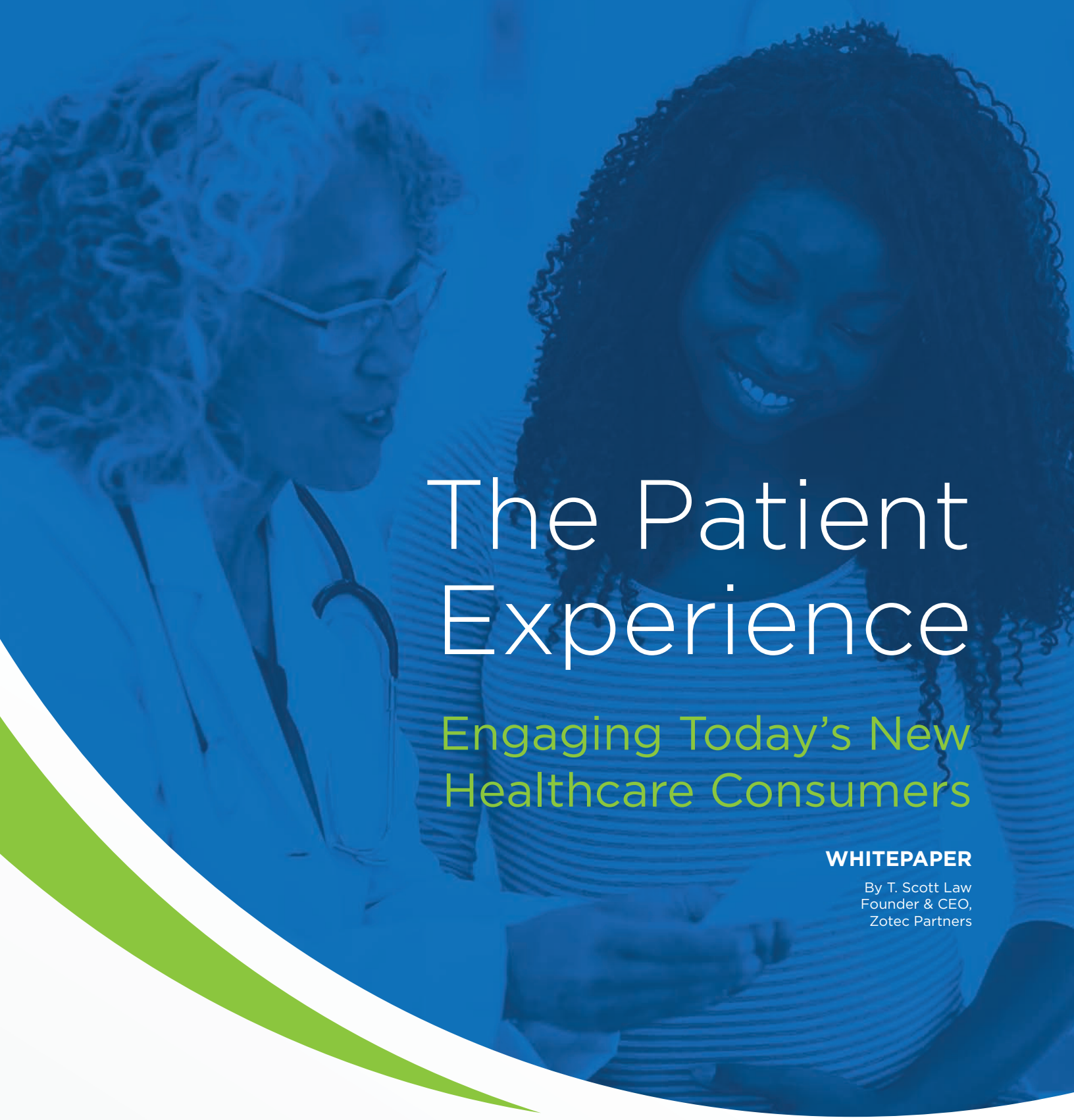
Our Revenuologists™ are passionate about connecting providers with patients so they can get paid accurately and efficiently for the work they do. If you're ready to enhance your patient experience and maximize your reimbursement with a fully integrated RCM solution, we should talk. Contact us at 317.705.5050 or sales@zotecpartners.com.

Connect with us

Complete Revenue Cycle Management.
Fast. Accurate. Compliant.

sales@zotecpartners.com | 317.705.5050
zotecpartners.com

ZOTEC PARTNERS®



The Patient Experience

Engaging Today's New Healthcare Consumers

WHITEPAPER

By T. Scott Law
Founder & CEO,
Zotec Partners

Business to Consumer
Starts With Zotec.

Your Success is Our Focus.

ZOTEC PARTNERS®

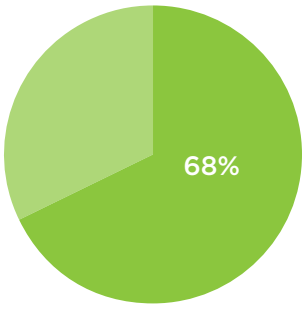
The Evolution of Healthcare and Shifting Financial Responsibility

Many providers now aptly view patients as "consumers," given patients' growing involvement in high-deductible healthcare plans (HDHPs), access to mobile health, and transparency in price and quality. The trend having a very significant impact on healthcare payments today is undoubtedly the shift of financial responsibility to healthcare's new patient consumers, with self-pay now being recognized as the third largest payer behind Medicare and Medicaid.[1] As a result, there is an increase in bad debt and patient liability from HDHP patients with self-pay balances after insurance. Providers are changing the way they do business and becoming increasingly aware that today's patients have more control over how they obtain care and pay for it.

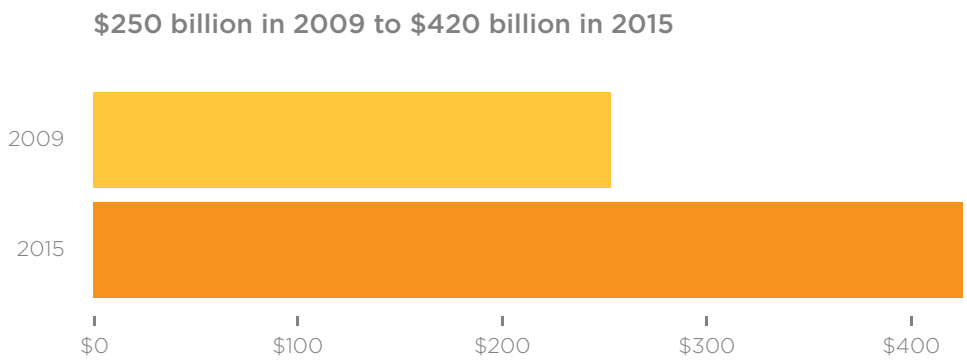
This paper will explore all these facets of evolving patient interaction requirements, and analyze ways providers can better reach consumers where they are. Readers will walk away with the ability to better meet the demands of today's patient consumer, as they glean insights regarding, 1) The business- to-consumer shift; 2) Customer service techniques; 3) Patient experience best practices and technologies; 4) New responsibilities in revenue cycle management; and, 5) Data security and patient privacy.

Executive Summary

Within the last decade, healthcare has seen a steady increase in consumerism among patients, who are faced with a gamut of choices and decisions when it comes to the quality and price of their medical care. This trend is largely a product of new patient consumers "picking up the tab" with hefty out-of-pocket deductibles brought about by the Patient Protection and Affordable Care Act. Recent statistics listed in a McKinsey Quarterly article confirm this, stating there has been a ten-fold increase in HDHP plans in the past seven years to more than 11.4 million people, and steadily growing. HDHPs are a driving contributor of the 68% increase in patient payment liability from $250 billion in 2009 to $420 billion in 2015.[1]



68% increase in patient payment liability

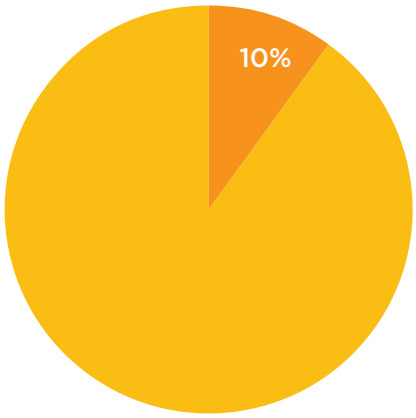


This is an increasingly prevalent occurrence, especially as insurance carriers are enrolling more consumers in HDHPs, in which they are responsible for a significantly greater share of their healthcare costs. Since the advent of the health savings account in 2003, deductibles have increased as employers resist escalating premiums. According to the Kaiser Family Foundation, the percentage of covered workers with deductibles of $1,000 or more rose from 10 percent in 2006 to 46 percent in 2015 — a 360 percent jump. Among covered workers with a general annual deductible, the average deductible for single coverage in 2015 was $1,318, up from $917 in 2010.[2]

