



Maturity Model Measurement Tools for Consumerism in Healthcare

hfma[™]

healthcare financial management association

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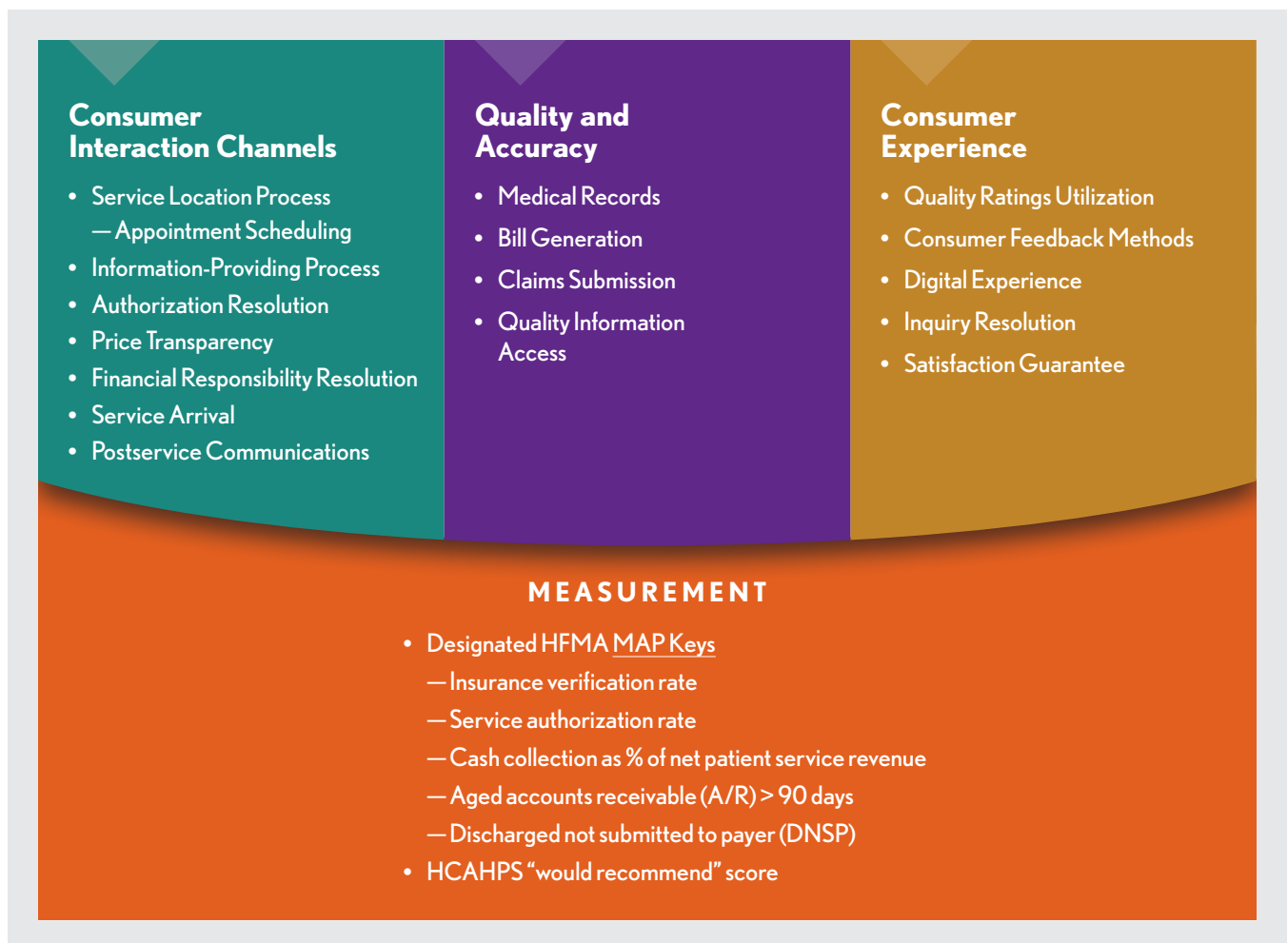
Executive Summary

Purpose of the Model

HFMA convened a task force of revenue cycle, finance and consumerism experts to help providers improve their patient financial experience and operationalize industry-consensus consumerism [best practices](#). The task force developed a detailed and comprehensive measurement structure, the Consumerism Maturity Model.

Components of the Model

The Consumerism Maturity Model has four components: Consumer Interaction Channels, Quality and Accuracy, Experience, and Measurement. Within the first three components, the task force identified key dimensions of the patient financial experience, as shown below.



