HIMSS

Rethinking Revenue Cycle Management

HIMSS Revenue Cycle Improvement Task Force

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Executive Summary

Revenue Cycle Management (RCM), as it exists today, is ill-equipped to handle the market forces impacting healthcare. Rapid growth in consumer payments, reduced payer reimbursement rates, an ever changing regulatory environment, and shifting consumer expectations have all contributed to the challenges facing RCM. The current approach of "bolting on" new technologies and reworking internal processes will not sufficiently address these challenges. In fact, that approach leads to greater complexities and costs to RCM processes. In response to the challenges facing RCM, the Health Information and Management Systems Society (HIMSS) has assembled a group of experts drawing from providers, payers, financial services industry, revenue cycle vendor and consultants, and healthcare associations. This group of over 60 members is the HIMSS Revenue Cycle Improvement Task Force (RCITF or Task Force).

This paper provides an overview of the work that has been done by the RCITF to date, including its vision of the consumer financial experience of the future and the impact of that vision on providers, payers, and, most importantly, consumers. The paper also includes a link to the first of a series of infographics to be produced by the Task Force. Each infographic is intended to articulate the Task Force's vision of the patient financial experience of the future in a variety of healthcare settings. The first infographic was intentionally designed to be relatively simplistic; as the Task Force goes forward we expect future infographics to display a greater level of sophistication and detail. Each infographic will include a survey link that allows visitors to the infographic site to provide feedback to specific questions posed about the infographic. Readers of this paper are encouraged to visit the site and submit feedback. Information on how to access the infographic can be found at the end of this paper.

In addition to the work of the RCITF, we offer a brief overview of the RCM process as it exists today and the challenges it is facing from changing fiscal demands within the industry, aging technology, and, equally important, consumer expectations. Consumers are increasingly influenced by their experience with other industries such as retail, technology or mobile computing, and we are seeing this influence played out in their frustrations with current revenue cycle processes.

Background

The need to reengineer revenue cycle management (RCM) has dramatically accelerated with the shift toward consumerism in healthcare. The advent of consumerism, the movement towards providing for the interests of consumers as they take on more responsibility for the payment of healthcare services, began in 2003 with the birth of Health Savings Accounts (HSA). The purpose of an HSA is two-fold: 1) allow individuals to pay their portion of healthcare

expenses using pre-tax dollars; and 2) provide individuals a way to accumulate pre-tax dollars that can be used at a later date to cover the individual's out-of-pocket expenses for a catastrophic health event, lessening the financial impact of that event. HSAs coupled with high-deductible health insurance plans created what is referred to in the industry as consumer-directed healthcare (CDH).

In a CDH environment, consumers typically shoulder more of the out of pocket costs associated with their healthcare, especially for routine medical encounters. After adjudication by the consumer's health insurance plan, a portion of the financial responsibility is passed on to the consumer through copays, deductibles or co-insurance. Payment for these items may be made using an individual's HSA (or other tax advantaged account such as a Flexible Spending Account (FSA)). With the implementation of the Patient Protection and Affordable Care Act (ACA)[1] in 2010, the trend towards CDH has grown exponentially. The increase in the number of individuals covered under CDH plans has led to an increase in the percentage of provider revenue attributed to patient payments. Historically providers have experienced a high level of bad debt associated with patient payments. As more and more of the provider revenue is the result of patient payments, it becomes imperative that providers find a way to encourage patients to pay early and that they reduce the amount of bad debt associated with this revenue stream. This requires massive changes in the way providers approach patient payments. We are now at the point where tune-ups and incremental bolt-on solutions are no longer sufficient. RCM systems, processes and, in some cases, staffing models must all be reinvented if they are to remain competitive in this increasingly consumer-driven world.

The RCM space requires a revolutionary step forward and industry-wide collaboration to create a model offering the necessary capabilities and operational efficiencies to put the consumer and quality care at the center of the RCM process. Providers are no longer able to rely on existing RCM processes and technologies to meaningfully address this far-reaching shift towards a consumer-centric model. A fresh look at enabling both a positive consumer financial experience and a reliable provider revenue stream is required.