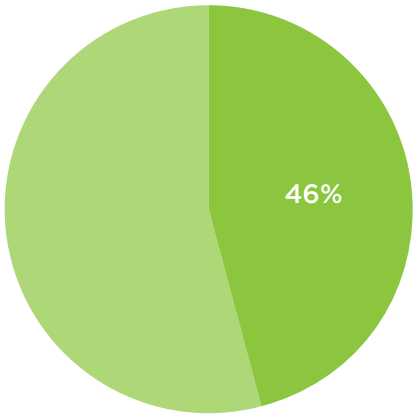
This trend isn't expected to cease either, with average annual growth of out-of-pocket healthcare expenditures projected to rise to 5.5 percent by 2023 from 3.2 percent in 2013.[1]

Because healthcare reform has increased patient responsibility for payment, providers are seeking the best ways to directly engage patients and understand their behaviors in order to collect money owed. Their goal, to provide consumers with multiple payment options, either during the point of service, or afterwards, utilizing website portals, mobile capabilities, payment plans, auto-deduction from health savings accounts, and sophisticated interactive voice technologies, to name a few.

Percentage of covered workers with deductibles of $1,000+

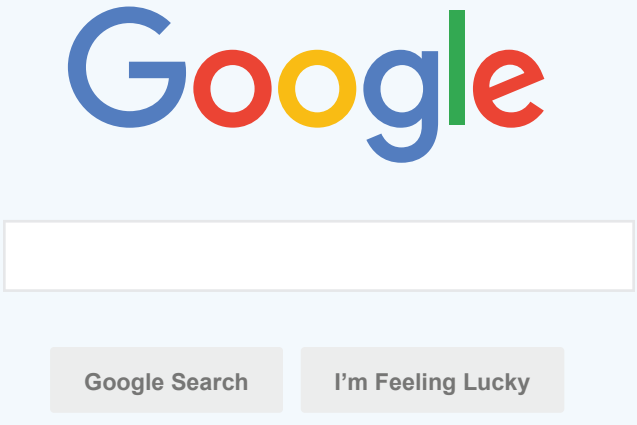


2006



2015

The industry is also abuzz over predictive analytics that give providers the optimal ability to collect payment from the new patient-consumer population. This approach involves the ability to accurately forecast propensity to pay for patients covered by HDHPs—all based on geographic, demographic, and historical payment data, and all of which deviate from seeking out a traditional credit score.



In this same vein, healthcare is currently undergoing the "Google effect," or the idea that people are no longer ever at a loss for answers because of powerful search engines. Data essentially eliminates gut reactions and personal bias from business decisions because it provides answers in black and white. Many providers have not been up to speed when it comes to putting a focus on how the patient experience fits into their revenue cycle. The management of clinical applications such as EHRs, plus administrative functions related to scheduling and admissions, all tie into the patient experience side of the equation, which has a direct and very relevant impact on physician revenue.

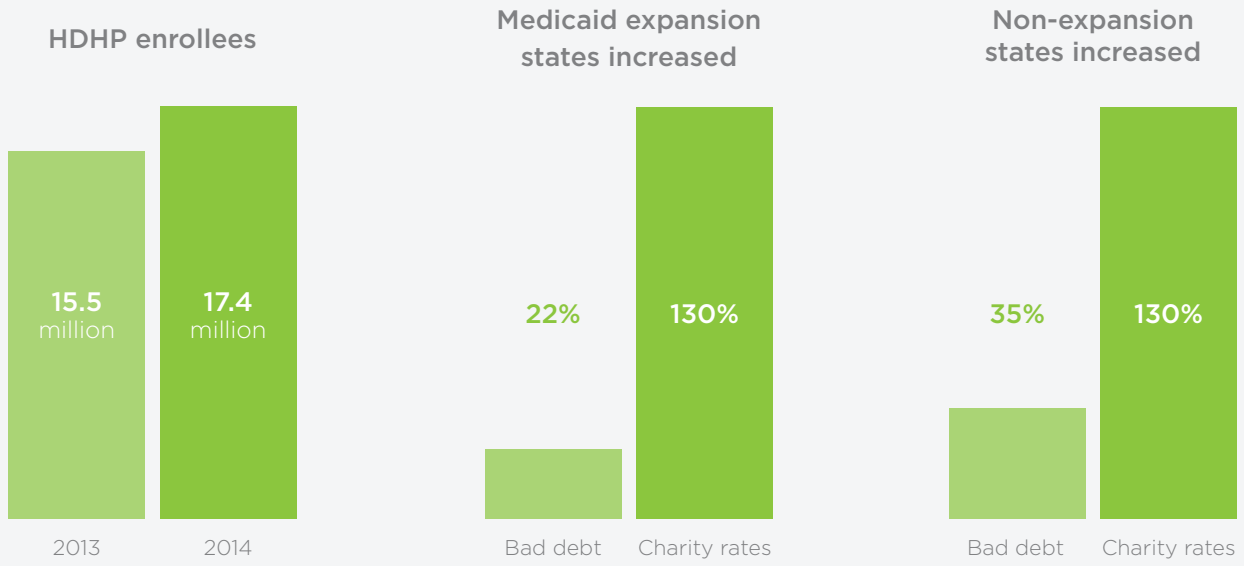
The Big "Business-to-Consumer" Shift

Physician groups have traditionally operated in a business-to-business model where patients' bills were paid largely by various government and private insurance payers. Physicians previously knew who to bill and what to expect in the way of payment from payers, but today's payer landscape has been transformed as well. As patients have been encouraged to take responsibility for the value of their healthcare purchasing decisions, so too have insurance companies used the notion of "**consumer-managed healthcare**" to shift the responsibility for payment to the patient by implementing high-deductible plans and health savings accounts. **Currently, healthcare providers find themselves increasingly working in this new business-to-consumer model, and they need to transform themselves and excel in their ability to connect, bill, and collect from thousands of individual payers rather than scores of corporate payers.**