Using the Model as a Tool

By completing a self-assessment and supplying selected key performance indicators (KPIs), providers may generate their consumerism maturity level and Consumerism Maturity Index Score (CMIS) using an online worksheet and calculator. The components are meant to be aspirational, and the score is relative to the highest possible level of consumerism best practices. The score indicates the level where an organization falls on the Consumerism Maturity Model Rating Scale: Consumer Centric, Emerging, Initiating, or Undeveloped.

The Consumerism Maturity Model may also be used as a roadmap for improving the patient financial experience by identifying areas for improvement, developing a consumerism process improvement plan specific to those areas, and monitoring progress periodically by rechecking scores.

Introduction

Consumer choice is more important than ever in the healthcare marketplace.

To make informed choices, consumers need solid information. As consumers take a more active role in choosing among a growing array of health-related goods and services, the healthcare industry is called upon to offer reliable, accurate and timely information on quality, price, convenience and experience.

Organizations that are committed to consumerism seek to improve all dimensions of value for consumers. Provider organizations that wish to improve their patient financial experience may draw on HFMA's industry-consensus consumerism best practices. Yet options for assessing progress toward developing a consumer-centric financial experience are limited or nonexistent.

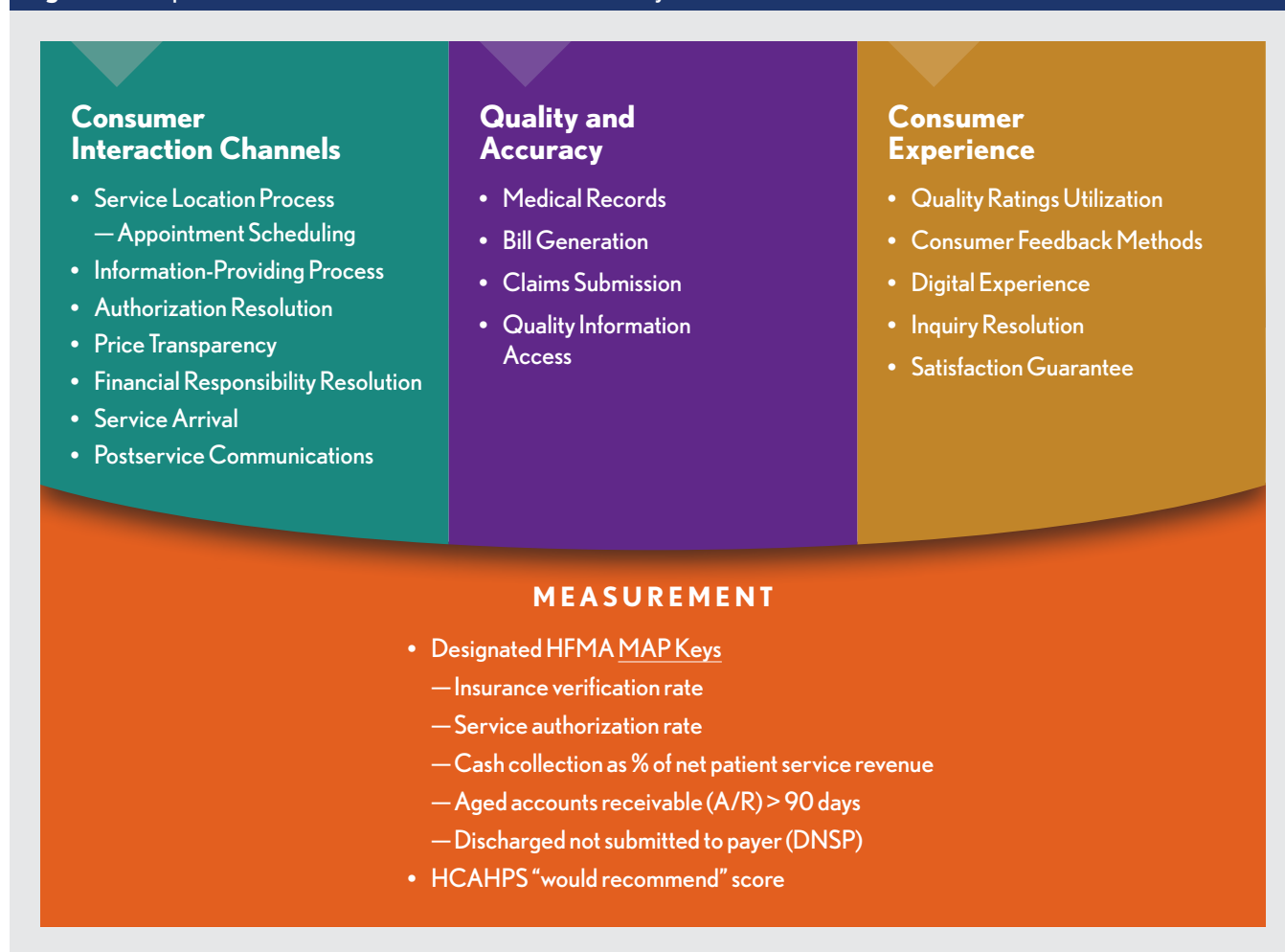
To that end, HFMA convened a task force of revenue cycle, finance and consumerism experts to review the current state of consumerism in healthcare and to develop and recommend a measurement structure that providers may use to demonstrate their progress toward achieving a more consumer-centric revenue cycle operation – in other words, to assess their consumerism maturity level and improve their patient financial experience.