In response to the mounting pressure to find a solution to the RCM challenge, even while the industry is swimming in a sea of change (think transitioning from ICD-9 to ICD-10, implementing electronic health records (EHR), and meeting Meaningful Use requirements), in July 2015 HIMSS directed its Revenue Cycle Improvement Task Force to focus its energies on creating a vision for the next generation of revenue cycle management tools and processes that keep administrative cost containment, interoperability, and consumer engagement front and center. Since 2011 the Revenue Cycle Improvement Task Force has been on a quest to address the

[1] Patient Protection and Affordable Care Act, 42 U.S.C § 18001 (2010).

emerging dynamic of the patient experience as it relates to their financial satisfaction when they engage with the healthcare delivery system. The Task Force provides thought leadership intended to drive the development of the next generation of revenue cycle management tools and reflect the impact of this dynamic. Over the last four years they have published a number of papers related to the patient's financial experience in the healthcare delivery system. To better support the broader scope of their current activities, the Task Force expanded its membership to include payers, mobile technology, and retail clinics. At the same time, there was a conscious effort to increase the participation of provider, financial institutions, and revenue cycle vendors and consultants. The goal is to create the most comprehensive collection of stakeholders possible to ensure that the vision produced by the Task Force represents a win for all affected parties, especially the consumer.

RCM in a Consumer-Directed Healthcare Environment

Historically, healthcare providers (e.g., physicians, hospitals, labs, etc.) have designed their revenue cycle systems and processes around business-to-business (B2B) relationships to communicate with, and collect payments from, government and commercial healthcare insurance companies (Payers). Consumer payments have been a secondary, although important, consideration. This approach made sense when the consumer represented approximately 13%[2] of the $2.1 trillion in payments made to providers, as was the case as recently as 2013[3]. By focusing on business-to-business payments, the healthcare industry could achieve a greater efficiency and drive down its cost of collections. However, with the shift in the marketplace to consumer-directed healthcare (CDH) and the 2010 signing of the ACA, providers are now ill-equipped to efficiently handle the expected dramatic increase in consumer payments.

The size of the problem of collecting consumer payments for providers is large and growing larger. Out-of-pocket expenditures for insured consumers are expected to grow to $420 billion in 2015, up from $250 billion in 2007[4]. This is an increase of 68%. A large portion of this increase is associated with previously uninsured individuals who are now accessing coverage through health insurance marketplaces[5] (HIMs) mandated by the ACA. The table below shows the impact[6] of HIM-related plans on a patient's financial responsibility for their healthcare:

[2] National Health Expenditure Data; Centers for Medicare and Medicaid Services; Office of the Actuary
[3] National Health Expenditure Data; Centers for Medicare and Medicaid Services; Office of the Actuary
[4] National Health Expenditure Data; Centers for Medicare and Medicaid Services; Office of the Actuary
[5] A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket

Plan Type	Covered Medical Expenses Paid by Plan	Covered Medical Expenses Paid by Consumer	Maximum Out-of-Pocket Costs	% of Plans Purchased by Consumers[7]
Bronze	60%	40%	$6,600 Individual, $13,200 Family	20%
Silver	70%	30%	$6,600 Individual, $13,200 Family	64%
Gold	80%	20%	$6,600 Individual, $13,200 Family	9%
Platinum	90%	10%	$6,600 Individual, $13,200 Family	5%
Catastrophic	>60%	>40%	$6,600 Individual, $13,200 Family	2%

Add to this the approximately 41 million Americans that have no healthcare insurance[8].

The impact of CDH is not limited to providers; payers, too, are being affected. Currently, payers and providers manage their relationship through negotiated contracts for reimbursement. If providers are unable to find a way to improve their collection of consumer payments, the increase in consumer payments is expected to lead to an increase in bad-debt rates, putting increased financial pressure on providers. This could translate to a demand for higher reimbursement rates from payers. Payers may be able to offset this transfer by increasing policy premiums, but this is becoming increasingly difficult in an environment where payers' balance sheets are receiving greater regulatory scrutiny than ever before and the market is rebelling against continually rising premiums. An even greater issue between payers and providers affecting revenue are changing reimbursement models, which create financial uncertainty for providers and make it even more important that they collect what they are due from consumers. It will be important for payers to participate in the process of designing new and better ways for providers to collect payments more efficiently from consumers.

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costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

[6] Out-of-pocket costs in the Health Insurance Marketplace (Healthcare.gov) https://www.healthcare.gov/choose-a-plan/out-of-pocket-costs/

[7] Addendum to Health Insurance Marketplace Summary Enrollment Report, October 1, 2013 – March 31, 2014, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (HHS); May 1, 2014.

[8] National Health Interview Survey from the Centers for Disease Control and Prevention and National Center for Health Statistics: September 2014.

Even with recent advances in standardization and automation, healthcare payment processing remains highly inefficient thanks to industry fragmentation, complex payment terms, and extensive manual processing. As a result, about $315 billion a year, 15 cents of every dollar spent on healthcare, is lost on claims processing, payments, billing, revenue cycle management, and bad debt. Add to that the complexities of effectively engaging with consumers and it becomes clear that the time has come to for all stakeholders in the healthcare industry to come together to design an efficient consumer-centric revenue cycle model that will bring healthcare squarely into the 21st Century. It was with this mission in mind that HIMSS re-focused the efforts of its RCITF.