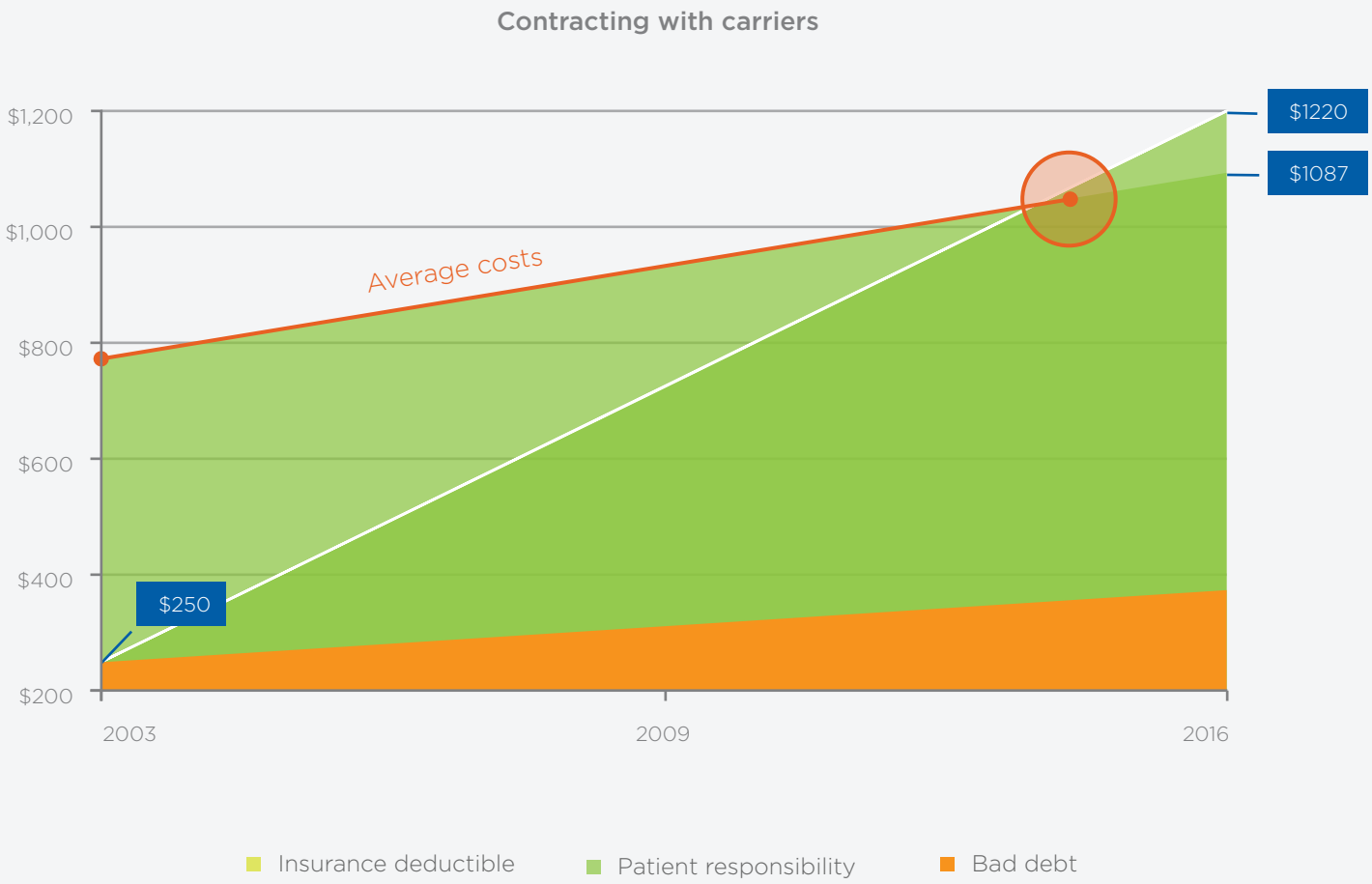
Consumer-managed Healthcare

Responsibility for payment is shifted to the patient versus insurance companies

Bad debt among the self-pay after insurance patient population is rising, according to public accounting and consulting firm Crowe Horwath's first quarter 2015 edition of its hospital benchmarking data.[3]



The Crowe RCA Benchmarking Analysis, which evaluated 420 hospitals, showed as the number of HDHP enrollees increased from 15.5 million in 2013 to 17.4 million in 2014, insured patients' share of total uncompensated care increased dramatically, with bad debt up 22 percent and charity rates up 130 percent in Medicaid expansion states. In non-expansion states, bad debt and charity rates rose 35 percent and 130 percent, respectively.[3]



As shown above, the average health plan deductible in 2016 was $1220, with the average healthcare cost per enrollee at $1087. Trends also show that the bad debt among providers has risen since 2003 and continues to rise. However, it should also be noted that Medicaid expansion has reduced unpaid bills and the need for hospital financial assistance overall. Recently cited by Modern Healthcare, the bad debt reported by 52 of the nation's largest hospitals and health systems declined overall by 5.6 percent. However, hospitals now write off growing losses on Medicaid patients as well, and the rising number of people enrolled in plans with high deductibles is prompting new strategies that include loans and more attempts to collect bills before or as patients enter the hospital.(4)

These trends underscore the need for hospitals and physician practices to implement solutions that can enhance the patient/consumer collections process and safeguard the revenue cycle by making the experience easier and less painful for patients.

This rapid shift to out-of-pocket healthcare expenditures is worrisome for hospital-based physician groups because the payment methodologies and systems used by many hospitals are outdated and inconvenient when it comes to payment transactions among the self-pay after insurance patient population. Hospitals and physician practices must quickly get up to speed as they meet the demands of the new patient-consumer.

Confusing medical bills and frustrating collection processes can derail satisfactory clinical experiences in the hospital or at a physician's practice.

New Focus on Consumer Service

Billing and payment for medical procedures are often overlooked aspects of the patient experience...and may be the reason that many physicians are seeing increases in patient complaints and their bad debt year over year. Confusing medical bills and frustrating collection processes can derail satisfactory clinical experiences in the hospital or at a physician's practice. Disgruntled patients unsettled by complex bills — then collection letters and poor interactive voice technology phone calls — are less likely to understand their financial responsibilities, and subsequently, less likely to pay on time or at all.

Therefore, the new post-reform environment has healthcare providers taking on a more customer service-centric approach as they face mounting pressures to provide revenue cycle processes that are more "retail" in design. Real-time adjudication and point-of-service collections with tangible and effective follow-up strategies are an absolute must for healthcare provider to interact with today's savvy patient-consumer, because as the role of the healthcare provider continues to evolve, so too will the way they handle payments.

In essentially all industries outside of healthcare, companies ceaselessly strive to provide the best possible customer service. Healthcare lags substantially in that sense because before now, third party payers paid the bills. At the same time, healthcare consumers have grown accustomed to exceptional customer service in other industries and expect the same consumer-centric treatment in their healthcare.

One great example is Amazon, one of the most highly esteemed companies in terms of customer service. On Amazon, you get prime service and your package is delivered right to your house — fast. Consumers are expecting that kind of interaction with healthcare billing. If a provider can't give that experience, it reflects negatively on the overall experience. When an Amazon customer reports a problem, a customer service professional responds in a rapid manner, illustrating an emphasis on fulfilling consumers' demands for immediate help, and highlighting Amazon's commitment to customer service. Unfortunately, that kind of timeliness is not common in healthcare. **When it comes to medical bills, which patients will likely have questions about, a lack of timely response can damage the patient's overall experience.**

amazon ★★★★½

Negative patient experiences can translate to reduced patient satisfaction scores in the HCAHPS surveys, which ultimately impact reimbursement. Bad experiences can also lead to patients not understanding or even avoiding paying their bills.

Another relevant statistic from McKinsey cites that, "...of the $2.7 trillion the country spends annually on healthcare, $400 billion goes to claims processing, payments, billing, revenue cycle management (RCM), and bad debt—in part, because half of all payer-provider transactions involve outdated manual methods, such as phone calls and mailings."[5] **Because of this, providers must be more diligent as they take on the patient-consumer population, creating new and better ways to make patient bills more understandable, with easier and more accessible payment options.** Zotec, for example, touches the patient multiple times, and through multiple channels in order to follow up for payment.

Patient input becomes increasingly important to physician providers, who must understand their (increasingly consumeristic) behaviors and offer options that benefit them. Physicians have to view the patient experience beyond clinical care, especially given the revenue cycle is analogous to a retailer's check-out process in that it can either increase or decrease the likelihood of future encounters, even more so given these relationships are more emotionally driven than say, buying groceries or taking a ride with Uber. The new **"patient-consumer"** requires a more integrated approach in their interactions with hospitals and physicians, therefore, the patient experience can and should be akin to the customer relationship management strategies that many retail and service-driven businesses employ. For patients, the clinical and financial experiences are one and the same, which is why providers have to be diligent on the back end as well as the front end.

Patient Payments Tie Into Patient Satisfaction

Healthcare institutions rely on billing and collections to remain financially stable, but they may not be aware of the large impact that billing and collections have on their patient satisfaction scores as well. In fact, when the Department of Health and Human Services decided to base 30 percent of hospitals' Medicare reimbursement on patient satisfaction survey scores, they did not factor in the methods that were being used to collect payments from patients, nor the vast cultural and demographic differences that each hospital sees, and must contend with, in order to keep patients happy. A billing process can greatly increase a patient's frustration with the hospital, which we then tie into a patient's propensity to complain.

Further supporting these issues, research suggests that 74 percent of satisfied patients paid their medical bills in full, compared to 33 percent of their lesser satisfied counterparts, thus proving that patient dissatisfaction with financial processes can negatively impact satisfaction scores...and an institution's bottom line.[7]

Patient Satisfaction

- ☐ Very Satisfied
- ☐ Somewhat Satisfied
- ☐ Neutral
- ☐ Somewhat Dissatisfied
- ☐ Very Dissatisfied

Educate Patients, Improve the Experience

Hospitals and physician practices must adopt a "help me help you" mentality when it comes to billing and collections. Whether they seek an external partner who specializes in securing patient payments or acquire the resources to enhance their own billing and collections department, interactions with patients should always be consumer-centric. In addition to providing the portals and tools for actually making payments, **the key is to provide patients with all of the information necessary to understand what they owe and when payments are due.**

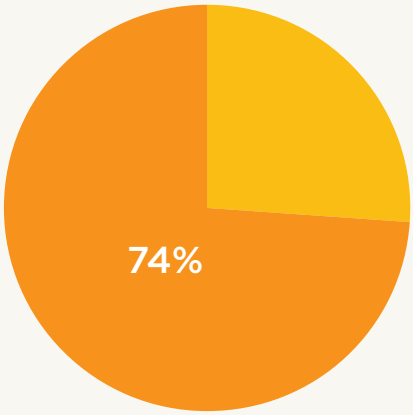
The first thing physicians must do is introduce the process to the patient at the time of service. Clearly explaining the series of steps involved in the billing and collections process to patients upfront remedies any worries they might have regarding the payment process. It also helps patients feel more in control of their healthcare experience because they will know what to expect when they receive their bills

That is why broader follow-up methods, such as claim-tracking status, patient portals, interactive voice response technology and text messaging, are more effective. These are all consumer-driven events that many providers are ill-equipped to handle without procuring outside support. While not representative of the majority of the patient population, some patients are inclined to avoid paying their bills, and the increasing rate of HDHPs will exacerbate this problem. Therefore, it is imperative to be as vigilant in collections and follow-up efforts as possible. These "**consumer-driven**" modes of communication also help expedite possible discounts that can be awarded to patients, in turn helping speed up receipt of payment.