The Consumerism Maturity Model

The Consumerism Maturity Model™ is a tool that providers of all types may use to determine the current maturity of their consumerism activities and identify areas for improvement. It is reality-based, especially from a technology perspective, and it is predicated on what is needed to support the consumer-focused revenue cycle of the future. The model explores the world of healthcare from the consumer's viewpoint and the activities commonly encountered by a consumer when seeking and receiving healthcare services.

The Consumerism Maturity Model has four components: [Consumer Interaction Channels](#), [Quality and Accuracy](#), [Consumer Experience](#), and [Measurement](#), as shown in Figure 1.

Figure 1. Components and Dimensions of Consumerism Maturity Model



Within three components, the task force identified key dimensions of the patient financial experience. For each dimension, the task force also identified scoring criteria on a scale of 1 to 5, with 1 representing the lowest score and 5 representing the highest. Scoring criteria are detailed in subsequent sections of this report.

The results of a provider's self-assessment are used to create a Consumerism Maturity Index Score™ (CMIS), which is a composite score relative to the highest possible level of consumerism best practices.

Validation

The model was drafted by knowledgeable revenue cycle professionals and others representing business partners and consumer groups. Feedback has been used to incorporate improvements in the value of the CMIS score.

Linkages between Consumerism Maturity Model and HFMA's MAP Keys

The original concept proposed to the task force was the development of a series of measurements derived from clinical and financial data, which would demonstrate a provider's performance in healthcare-related areas of consumerism. However, after reviewing the current consumerism literature, the task force landed on the concept of a maturity model, where the highest level of maturity represents the most advanced and highest level of performance needed to support a consumer-focused approach to revenue cycle operations.

This five-level maturity model is a compilation of dimensions that encompass most consumer interactions with healthcare providers. To use the model, the provider does a self-assessment. The results of this self-assessment are then used to calculate a CMIS, a composite score relative to the highest possible level of consumerism best practices and financial performance on selected key performance metrics (KPIs). This correlation index provides a relative score that providers may use to measure their progress in pursuing consumer-focused activities over time. Organizations pursuing an effective consumerism strategy should see an increase in the various maturity levels, and improvement in revenue cycle results, resulting in an improved CMIS.

The CMIS is linked to HFMA's MAP Keys, an industry standard approach to revenue cycle benchmarking. Table 1 shows the KPIs that HFMA has designated as a component of the CMIS, along with their relationship to the dimensions of consumerism that are assessed by the Consumerism Maturity Model.

Table 1. Key Performance Indicators (KPIs) Used to Calculate the Consumerism Maturity Index Score

MAP KEY	DIMENSION OF CONSUMERISM
Insurance verification rate	How effectively have you verified consumer coverage for services?
Service authorization rate	How effectively have you received authorization for consumer services?
Cash collection as % of net patient service revenue	How effectively have you communicated to and collected payment on behalf of consumers?
Aged accounts receivable (A/R) > 90 days*	How effectively have you resolved consumer accounts in a timely manner?
Discharged not submitted to payer (DNSP)*	How effectively has your information-gathering process worked on behalf of consumers?
HCAHPS "would recommend" score	How likely are consumers to recommend your organization or practice to others?

* Before entering the data for this metric, it must be normalized against results achieved by HFMA's MAP Award for High Performance in Revenue Cycle winners. See the online CMIS Worksheet for instructions.