The Revenue Cycle Improvement Task Force

The HIMSS RCITF brings together a cross-section of industry thought leaders from all major stakeholder groups, including healthcare providers, health plans, retail clinics, mobile providers, revenue cycle technology vendors and consultants, and other healthcare associations to create a vision for the next generation of revenue cycle management business processes and tools. The RCITF members have approached the design of the revenue cycle management business processes not only through their own individual expertise, but more importantly as consumers of healthcare themselves.

Consumers have newfound expectations of their healthcare experience, heavily influenced by their interactions with other industries where automation and an emphasis on customer satisfaction are the norm. These higher expectations are further fueled by the increase in patient financial responsibility; the greater the amount of money an individual is going to spend out of their own pocket, the more information they expect to have available to them beforehand and the more options they expect to have to facilitate payment.

The combination of this age of consumerism in healthcare with the other legislative and industry forces in motion, such as the ACA, American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health Act (HITECH), and the evolution of new system capabilities mainly in the area of EHR systems is powerful and will require organizations to reconsider their revenue cycle strategies, systems, people, and processes to truly adapt. The RCITF recognizes that these forces require a revolutionary leap forward with respect to successful revenue cycle management. They have applied this philosophy to the design of their recommendations.

The Process

The RCITF has held several meetings since September 2014 to create a high-level design for an optimized approach for RCM and consumer engagement. These meetings produced several

deliverables that were synthesized into a comprehensive and cohesive solution, articulated in an infographic that can be found on the HIMSS web site. To simplify its approach, the RCITF focused their first efforts on designing the process around a non-emergent visit to a consumer's primary care physician. From this starting point, more complex consumer healthcare scenarios will be worked through and developed, though many of the core components will be able to be leveraged regardless of the level of complexity of the use case being considered.

The Vision

Keeping in mind the initial scenario of a consumer's non-emergent visit to their primary care physician, the RCITF identified five key milestones for the future-state of the process: Research, Appointment Scheduling, and Registration; Check-in; Clinical Encounter; Check-out/Payment Resolution; and Patient Relationship Management. Key stakeholders were also identified by the RCITF: Patients and/or Patient Advocates; Providers; Health Plans; and Financial Institutions. Lastly, to tie the milestones and stakeholders together, a technology was envisioned called the Health Data Intelligence Hub. The vision itself was given the title of "Patient Financial Experience of the Future."

Under the RCITF's vision for the Patient Financial of the Future, revenue cycle management is moved from a back-end function to a front-end function. All of the processes supporting a patient's decision to seek care are automated and centralized. The patient is able to determine their health plan benefits; research available providers within their health plan network; identify the cost of the services they are seeking; see the provider's quality and patient satisfaction ratings; choose a provider and schedule an appointment; and make payment arrangements prior to visiting the provider's office – all while signed into a single portal that has been accessed through the use of a standardized digital identity/authentication process.

The theme of automation continues for the provider. The provider office receives an electronic notification of the patient's upcoming appointment, the reason for the appointment, verification of benefits, and explanation of payment arrangements. The provider's office is then able to request the patient's external medical records through the same "hub" that facilitated the patient's interaction described in the above paragraph.

The Health Data Intelligence Hub (or Hub) is envisioned as an information highway over which disparate organizations may securely share authorized personal, financial, and healthcare information for the same individual to facilitate a seamless financial experience for the patient encountering the healthcare delivery system. It is not a storage facility or warehouse of information; its only job is to securely transmit information in real-time from Point A to Point B without interruption.

Within 24 hours of the patient's appointment he or she will receive an electronic reminder through a means they chose when they initially made the appointment. When the patient arrives for their appointment they sign in electronically using the same standardized digital identity/authentication process used to log into the Hub. The provider's staff receives an electronic notification that the patient has arrived, and completes any additional preparation with the patient to ensure they are ready for their clinical encounter.

Following the practitioner's clinical evaluation of the patient, the provider and the patient engage in a conversation about the patient's options for treatment and/or follow-up care. This conversation includes consideration of both the clinical aspects of the available options and the patient's individual circumstances, such as financial resources, lifestyle and support structure. During this conversation the provider is able to access and share with the patient in real-time how their benefits would be applied to the various treatment options; which providers are available to deliver the recommended care, where those providers are located, what their quality and patient satisfaction ratings are, and what they charge for the recommended services; and similar information about ancillary services, such as durable medical equipment (DME) or prescription medications. Through the sharing of this information and consideration of all relevant information the patient and provider decide together what the best next steps are for the patient.

