# How is the Revenue Cycle in Healthcare Changing?

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As revenue cycle management (RCM) in healthcare has morphed over the last several years, RCM systems have focused on optimizing federal, state and commercial claim processing. In particular, the onset of consumerism in healthcare has required the industry to be more "patient centric" and has forced industry leaders to revisit the patient financial experience. In theory, the development of the patient experience is modeled from a clinical perspective. In the last few years, providers have recognized that it extends far beyond patient care into the challenging world of finance. I am a firm believer that an institution offering the best clinical care can botch total patient satisfaction with a negative financial billing experience.


This article reviews the patient care journey, from pre-care through treatment, including coordination of care, financial challenges and, ultimately, patient satisfaction. The healthcare industry historically looked at this process—from scheduling to final resolution of the patient's bill—as very linear. Those days ended with the advent of consumerism, new tools, and the patients' increasing desire for a customized process. The old-school way of designing processes in a vacuum and believing that we, as healthcare leaders, know what is best for the patient is gone. The decision-making process directly parallels patient satisfaction. The challenge now is that while the patient would prefer a simplified administrative process, providing the flexibility that helps in decision making is not always congruent with their understanding and expectations. This article is designed to help readers think outside of the traditional healthcare process and see it from the patient's perspective.

Within the past few years, have you gotten the sense that someone said, "Self pay is going away?" Growing consumer financial responsibility has led to the expected billing and collections challenges that were weak points of most legacy RCM systems

and processes. However, what providers didn't consider was how much more information a patient with greater financial responsibility would come to expect.

Traditional models for accessing and sharing health insurance and financial and clinical information, and the siloed systems that support these models, are insufficient for providing the price transparency and real-time information patients now demand. As patients assume larger amounts of direct financial responsibility for their healthcare, they begin to view the process as more of a retail experience. As such, they may expect a typical Visa, American Express, MasterCard and/or banking transaction to work for their healthcare experience. More patients are also researching their options before deciding where to go for care. They expect to be able to use their day-to-day tools—computer, phone, etc.—to determine the level of care available to them through their health plan's provider network, or to quickly access pricing and patient satisfaction information. They want the ability to compare providers in the same way they might compare products when shopping online. In addition, they expect their financial responsibilities to appear in one single bill or statement, just as they receive one consolidated bill for buying a home or a vehicle—even though multiple parties may have participated in producing the final product.

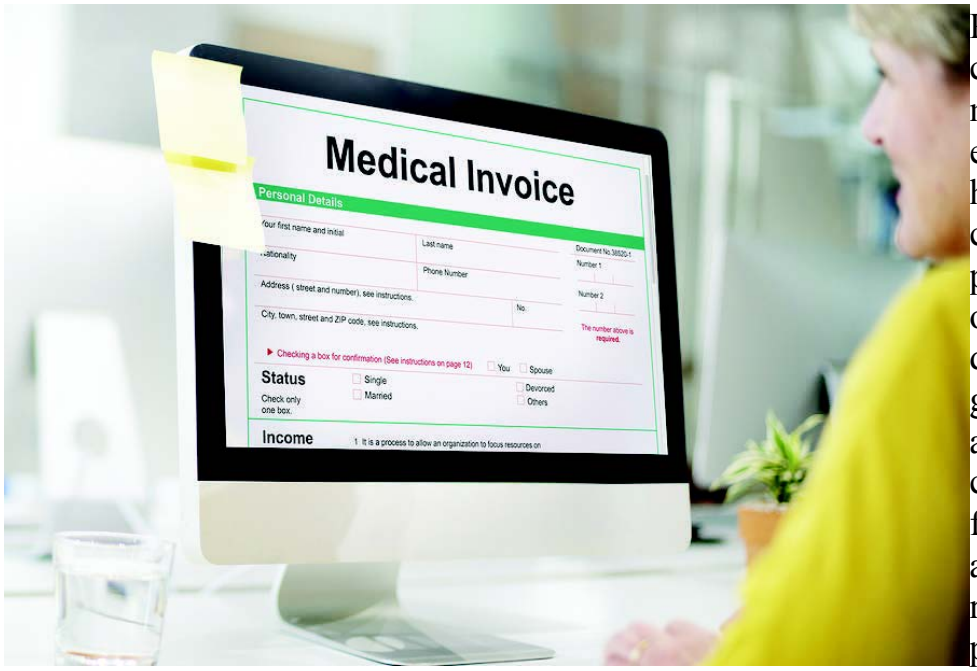
Healthcare leaders have acknowledged the need for health plans and providers to share clinical and financial data with patients in a more coordinated fashion, to both promote consumerism and enhance the patient experience. Hence, we find ourselves in the new healthcare millennium that recognizes the link between clinical and financial systems to improve RCM and the patient financial experience.