Build a Foundation Grounded in Best Practices

A critical question posed by healthcare providers recently is, where does the self-pay after insurance payment responsibility now lie...with the patient, or with the physician provider? Recent studies suggest part of the problem could lie in the physician provider approach, noting that 74 percent of insured consumers indicated they are both able and willing to pay their out-of-pocket medical expenses up to $1000 per year.[6] So then, the next question would be, **"how easy is it for the patient-consumer to make the payment?"**

Pay out-of-pocket medical expenses up to $1000



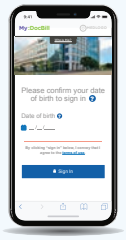
74% of insured consumers indicated they are both able and willing to pay their out-of-pocket medical expenses up to $1000 per year.

Patient Outreach

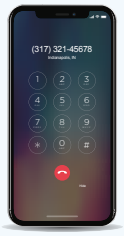
Follow-up protocols to patients are essential to collecting payment, and following up with the patient-consumer should go far beyond traditional methods, which typically only include a statement, pre-collection letter and collection write-off. Patient outreach tools have the capability to generate improved patient revenues for physician groups.

The patient outreach methods used by Zotec include a dedicated patient portal, patient phone calls woven into the traditional billing cycle of bills and statements, and multiple ways for patients to pay for their bills – including a new option for patients to receive a bill, view and update their account, and make payment directly from their smartphones. Giving physician groups the ability to connect with consumers – especially younger generations that conduct business from their personal devices – is revolutionary for the healthcare market.

Patient Outreach Methods

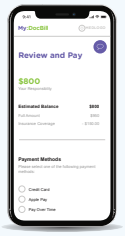


Dedicated patient portal



Patient phone calls

Traditional billing cycle



Mobile pay

Managing Expectations and Empowering Patients

To prevent the billing process from tarnishing patients' experiences, healthcare providers must focus on two principal strategies: managing patients' expectations upfront and empowering them to be more accountable for fulfilling their financial responsibilities.

Central to managing patients' expectations is presenting the hospital or physician practice's billing department as professional, friendly and dedicated to providing the most worry-free collections process. It is concerning when physicians must oversee billing and collections duties on top of caring for their patients. These added responsibilities can have a negative impact on the overall quality of care and may also contribute to a diminished view of the practice overall, as well as result in poor interactions between patients and staff.

Practices and hospitals should be investing in training their people, and there should be staff who are there solely for collecting money and insurance information, as opposed to clinicians juggling these responsibilities on top of their clinical ones. However, in reality, many physician practices and hospitals do not have the resource capacity to designate or hire employees to work exclusively on billing and collections. In these cases, providers might outsource these responsibilities to revenue cycle solutions companies that can implement effective billing and follow-up methods to ensure patients pay their bills.

Zotec's solutions enhance revenue cycle interactions to help instill positive patient perceptions of the healthcare experience and secure reimbursement and future service revenues for providers. By employing a patient experience methodology, patients are empowered to make payments through several tools that are easy and convenient to use.

Zotec's advanced interactive voice response technology includes a simple authentication process, an understandable format with minimal menu options so it is easy for patients to navigate, convenient text-back features, quick payment options, and immediate live operator assistance. Zotec operates a call center led by a customer service expert trained in optimizing the patient experience. It also offers a secure and user-friendly patient portal that can be used on a desktop computer or mobile device. Using the portal, patients can pay their bills, view their account history, request statements and update insurance information.

As in other industries, the key to securing a positive experience and safeguarding payments from consumers is simplicity and ease of use. With solutions like those offered by Zotec, patients have access to several convenient and straightforward tools to pay their bills. However, it is important to vet revenue cycle companies carefully as they are not all created equally — many still use outdated follow-up collections methods that emerged years ago.

With companies that specialize in billing and collections and help safeguard positive patient experiences, there is no need to overburden the clinical staff to manage these responsibilities, which can be challenging for people who are not trained to handle them. It's important to remember that physicians are seasoned professionals in caring for their patients and diagnosing the issue based on their training and education, and not just on what patients say, therefore it's important to apply that same science to billing.

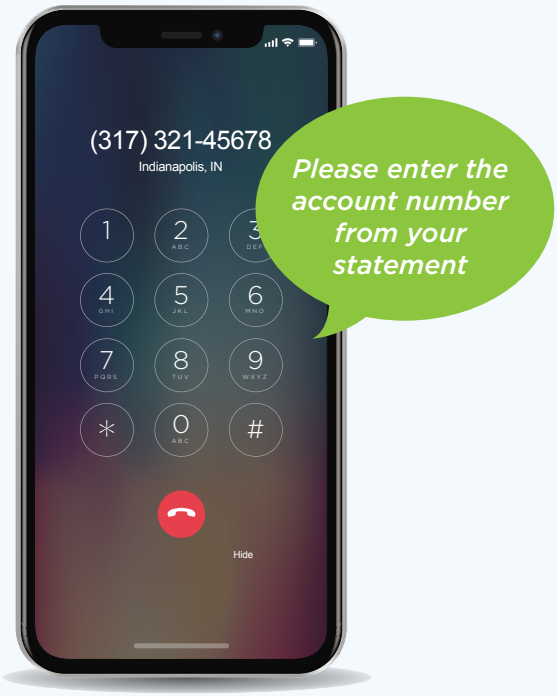
The Technology Factor – A Necessary Component

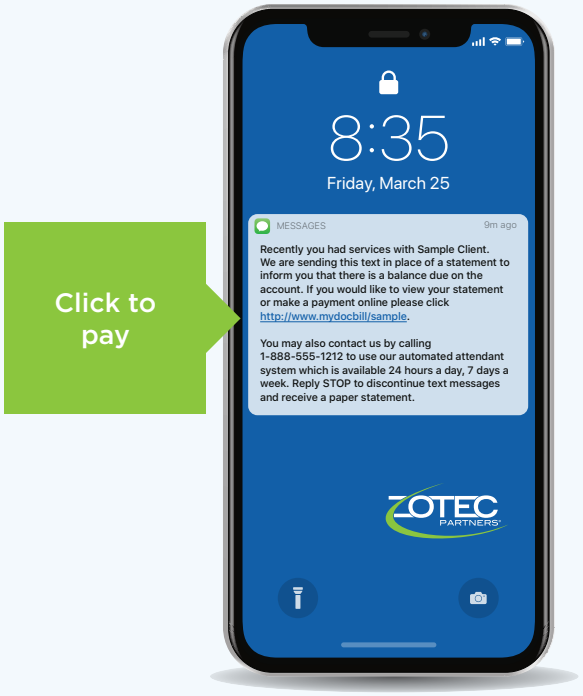
Achieving payment would not be possible without tools and technologies that give physicians a way to more closely leverage the opportunity to enhance the patient billing experience, including Interactive Voice Response (IVR), mobile text messaging and patient portals, for instance. **Technology is a key factor in creating patient experience methods, such as follow-up texting campaigns, that will impact collections from HDHP patients. In fact, technology is evolving at a rapid pace, and today's savvy patient-consumer is accustomed to having easy access to mobile tools to manage information anywhere, at any time.**

Automated Calls Still Effective

IVR is automated phone technology that is used by virtually every industry to provide enhanced and more efficient customer service. Companies that use IVR technology create a convenient and efficient avenue for customers to perform important, albeit simple, transactions and obtain necessary information from virtually anywhere, at any time. As the decades have passed and automated phone technology has become more streamlined, IVR technology has emerged as a highly efficient and effective way for smaller and mid-sized businesses to provide more self-service options for their customers. The consumer's expectation for instant access to account information and bill pay from virtually any location at any time is now a reality that leading health care providers can accommodate with IVR usage.