After the patient and provider have agreed on next steps, the patient transitions to check-out. During the check-out process, members of the provider's office confirm that the conversation between the patient and provider and all decisions made are properly recorded in the patient's electronic health record (EHR). Using the Hub, follow up appointments are scheduled, DMEs and medications are ordered as appropriate. The patient may choose to make payment arrangements for these services now or request that they be contacted at a later date to make arrangements.

As the patient leaves the physician's office they receive an electronic survey regarding their experience with this particular encounter. The survey includes questions about the ease of using the Hub, their financial experience, and satisfaction with their clinician and his or her staff. The survey is transmitted to and from the patient using the Hub; however it is administered and managed by an independent third party. Scores that fall below an industry-established threshold are immediately shared with the affected stakeholder so that they may immediately consider and apply the feedback to improve interactions with their patients and customers. Survey results are applied to affected stakeholders and results are shared with those stakeholders at established intervals. Stakeholders then use this information to adjust their business processes and policies accordingly to ensure that they are able to be as effective

and efficient in their efforts while at the same time ensuring the highest level of satisfaction for the patients, both clinically and administratively.

Key Take-Aways

- RCITF work to date has focused on the *what*, not the how. In FY16 they will begin to address the how.
- There is complete agreement among RCITF members that the RCM of the future must be consumer-centric. This requires the industry to move away from a siloed approach to RCM to a more collaborative and integrated approach between business partners; although each stakeholder has responsibility for a different piece of the process we have one thing in common – we are all trying to serve the same patient/consumer.
- The RCITF vision for the future requires the establishment of a central healthcare data hub to facilitate a consumer-friendly experience. The RCITF does not underestimate the challenges presented by this requirement. They are actively engaging all stakeholders and monitoring state and federal conversations regarding privacy and security, data sharing and identity management to ensure that necessary connections and that national standards and regulatory actions support this shared vision.
- The RCITF vision for the future could create the opportunity for new players to enter the market (e.g. the Hub; a centralized survey organization; an entity or group of entities responsible for applying and tracking national quality metrics; third part entities who assume financial risk and remove providers from patient financial transactions altogether).
- The RCITF vision for the future could lead to a change in roles and responsibilities for traditional players.
- This is not going to be a quick fix; there are layers of legacy work flows, technology systems and regulatory requirements that will need to be considered and addressed as we move forward.
- This is not impossible; difficult, yes, but not impossible. It will take a village of determined, possibility-thinking individuals who are not afraid to tackle the challenges of doing the right things for the right reasons.

The Road Forward

In FY16 the RCITF will focus on the following:

- Consider high-level assumptions represented in Infographic
    I. There will be wide-spread fully-functioning Health Information Exchange (HIE)
    II. There will be wide-spread adoption of a consistent approach to patient matching
    III. There will be healthcare cost transparency

IV. There will be uniform quality of care metrics
V. There will be one central "source of truth" for distribution of patient satisfaction surveys and a standardized process for sharing results with affected parties
VI. Technology will fully support sharing of information between providers, payers and financial institutions
VII. Reimbursement methodologies will not complicate the patient financial experience

- Prioritize the importance of these assumptions to the success of realizing the vision articulated in the Infographic
- Identify those items from the above list that are already being addressed by other bodies and pursue opportunities for collaboration
- Develop recommended approach for moving forward on those priorities not already addressed by another group
- Create a second infographic that represents a more complex patient encounter (e.g. inpatient procedure; outpatient procedure involving multiple providers; etc.

Add Your Voice to the Conversation

We invite you to join the conversation. Visit the HIMSS Patient Financial Experience of the Future infographic. After reviewing the infographic, click on the "Join the conversation" button at the top of the page. Complete and submit your response to the survey questions listed there.

You can also track the progress of the HIMSS RCITF by visiting the HIMSS website and follow us on Twitter at #RethinkRCM

Conclusion

The work of the RCITF represented here is the first step towards the creation of an optimized revenue cycle model that keeps administrative cost containment, interoperability and consumer engagement front and center. This work will continue to be refined and expanded upon, drawing from experts inside and outside the healthcare industry. The results of this massive undertaking will be a revenue cycle management process that considers the needs of all affected parties, maximizes technology and supports full patient engagement in managing the financial aspects of their healthcare.

> ***The ones who are crazy enough to think they can change the world are the ones that do.***
>
> *Anonymous*

HIMSS wishes to thank the following authors and contributors to this white paper

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