Numerous examples of providers working to improve the patient financial experience are emerging across the industry. Up to this point, however, the healthcare sector has only dabbled in each segment of coordination and communication. We are guilty of

picking and choosing our battles rather than accepting that the process will force us to take a more holistic approach. New reimbursement models are here to stay. How they are affected by the shift from the traditional model to payment reform is yet to be determined. We as healthcare leaders cannot have blinders on—those of us who lived through capitation, ACOs, big data/fast data, and Obamacare realize that the only constant about healthcare is change. With that said, many of us have made a career out of that, and in some sick way enjoy it.

We are taking on the new world with payment reform in small doses. Unfortunately, it does not keep up with the competition in healthcare, mergers, technology, or, most importantly, the patient experience. Let's face it . . . changing the model to require clinical and financial alliance from fee-for-service to value-based and population health requires dramatic change and outside-the-box thinking. The government, up until now, has mostly driven around programs like Recovery Audit Contractor (RAC), 501(r), Population Health, Electronic Health Record (EHR), Readmission Penalty, Hospital-Acquired Condition, etc. Pick your poison, but it has been the driving force and the new political leadership will continue to shift the changes.

In January 2015, U.S. Department of Health and Human Services (HHS) Secretary Sylvia Burwell announced that by the end of 2016, thirty percent of all Medicare payments made to hospitals and physicians will be based on pay-for-value models, and this figure would rise to fifty percent by the end of 2018. She also said that the remaining fee-for-service payment arrangements would be adjusted so that eighty-five percent of Medicare hospital payments would be tied to quality or value by the end of 2016, with an increase to ninety percent by the end of 2018. But the industry is still operating in a fee-for-service model! In addition, "patient consumerism" is an initiative involving requirements and capabilities not previously expected in healthcare, or that have not matured to the level consumers experience in other service industries.




Patient consumerism is a movement that encourages healthcare consumers to participate in their own medical decisions and take greater control of administrative, clinical and financial arrangements. It requires that patients know more about the healthcare issues they may be facing and the options available to them, and it is forcing providers to create something new in the healthcare sector. With increased patient financial accountability has come increased patient expectations for retail-like service levels and better value for their healthcare investment. Many payers and providers are also making patient satisfaction a priority in the overall healthcare experience.

Service price transparency continues to be a key requirement for patients who simply want to understand what they are being asked to pay for, how much they are being asked to pay, and how the price they are being charged by one provider compares to the price another provider charges for what appears to be the same service. Patients tend to choose their provider based on their specific health plan. If the American Healthcare Act, as it was presented to Congress, should ever pass it would revert to the old model [pre ACA], and the benefit design will become more complex for providers. A technical connectivity solution with the ability to determine and match the details of the health plan—provider network, healthcare benefits, copay and deductible—with the patient's immediate healthcare needs and geographic location will simplify this task.

In the patient financial experience of the future, a patient will choose a provider, make an appointment and complete a registration form online. We will have a single-point solution in which the patient's medical information—including complete medical history, list of current medications and treating or prescribing provider—feeds into the provider's portal and auto-populates appropriate fields. The only information the

patient will need to input will be relevant to their current medical need. The industry has pieces and parts in place, but it is not there yet!

As a part of scheduling and registration, the patient will be able to give appropriate parties permission to retrieve and review their medical records. However, this cannot happen until we adopt national standards and uniform operating rules for patient matching and data transfer. In the patient financial experience of the future, patients will also be able to submit payment or make payment arrangements before or at the point of care. This will require a tool that estimates and communicates patient financial responsibility (or liability), including payment options and financial counseling resources, in real time. Leading practices will include online payment, setting up payment or loan plans and meeting the IRS 501(r) requirement.

In situations where the patient is required to complete pre-visit activities, such as fasting or lab work, they will be able to choose how to receive related information—for example, via text message, through email, etc. Such information will include the patient's financial responsibility, if any, for these services, as well as an appointment reminder for the visit.

Appointment technologies such as email and text platforms are now common, and widespread adoption of these tools will help provide patients a consistent healthcare experience, regardless of where they live, what provider they are seeing, what insurance coverage they have and what their financial responsibility would be.

As with the online registration processes, this solution will require national standards and uniform operating rules to ensure that the right information syncs with the right individual. Electronic awareness and connectivity through mobile phones and related technology is something we can increasingly leverage. And let's not forget the appointment arrival process, which more and more patients would like to complete through a kiosk.

After the patient checks in and vital signs are taken, the medical history/reason for the visit is reviewed. The vital sign capture could be expedited through wearable technologies programmed to transmit the wearer's stats to a treating physician in real-time. While some such technological solutions exist today, we still lack the ability to access and share patient medical history between multiple providers and multiple health systems.