How to use the Consumerism Maturity Model

Using the model as a consumerism self-assessment



The Consumerism Maturity Model

Discover your organization's consumerism maturity level and Consumerism Maturity Index Score (CMIS) by taking these four steps.

- 1. Score your organization's maturity level.** Review the information in this report about the three model components that are used in your organizational self-assessment. Each component has several elements. This report includes a table for each element, with criteria for scoring your organization's level of consumerism maturity for that element on a scale from 1 to 5. When you're ready, record your scores on the CMIS Worksheet.
- 2. Gather data on six organizational key performance indicators (KPIs).** Two KPIs will need some adjustment. The specifics are provided on the CMIS Worksheet. Record the data on the worksheet.

- 3. Transfer your self-assessment scores and KPIs from the CMIS worksheet to the online calculator.** The calculator will combine your self-assessment score with the KPIs and compute your organization's CMIS.
- 4. View your CMIS and consumerism maturity level.** Along with generating your CMIS, the calculator will indicate the level where your organization falls on the Consumerism Maturity Model Rating Scale: Consumer Centric, Emerging, Initiating or Undeveloped.

Using the model as a consumerism process improvement tool

After you receive your CMIS level and score, continue using the Consumerism Maturity Model as a roadmap for improving the patient financial experience. Here's how:

- 1. Identify areas for improvement based on your organizational self-assessment.**
 - Review the components of the report where your organization scored less than 5 in the self-assessment.
 - Prioritize your lowest score areas or areas that your organization has already identified as candidates for process improvement.
 - Refer to the relevant tables in the report that list the attributes for each scoring level.
 - In consultation with your colleagues, identify attributes associated with higher performance levels that are aspirational for your organization, considering community needs, organizational goals and applicable resource constraints.
- 2. Identify areas for improvement based on your KPIs.** Work with your organization's quality improvement team, quality committee and others engaged in improving HCAHPS scores. Also, review information about HFMA's [MAP Award winners](#), [best practices](#), and other tools. Take advantage of HFMA's consumerism-related [eLearning and certification programs](#). Plan to attend HFMA's [Revenue Cycle Conference](#).
- 3. Develop a consumerism process improvement plan.** Now that you have a roadmap for improvement, you are ready to develop a process improvement plan. Be sure to integrate your plan with your organizational budgeting process, strategic plan, and marketing plan, and seek consumer feedback on your proposed improvements. Most process improvement plans will incorporate HFMA's [consumerism-related best practices](#) as embodied in the Consumerism Maturity Model.
- 4. Check your progress.** After you have implemented your process improvement plan, take the self-assessment again and use the online calculator to generate your new score and level. Celebrate your accomplishments with your colleagues and share them with the HFMA [Community](#). Then, begin again. That's the essence of continuous process improvement.

Consumer Interaction Channels

The Consumer Interaction Channels component of the Consumerism Maturity Model includes scoring on the following dimensions of consumerism: Service Location Process, including Appointment Scheduling; Information-Providing Process; Authorization Resolution; Price Transparency; Financial Responsibility Resolution; Service Arrival; and Postservice Communications. Scoring criteria for each dimension are detailed in this section.

Consumer Interaction Channels

- Service Location Process
 - Appointment Scheduling
- Information-Providing Process
- Authorization Resolution
- Price Transparency
- Financial Responsibility Resolution
- Service Arrival
- Postservice Communications

Quality and Accuracy

- Medical Records
- Bill Generation
- Claims Submission
- Quality Information Access

Consumer Experience

- Quality Ratings Utilization
- Consumer Feedback Methods
- Digital Experience
- Inquiry Resolution
- Satisfaction Guarantee

MEASUREMENT

- Designated HFMA MAP Keys
 - Insurance verification rate
 - Service authorization rate
 - Cash collection as % of net patient service revenue
 - Aged Accounts Receivable (A/R) > 90 days
 - Discharged not submitted to payer (DNSP)
- HCAHPS “would recommend” score

Service location process: How consumers locate and receive services

Healthcare providers make information about their services available to consumers electronically. Consumers may also search for providers in their health plan’s network who are conveniently located and accepting new patients using their health plan’s website, or via a mobile app designed to provide additional information about providers and access to their services.

Additional information includes quality ratings, hospital privileges, hours of service, languages spoken and payment policies. Alternatively, consumers may find this information on the provider’s website via a secure access point. Uninsured consumers may use provider websites and web-based tools to locate providers and receive price estimates for services.

The maturity scale scoring criteria for the Service Location dimension of Consumer Interaction Channels is shown in Table 2.