The proof is in the pudding, so to speak. With the addition of auto-generated outbound phone calls to patients, Zotec's clients experienced significant improvements in self-pay collections.





The Movement to Mobile

It is also no secret that mobile usage has risen in recent years. From a medical billing standpoint, physicians should take advantage of this prime opportunity to directly reach their patients. Mobile technology gives physicians an ideal opportunity to engage patients in a platform that is most frequently used in near real-time. Recent statistics cite that Americans used mobile devices more than PCs to access the internet,[7] and the percentage of bills paid using mobile devices grew by 69 percent in 2014.[7]

According to a 2014 Pew study, over two-thirds of cell phone owners check their phones for calls, alerts, and emails – even when they haven't noticed it ringing or vibrating.[8] These statistics drive home the point that physicians should be taking advantage of a critical component to bill paying strategies. This confirms that notices and alerts can be very useful throughout the entire patient experience, as patients can be reminded of their financial accountability during various points of a medical encounter, with access to electronic statements for payment throughout.

In fact, Zotec is doing for health care payments what Google Wallet and Starbucks are doing for some consumers, creating a huge convenience factor by turning patients' mobile phones into a payment source. **With mobile payment and text capabilities, patients are not only empowered and accountable to self-manage their balances, make payments or create payment plans, but they are also reminded of payment due dates.** It is ultimately important to make the payment process convenient, easy-to-understand and secure for the patient while also increasing collections for the providers, who now have an incredible opportunity to fully engage patients to make payments through multiple channels, especially given today's evolving technology and data mining capabilities.

One thing is clear, mobile phones are replacing the credit card in today's patient consumer interactions, and paying bills has never been easier. According to a recent study at Harvard University, the mobile phone is a strong contender as a key transforming agent in the future of health and health care, additionally citing there are now more than 5.3 billion cell phone users around the globe, with 90 percent of the world's population covered by a commercial wireless signal. In other words, there are now channels to contact people who could not be contacted before, and certainly to provide health care services to them outside of traditional facilities. The study goes on to say that, by providing patients and practitioners with the information they need, where they're at, they are able to make informed decisions regarding a gamut of health issues.[9]

Customize the Channels

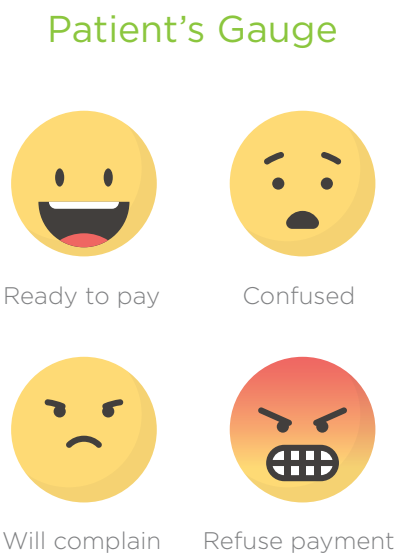
Interestingly, research from Fiserv suggests that a single technology is not efficient in patient follow-up, noting that the average U.S. household uses three different bill payment methods each month, and that users' preferences for paying the same bill aren't always consistent on a month-to-month basis. For example, 42 percent of consumers will use a different payment channel than they did last month to pay the same bill, which makes providers' understanding of patient behaviors even more critical as they seek to obtain payment for services rendered.[10]

This goes to show that the latest interactive voice technologies, mobile methods and patient portals are critical platforms that should be intuitive for patients as well, but ultimately, providers must take a multiple approach in patient engagement and employ a variety of tools that will suit all their consumer's preferences. Because no patient is the same, the way providers engage them should not be **"cookie cutter"** either.

New Responsibilities in RCM

A cautionary suggestion for providers: no amount of payment technologies will be valuable if providers do not analyze their current and projected patient mix, and gain a distinct understanding of patient behaviors. If the upfront effort isn't there, then providers may see little to no improvement, especially if it's determined that mobile payments are not the most viable or desired payment option.

Patients are becoming increasingly frustrated when navigating confusing healthcare payments, and therefore it makes sense to offer solutions within the revenue cycle. For providers to expect payment from a healthcare encounter, they must give patients the same experiences they're getting when they make everyday consumer purchases. Adding to that, providers also have the ability to implement this process into their revenue cycle and gauge a patient's propensity to pay a bill or on the flip side, complain about a bill and refuse payment. On the patient side of the equation, Zotec has developed online and mobile billing tools that are better suited to today's increasingly retail-oriented healthcare payment environment, but on the physician side, the company is also able to use predictive analytics to determine patient tendencies ahead of time, in order to obtain a firm understanding of who they are and what they like, or if they have a preference for mobile use, for instance.



The Institute of Healthcare Consumerism (IHC) shares this notion, stating, **"There is a greater expectation for personalized experience in healthcare, and healthcare technologies that seek to know each patient, remember preferences and engage with them effectively, and via the communication channels they are used to in daily life will be at the forefront of taking patient care to its next inevitable level."** The IHC also suggests that these patient experience technologies can ultimately lead to higher patient volumes, revenue, profitability and an overall standard of care.[11]

Providers should not, however, invest a lot of time and effort on collecting from patients that are predicted to pay, on the contrary they need to know they are putting their efforts on the right patients, based on what is reflected in each patients' expected collection amount and his/her risk or propensity to complain. By giving patients the capacity to immediately pay their bills anytime and from anywhere, we ultimately give providers the ability to collect and post payments faster and more efficiently, without manual processing errors.

Demographics and Big Data

Healthcare providers are certainly aware of the complexities they face, including what and when to bill patients throughout the revenue cycle, and especially calculating a patient's propensity to pay. By using data to calculate a patient's propensity to pay, health providers can determine which collections strategy will most likely get the maximum return in revenue. There are millions of data elements generated in a year, including social data, demographic information, social patterns, clinical data, and buying patterns, including when patients like to pay their bill.

As the healthcare industry becomes more focused on meeting the demands of consumer behaviors, understanding patients' tendencies toward payment is increasingly central to revenue cycle management and collections. This is especially true in an era when high-deductible health plans are more popular and patients carry more responsibility for their coverage. **What used to be a physician-to-carrier relationship, has now been transformed into a physician-to-patient relationship.** Consumers are now forced to do in healthcare what they do in other consumer-driven business exchanges, wanting their healthcare exchanges to match the experiences they get with Amazon, Uber, and Google, from the convenience and fast automation, to the cashless transaction.

As patients continue to rely more on their time-tested consumer behaviors and tendencies in their healthcare interactions, hospitals must now oblige them where they are. This is where big data can come into play. Providers need to be more mindful of who they are dealing with on a patient-by-patient block in order to customize the patient experience and get the best results. Direct, clear communication with patients is also key in these interactions, so it is important for patient responsibility determination to occur after a provider ascertains a patient's eligibility status, co-pay amount owed, deductible balance and other miscellaneous information related to fees.

Patient "Personas" Before Propensities

Merriam-Webster defines a persona as "the aspect of someone's character that is presented to or perceived by others." Zotec uses a platform that draws from troves of data to similarly create "personas" of individuals and payers in order to optimize the revenue cycle. The company has discovered that by analyzing individual's personas, providers can determine an individual's propensity to pay, or the propensity for friction. Knowing these tendencies ahead of time allows providers to tailor billing interactions and collection techniques to individuals to minimize friction in making payments, and to maximize collections.

A patient's demographics can suggest the likelihood that he or she will respond to a text message notification about medical bills versus receiving paper statements in the mail. For example, an elderly patient may not be as technologically savvy as a younger patient, who may prefer to make mobile payments. Therefore, providers must employ payment strategies that are based on payment history as well as demographic data for each patient category. Based on these patient characteristics and tendencies, hospitals can decide how to best interact with individuals and ultimately collect money.

Providers should, however, view their collection efforts as a return on investment, applying their resources on accounts where extra efforts will yield net cash returns, specifically on patients who have a propensity to complain. If a patient's persona reveals a strong propensity to pay, then groups can likely avoid investing collection resources on accounts that would pay anyway, especially given a patient's payment history paired with other elements of the patient persona. Patient personas should reflect both the expected collection amount and risk/propensity for friction, in order for providers to ensure they are putting their efforts on the right patients, and with the right frequency.

Keep Security a First Priority

In a recent Money Magazine article, a large provider of mobile payment services suggests that mobile payments are inherently more secure than using a plastic credit card, because most mobile payments are conducted on phones that have GPS, stating, "with GPS capabilities, payment providers can determine who you are and whether the transaction is a legitimate one, with a lot of data around the transaction that can actually be utilized to protect people, as opposed to what isn't found on a plastic credit card."(12) This is good news for healthcare as well, but only if companies keep patient security and privacy at the forefront when considering mobile payment options for patients.