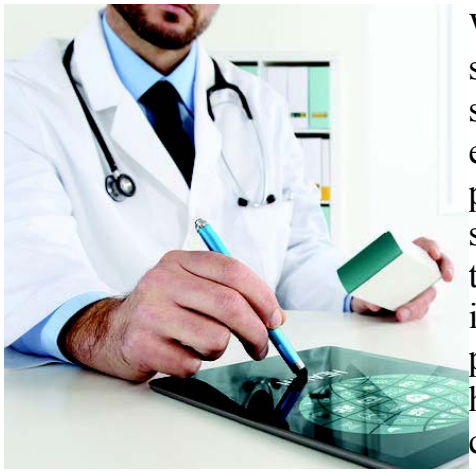
In the patient financial experience of the future, the provider's office will have real-time access to the patient's benefit information, including copays or deductibles, provider network and pricing information. They will be able to share that information in a way that allows the patient to make the most informed decisions possible by comparing both the efficacy and cost of treatment options. The provider will also be able to provide information about payment options for the patient's financial responsibility and be able to facilitate payment arrangements at the point of care.

The challenges in realizing this vision for the future are more than technical, but healthcare systems are not currently structured to utilize a universal communication process that supports patient consumerism. How many times have you experienced or heard of receiving separate bills from the emergency department, lab, radiology and community provider? The list goes on . . . and let me add that, even if they all could talk technically, they all have different cultures, policies and procedures and DO NOT march to the same music. Many providers are not accustomed to including financial considerations when discussing treatment options with their patients. Some are concerned that doing so may discourage the patient from choosing the best possible treatment from a purely clinical perspective. For the patient, however, choosing the best course of treatment may include considering their financial situation and the amount of social support available.

When patients and clinical staff agree on a care plan, the framework of that decision will be captured electronically and shared with the patient and any care providers involved. Although many providers can facilitate such communications with their patients, fewer are able to include other providers, particularly those not directly affiliated with the primary physician's medical organization.

In situations where the initial office visit is also the last visit, providers will be able to give patients a final bill, including an accurate statement of the patient's financial responsibility, before the patient leaves the office. They will also be able to process whatever form of payment the patient chooses to satisfy their portion of the bill at that time. In order for this vision to be realized, insurers must find a way to determine and communicate patient financial responsibility in real time. This could happen in a number of ways: through newly designed benefit structures that support alternative payment models which make it easier to predict patient financial responsibility; through revised business processes related to claims adjudication; or by developing technical solutions that provide real-time claims information among all affected parties.

For situations requiring follow-up care or a referral to another provider, appointments can be made before the patient leaves the referring physician's office and all applicable patient information will be automatically shared between providers.



While the major EHRs assist with this functionality to some extent, we still lack a universally adopted scheduling tool and widespread information exchange, especially between non-affiliated providers. When a patient arrives at an ancillary service or other healthcare provider's office for treatment or services, all pertinent personal and health information will be available to that provider—the patient will not have to repeat their full medical history. Sharing this type of information among all care providers, including those not associated with the same medical facility or healthcare system, will require the establishment of national standards, uniform operating rules for sharing personal healthcare information, and widespread adoption of electronic health information exchange capabilities. Many of the activities and gaps identified in the treatment category of activities, such as decisionmaking tools and payment options, apply to coordination of care as well. A major difference, however, will be the consolidation of financial information.

In today's world, someone receiving treatment for a single episode of care involving multiple providers in various healthcare settings can expect to receive multiple bills and explanations of benefits. This creates a great deal of confusion and frustration for the patient, who simply wants to know—bottom line— who they owe, how much they owe and what their payment options are.

In the patient financial experience of the future, financial and clinical information will follow the patient throughout their episode of care and include realtime updates as they occur. When the patient completes their final office visit and is released from care, they will receive one final consolidated bill that includes charges from all providers involved and clearly states the patient's financial responsibility.

Having received an estimate of financial responsibility at the time treatment was chosen, the patient will have the opportunity to settle their portion of the bill at the time of care or automatically execute the payment arrangements made earlier in the process. In the patient financial experience of the future, the healthcare delivery system understands how important complete patient satisfaction is. Before a patient departs a provider's office, they will receive a customer satisfaction survey covering all elements of the care experience, from ease of finding a provider, to the simplicity of the registration process, to the patient's interaction with their provider, to how well they understood and were able to address their financial responsibility for the care received.

Support the processes described in this roadmap for the future. The challenge going forward is to create the interoperability and connectivity coupled with security and access that results in a healthcare system that provides a seamless clinical/financial experience for patients. At the same time, keeping administrative cost containment and consumer engagement front and center, regardless of the reimbursement methodology that providers will be required to support along with the evolution of the healthcare processes.

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