Compliance with regulations that protect consumers' privacy is a key component in patient-consumer communications, especially in regards to new mobile consumers and text messages, which are essential in today's communications efforts with patient consumers. Third party billing partners should legally rely on the demographic information patients voluntarily provide to hospitals and providers to ensure the patients' most up-to-date express consent is obtained for text messages. When it comes to patient interaction, it is important that providers strive to ensure phone calls and text messages always comply with the Telephone Consumer Protection Act and the latest Federal Communications Commission regulations. Zotec's follow-up protocols to patients are made on behalf of its physician clients in order to collect payments, and only those patients that have provided prior express content receive texts and phone calls, for example.

Meeting the Demands

We've established the paradigm shift in how patient payment responsibility carries over into a business to consumer reality for healthcare providers, and healthcare reform has forced physician practices to adapt to ongoing changes. The closing question for providers is, **"how can you meet the demand for a multi-channel approach to patient billing and payment – in addition to the mobile options discussed earlier?"**

When it comes to healthcare, patients expect and demand the same level of customer service they are used to receiving in the retail, dining and travel industries. Billing and collections — though not a clinical aspect of healthcare — is a critical factor in determining patient satisfaction. With the proper systems and tools, hospitals and physician practices can empower their patients to take greater accountability for their financial responsibility, and providers will see an increase in revenues.

A shared objective among healthcare providers and their revenue cycle management partners is to give the new patient-consumer population options to pay their bills at any step in the revenue cycle process – be it before, during or after a medical encounter and using a variety of methods and technologies. Physician providers must work hard to optimize patient payments in order to build integrity into their revenue cycle, viewing it as a large part of the clinical experience as well, with revenue cycle management partners often serving as trusted advisors.

Conclusion

As the population of patients with HDHPs grows, the need to enhance the billing and collections process has become particularly pertinent. The evidence is plain; data shows a positive correlation between the increasing rate of HDHPs and uncompensated care, as well as patient complaints or requests for discounts. Hospitals and physician practices can implement best practices to mitigate these trends in their billing and collections department, such as managing patients' expectations upfront and empowering them to be more accountable to pay their bills. Alternatively, healthcare providers can seek help from dedicated professionals trained to do it, since all of these changes in healthcare are fueling innovation with companies like Zotec, to develop payment solutions to meet the evolving needs of health care payers, providers, and their patients. Providers wanting to improve their patient satisfaction ratings, decrease bad debt, and gain an edge on the competition should create multiple traditional and non-traditional options to interact with patients, and especially taking into consideration the electronic and mobile demands of today's patient consumers.

Whichever direction providers choose, it is essential to no longer just believe carriers are going to pay for services rendered and ignore the third largest payer...the patient, or they will see the effect in their bottom line. And while traditional payment methods are still necessary among healthcare's varying demographic populations, mobile payment transaction volumes and payment amounts are quickly increasing, and mobile use has skyrocketed. Providers must step up to the plate and begin to offer patient consumers an easy mobile experience, but only if it sparks the patients' propensity to pay. If providers want to see increases in collections from patients who continue to have rising patient responsibility, mobile efforts that are strategically combined with traditional ones will often yield the best results.

In closing, organizations must think through the entire transaction and the impact it will have, and not just for one individual patient. The greatest takeaway in today's new collections strategies is that they must be anything but cookie-cutter. Providers must attempt to balance their revenue cycle management techniques with efforts that reach the patients on a personal level, including getting to know each patient, in order to improve each patient's unique experience while positively impacting cash flow for the hospital or physician group.

References

1) Kneller, Seth. Triple Tree, Innovators Wanted: Mounting Patient Financial Responsibility Driving Provider Demand for Positive Disruption and Change (Part 1 in a 3 Part Series). http://www.triple-tree.com/blog/2015/12/17/innovators-wanted-mounting-patient-financial-responsibility-driving-provider-demand-for-positive-disruption-and-change-part-1-in-a-3-part-series/

2) Bailey, Michael MD; Calkins, Sarah; Levine, Ed MD; Marchado-Pereira, Monisha. McKinsey Quarterly, Hospital Revenue Cycle Operations: Opportunities Created by the ACA. http://healthcare.mckinsey.com/sites/default/files/793544_Hospital_Revenue_Cycle_Operations.pdf

3) Crowe Horwath, The New Reality: Increasing Hospital Financial Risk From Insured Patients. http://www.crowehorwath.com/folio-pdf-hidden/Benchmarking-Report-Q1-PERF16614.pdf

4) Evans, Melanie. Modern Healthcare, The Affordable Care Act isn't Wiping Out Unpaid Hospital Bills. http://www.modernhealthcare.com/article/20160305/MAGAZINE/303059966

5) Pellathy, Thomas and Singhal, Shubham. McKinsey Quarterly, The Next Wave of Change for US Healthcare Payments. http://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-next-wave-of-change-for-us-health-care-payments

6) Kaiser Family Foundation, 2015 Employer Health Benefits Survey. http://kff.org/report-section/ehbs-2015-summary-of-findings/

7) Gooch, Kelly. Becker's Hospital CFO, Study: Satisfied Patients More Likely to Pay Medical Bills in Full. http://www.beckershospitalreview.com/finance/study-satisfied-patients-more-likely-to-pay-medical-bills-in-full.html

8) Pew Research Center, Mobile Technology Fact Sheet; Oct. 1, 2014. http://www.pewinternet.org/fact-sheets/mobile-technology-fact-sheet/

9) Aylward, David. Harvard Business Review, How Mobile Phones Can Transform Healthcare. https://hbr.org/2011/03/david-aylward-the-mobile-phone

10) 7th Annual Billing Household Survey from Fiserv. http://www.slideshare.net/FiservPR/fiserv-seventh-annual-bill

11) The Institute for Healthcare Consumerism, The Consumerism of Healthcare: What Patient Experience Means to Our Future. http://www.theihcc.com/en/communities/health_care_consumerism/the-consumerization-of-healthcare-what-patient-exp_h333dkhj.html

12) Bortz, Daniel. Money Magazine, How Safe Are Mobile Payments? http://money.usnews.com/money/personal-finance/articles/2012/05/02/how-safe-are-mobile-payments

Notes

Notes

Let's talk.

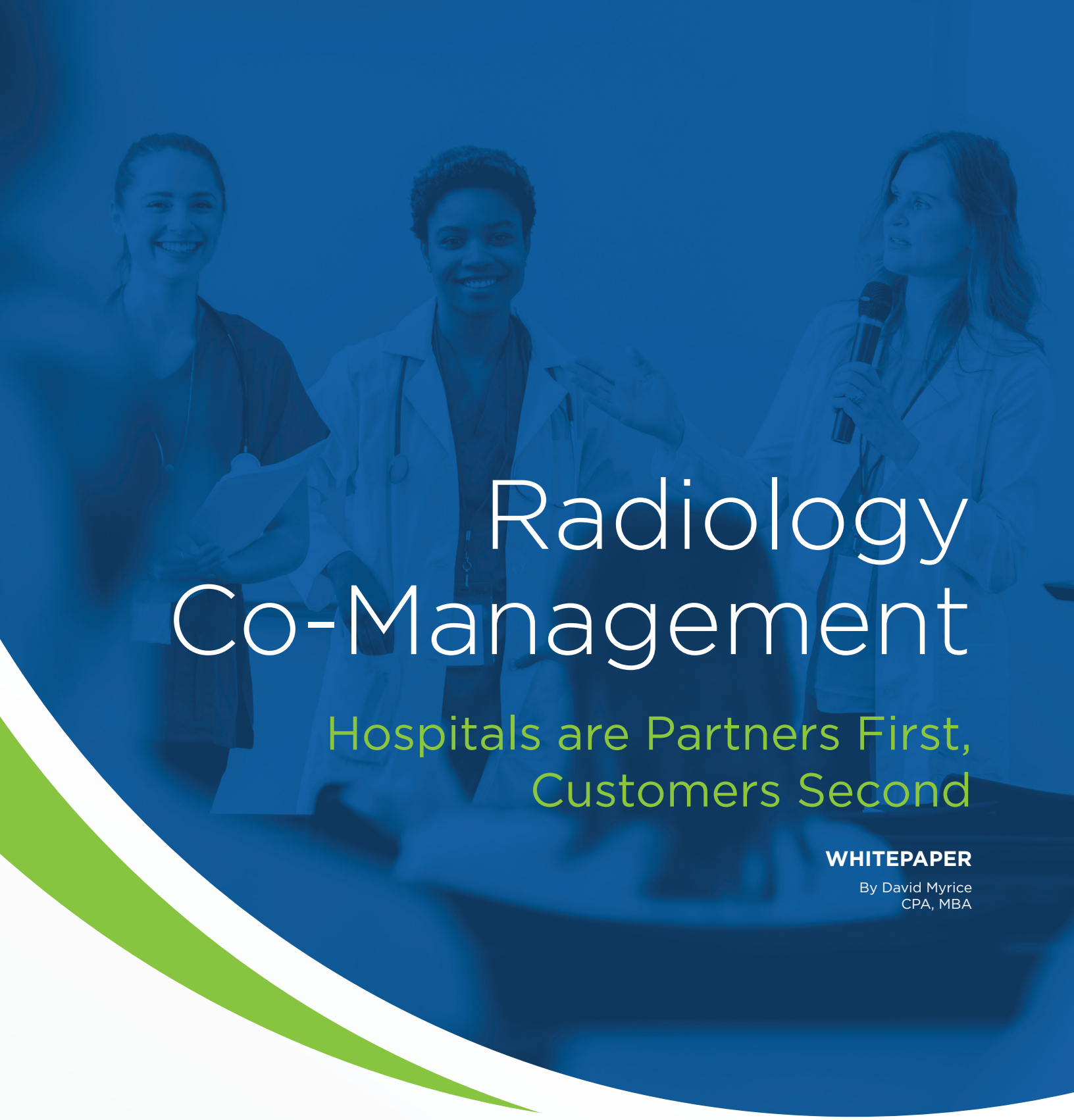
Our Revenuologists™ are passionate about connecting providers with patients so they can get paid accurately and efficiently for the work they do. If you're ready to enhance your patient experience and maximize your reimbursement with a fully integrated RCM solution, we should talk. Contact us at 317.705.5050 or sales@zotecpartners.com.

Connect with us

Complete Revenue Cycle Management.
Fast. Accurate. Compliant.

sales@zotecpartners.com | 317.705.5050
zotecpartners.com

ZOTEC PARTNERS®



Radiology Co-Management

Hospitals are Partners First, Customers Second

WHITEPAPER

By David Myrice
CPA, MBA

Business to Consumer
Starts With Zotec.

Your Success is Our Focus.

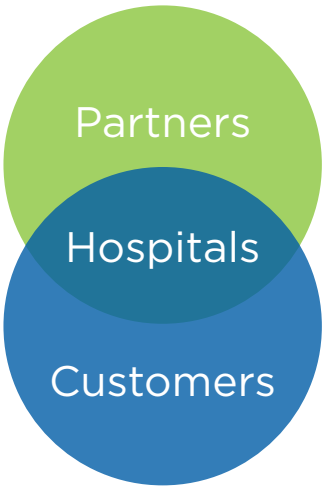
ZOTEC PARTNERS®

Hospitals are Partners First, Customers Second

Radiology practices are in a new climate of increasing competition that requires self analysis and more in-depth views of market trends that can be compared to their own business models. Whether it is the emergence of accountable care organizations (ACOs) and integrated service models, the ongoing relationship between teleradiology groups and hospitals, competitive hospital contract bids or the independent formation of radiology groups, more and more radiology practices are realizing that the time for "doing what has always been done" is over.

Market trends reveal many hospitals' immediate focus is on non-traditional service options. With increasing regulation, practices are finding inconsistent application of new policies and funding problems that are leading to a tightening cash flow. The result is often a direction of imaging to larger national practices, varying care delivery models, or a complete loss of group independence. One thing is certain: traditional radiology practice models are now being pressed from multiple directions.

In a complex era of health care reform, every practice arrangement must be built on true clinical integration; and whether a radiology practice is independent or employed by the hospital – nothing is sustainable without it. The advent of accountable care models, bundled payments and quality reporting, and payment initiatives will force integration.



Hospitals should be viewed as both partners and customers in the minds of radiology practice stakeholders and leadership.

The New Hospital Environment

Hospitals are indeed looking ahead as they consider ACOs and integrated service delivery. Today's hospital environment is comprised of reduced reimbursement, and it often offers pay for performance incentives for its physicians – either for those employed directly or through a contract. There are also increasing employment alternatives for hospitals, especially if they consider employment-based physician staffing in place of a traditional contract model with a radiology practice. All of these reasons give radiology practices the need to improve their relationships with hospitals in an effort to maintain autonomy. Hospitals should be viewed as both partners and customers in the minds of radiology practice stakeholders and leadership.

Want Versus Need

What should groups first do? Consider what it is hospitals have always wanted from groups. Hospitals desire more coverage of radiology services. With Medicaid expansion and the advent of insurance exchanges, this will likely only increase. They also want groups with issue-free physicians and those that have referring physician satisfaction. And of course, there is always the need for quicker turn-around times.

Not only does the hospital have wants that a practice must take into consideration, but also there are requirements:

- Economic pressures are creating an adversarial climate in some areas and pushing physicians and hospitals together in others. Competition of services is a hot button issue and often, hospitals require strategic alignment from groups with no competing or outside ventures.
- As the health care community tries to transform itself from a volume-based to a value-based system, costs are even more constrained. To succeed, hospital leaders must manage costs by identifying effective resources and integrating service distribution plans. Often, the radiology group will be required to employ cost containment strategies for hospital expenses including expensive equipment and facility space.
- Of late, many hospitals require committee participation and strategic planning involvement from its physician partners. This means health systems are encouraging physicians to be on various boards and committees at every level of the organization, and physicians are stepping up to do so. Some health systems have dedicated physician organizations to provide direction to the institution, while others have physician leadership training programs to ensure they have doctors with the skills to fill key roles.
- Finally, patient and surgeon satisfaction still is and has always been the largest hospital requirement of radiology groups.

Still, emerging trends suggest hospitals are veering away from employing physician groups. It has been well documented that employed physicians are not as productive as those who are independent, and hospitals also face recruiting challenges in this sense. What this says is that physicians must bring more to the table.

How Do You Measure Up?

A recent survey conducted by Zotec Partners among a group of its radiology practice clients illustrates light practice participation in health care service measurements as compared to what hospitals measure, as shown to the right:

Service Measurement	**Practice** Measures This	**Hospital** Measures This
On time starts	0%	82%
Patient satisfaction scores	12%	93%
Surgeon satisfaction results	0%	79%
Number of case cancellations	0%	64%
Clinical quality metrics	6%	79%
Pre-op assessment	0%	11%

Despite these numbers, radiology is still an industry that has an impact and a long history in the hospital setting. Diagnostic radiology brings $175 billion to the United States every year and comprises 7.5 percent of all health care costs[2].

Radiologists have undertaken several initiatives that are important to note, including communication about utilization rates, mammography recall rates, JCAHO requirements for performance assessment and costs associated with transcription and stipends. Safety and quality measures, such as turnaround times, interpretive accuracy and critical results reporting are also areas that radiologists are communicating in an effort to improve industry research and education.

Diagnostic radiology brings $175 billion to the United States every year and comprises 7.5 percent of all health care costs[2].

Trouble in Paradise

Remembering that there are more options for hospitals now than ever before, radiologists working in independent groups can become sensitive to these issues, which bleeds into the psyche of the entire staff. Societal changes are often reflected in physician behavior. The competitive and threatening atmosphere between hospitals, payers and other groups can foster bad moral for independent groups, and in turn this moral lends to unintended group consequences. For example, radiologists who feel threatened can exhibit behavior that affect group health, including rudeness, tardiness, incompetence, weak skills, poor work ethic or confidentiality breaches.

This is hard for groups, especially since physicians are not usually confrontational with their own staff and often have the blind faith that the behavior will correct itself or simply go away. In the end, many groups do not seem to understand the consequences these problems can bring. There is often a lack of process available to deal with these behaviors or to stop them from occurring from the start. Groups that are considering a change or a solution to an existing problem with their radiologists have several options to consider:

Creating a discipline policy

Establish policies that deal with actions instead of individuals

Be consistent in applying policies that are established

Not be too punitive or too permissive with those exhibiting “bad behavior”

Create an employment agreement with clauses, such as termination without cause

Reinvent the culture of the group

Getting Down to Business

Once a practice has firmly established it is willing to improve its culture in an effort to help the hospital meet its needs, it must also focus on its own growth and diversify with effective outpatient and system strategies. Using service execution, finding new sources of revenue, and growing its distributed reading business are a few ways it can do so. Aligning with the hospital is also crucial to its growth, especially in the planning of physician management and recruitment efforts. Most important is that a practice should always plan for financial security and any risks/losses associated therein.

The radiology group can strategically build its relationship with the hospital by first adding market value where it is needed. Performing clinical integration and reporting the value therein is a great first step, while also striving to meet the customer-focused service the hospital demands. Meeting the needs of specialists and generalists are also ways radiologists can build relationships outside of the hospital's leadership, helping them to develop a greater network communications strategy and gain market leadership.

Exclusive of the hospital's needs and wants, radiology practices that operate in a businesslike manner can showcase more confidence in both leadership and service execution. In addition, contrary to the beliefs of many physicians, just because a practice runs in a business fashion, does not mean patient care is forgotten. Patient care is a practice's business!

Soundly run businesses that can operate in an independent manner will garner hospital respect and admiration from the start. The bottom line is that for an ideal hospital relationship to emerge with a radiology practice, a combination of service, trust, financial viability and common goals must be shared – which is where an ideal integrated model comes into play.

The bottom line is that for an ideal hospital relationship to emerge with a radiology practice, a combination of service, trust, financial viability and common goals must be shared.

There are multiple alignment models for physicians and hospitals that can give each the perceived benefits of closer alignment while allowing doctors to remain autonomous. Limited alignments give physicians more autonomy but modest financial rewards. With full alignment, autonomy is low but financial gains are likely to be higher. Moderate alignments fall in between. The more limited the deal, the easier it is to get out of.

One such example of a moderate alignment model is clinical co-management, whereby hospitals and physician groups are working toward shared goals such as lowering costs for particular services. Historically, gain-sharing arrangements have been against federal law. But with the advancement of ACOs, the concept has received more of a push as incentives are created to help physicians and hospitals save money and improve care.

Achieving Hospital Integration and Group Independence with Co-Management

A co-management agreement is when physicians are engaged through a contract to provide management services in concert with hospitals for programs or services. The agreement usually has some form of fixed fee-for-services, as well as performance incentives based on predefined quality, satisfaction and/or efficiency metrics that help the hospital meet its goals.

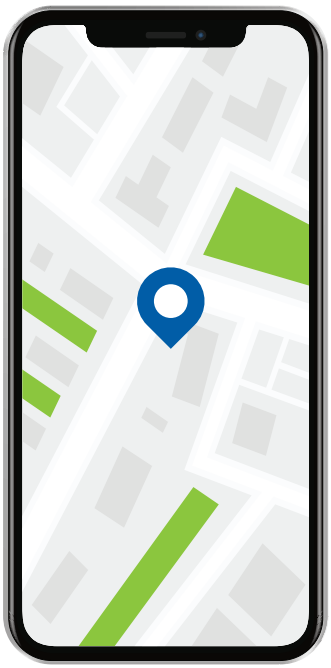
The purpose of clinical co-management is to ensure collaboration between a hospital and physician group in developing, managing and improving the quality and efficiency of the hospital. The goal is ultimately to increase hospital-physician alignment, while maintaining the independence of the physician group.

This is the best option for the practice that does not desire complete hospital control or a "divorce" from the hospital. In this agreement, both the hospital and the practice agree on how they will play ball and each can agree to provisions that are mutually beneficial. It can provide for the performance of a variety of services, including, for example, medical director services, strategic planning, scheduling and staffing, and human resources duties.

The layout of a co-management agreement starts with a shared governance structure with an agreement on complete transparency of data. Physicians are still in control, but also commit to the care of the hospital's resources. Performance metrics include evidence based protocols and quality measures for baseline and readjustment. All services are set at a fixed price and incentive compensation must be fair market value. All of which ultimately leads to increased value.

A quality co-management service agreement should reflect a clear understanding between the hospital and the radiology group as to what the effect the hospital's retained governance authority will have on the group's ability to perform the management services it is responsible for under the agreement.

Provided the parties to a co-management service agreement clearly understand their respective rights and responsibilities, the arrangement contemplated by the agreement can have the benefit of enhancing the physician group's satisfaction with its hospital alignment by allowing it to participate in the operational and strategic efforts of the hospital. The hospital on the other hand can gain from possible cost reductions and securing the services of a valuable physician group in an important service line of the hospital.



The Office of Inspector General (OIG) provides a useful road map for structuring a co-management arrangement to comply with applicable law.

What About OIG Scrutiny?

The operational risks associated with such arrangements can be minimized by making sure that the parties' enter into a co-management service agreement that clearly describes what the hospital is willing to let the physician group manage and the specific tasks and functions the physician group will be responsible for performing. For example, in its final Advisory Opinion of 2012 (OIG Advisory Opinion 12-22, issued: Dec. 31, 2012), the Office of Inspector General (OIG) provides a useful road map for structuring a co-management arrangement to comply with applicable law. In that Opinion, the OIG approved a co-management arrangement in which a hospital paid a cardiology group to manage the hospital's cardiac catheterization laboratories. The compensation paid by the hospital included a fixed management fee and a performance bonus, based upon achieving certain quality and costs savings benchmarks in connection with operation of the catheter labs.

The OIG determined that, although the Arrangement (1) could potentially constitute an improper payment to induce the reduction or limitation of health care services, in violation of the Civil Monetary Penalties Statute, and (2) could potentially generate prohibited remuneration in exchange for referrals under the Anti-Kickback Statute, the presence of certain "safeguards" minimized the possibility of violation of the applicable statutes. Because the likelihood of violation of these statutes was minimal, the OIG stated it would not seek to impose sanctions against the parties.

There are, however some safeguards for groups as indicated in the OIG opinion. The hospital's certification that both the fixed fee and the performance bonus represented fair market value compensation for the services performed. The compensation paid to the physicians did not vary with the number of patients treated. The Arrangement would not serve as an incentive for the physicians to refer patients to the hospital instead of to a competing facility. Instead it was designed to improve quality rather than to reward referrals, and the Arrangement had a limited duration.

Heightened Urgency in Hospital-Physician Relationships

As health care reform spurs the industry to focus on cost control and the delivery of high quality care, improving hospital-physician relationships requires immediate attention. While there are a variety of ways to structure a relationship and/or contract with a hospital partner, groups that move forward with a co-management agreement can position the hospital as the customer, taking an approach that will yield increased value, quality and harmony. There are no guarantees in any hospital employment agreement, and an arrangement that “goes bad” is very difficult and expensive to unwind.

Regardless of how an arrangement is structured, radiologists must remember these current instabilities and relationship woes will not be solved by the health care market or the government. Radiologists must seek ways to reinvent their culture from within and approach new integrated care delivery with meaningful strategies if they want to maintain independence and sustainability.

References

(1) Maat, Sue Ter, "Hospitals are Buying, But Doctors Don't Have to Sell," American Medical News - April 2013: http://www.amednews.com/article/20130422/business/130429981
(2) Yates, Teri, "The Case for Standards-Based Performance Assessment," Patient Safety and Quality Healthcare - September/October 2012: http://www.psqh.com/september-october-2012/1402-the-case-for-standards-based-performance-assessment.html
(3) Office of Inspector General: Advisory Opinion of 2012 (OIG Advisory Opinion 12-22, issued: Dec. 31, 2012)

David A. Myrice, CPA, MBA, is a director of practice management and practice administrator with Zotec Partners out of its Toledo, Ohio office. He has specialized in business financial operations since 1981 and is a Certified Public Accountant and a Licensed Nursing Home Administrator in Ohio. He holds a Master's in Business Administration from the University of Toledo and graduated from Bowling Green State University with a Bachelor's Degree in Accounting. Mr. Myrice has four years of public accounting experience, 10 years of long-term care health care experience, and two years of physician practice management experience before joining Zotec Partners. Mr. Myrice is proficient with computerized systems, an experienced finance manager and has a firm understanding of human resource issues and operational management. He also has a solid understanding of pension and profit sharing rules and regulations, joint venture structures in health care and legal contract language. He began his career with Zotec Partners (formerly MMP) in September 2002 as a finance manager.

Notes

Let's talk.

Our Revenuologists™ are passionate about connecting providers with patients so they can get paid accurately and efficiently for the work they do. If you're ready to enhance your patient experience and maximize your reimbursement with a fully integrated RCM solution, we should talk. Contact us at 317.705.5050 or sales@zotecpartners.com.

Connect with us

Complete Revenue Cycle Management.
Fast. Accurate. Compliant.

sales@zotecpartners.com | 317.705.5050
zotecpartners.com

ZOTEC PARTNERS®