Table 2. Maturity Scale for Service Location Process

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> The health plan’s provider information is available in printed form and updated at least annually. More current information may be available on the plan’s website. The provider only posts the mandatory charge posting as required by CMS.
2	<ul style="list-style-type: none"> The health plan provides online access to its provider enrollment information, office locations and hours, as well as quality ratings for providers (i.e., physicians and hospitals). Network participation is not made available by the provider; consumers are referred to health plans for all eligibility and benefit information, pricing and network status information.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> Price information for the most common services from in-network providers may be available from the providers. Ability to accept new patients is identified.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> Providers may provide links from their websites to health plan websites.
5	<p>Incorporates all applicable aspects of the lower levels plus:</p> <ul style="list-style-type: none"> Health plans and providers support visibility and access to online and mobile tools for: <ul style="list-style-type: none"> — Provider enrollment information — Office locations and hours — Quality ratings for providers (all types) — Price information for all services from in-network and out-of-network providers — Consumer’s current benefit status for deductibles and other out-of-pocket responsibility Physicians accepting new patients are identified. Links to individual provider websites are included for in-network providers. Other innovative ways or initiatives to improve the patient experience are sought.

Appointment scheduling: How consumers schedule services

Consumers may choose to schedule services by various methods, including telephone, online or mobile app. A search function allows consumers to directly access the provider’s online scheduling application. In some cases, the physician’s office may schedule services on the patient’s behalf. The ability to schedule and complete a registration form online or via mobile app streamlines the arrival process.

When the appointment is scheduled, relevant medical information is captured or transferred from an electronic health record (EHR) to provide the clinical record. The clinical information is reviewed via artificial intelligence application to proactively suggest scheduling needed services, such as screening mammograms, routine diabetes rechecks, etc. Likewise, health plan and referral/authorization information are captured from the health plan and resolved electronically. The EHR is automatically monitored to identify and resolve no-show and cancellation situations.

The maturity scale scoring criteria for the Appointment Scheduling component of the Service Location Process is shown in Table 3.

Table 3. Maturity Scale for Appointment Scheduling

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Providers schedule services based on a consumer call or upon receipt of a request or order from the physician. • When ordering a service, the physician instructs the consumer to contact the provider or the provider contacts the consumer to schedule based on the physician’s order. • Orders may be received via fax, hardcopy or electronically, and incorporated into the electronic health record (EHR). • Schedules are updated and electronically distributed to the preservice team and service departments.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Scheduling is primarily initiated by physician offices. • Preregistration information is collected but not validated with consumers until they arrive for service. • If provided, insurance information is verified.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Consumers may call or use a patient portal to request services. • Confirmation of the scheduling request is usually available within 2 or more days of the request. • Required orders are distributed electronically within the health system or via fax to external provider organizations by the ordering physician. • Additional calls from providers to the consumer are needed to complete the preregistration and financial clearance processes.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • Confirmation of the scheduling request is available within 24 hours. • Basic registration information and insurance information is collected. • Insurance is verified and price information is provided upon request. • Account resolution is pursued for designated high-dollar cases.
5	<p>Incorporates all applicable aspects of the lower levels plus:</p> <ul style="list-style-type: none"> • Comprehensive electronic tools are provided for real-time scheduling access to provider services, including secure online, portal or mobile apps for use by providers and consumers. • The experience is customized with consumer preferences for functionality, providers, days, times and locations. • The clinical information is reviewed via artificial intelligence application to proactively suggest scheduling needed services, such as screening mammograms, routine diabetes rechecks, etc. • Chat applications are used to provide real-time assistance and resolution of inquiries. • Required orders are processed via the provider’s EHR. • Scheduling confirmations are automatically generated and distributed to providers and consumers. • All information needed for completing the access process is identified, collected and distributed electronically. • Appointment reminders are auto-generated and delivered according to consumer preferences. • Other innovative ways or initiatives to improve the patient experience are sought.

Information-providing process: How consumers provide comprehensive information prior to service

Consumers use electronic tools, including online access, a mobile app or a biometric interface to provide, confirm and update demographic information needed to complete an accurate patient match and establish an accurate record in the provider’s EHR. Applicable insurance information is confirmed with the consumer’s health plan. Providers record both insurance eligibility and the applicable benefits. The status of cost-sharing amounts as of the current date is provided by the health plan. Applicable benefits are confirmed, or the consumer is made aware of, and resolves, any issues related to the applicability of insurance benefits to the scheduled service.

If an individual is uninsured, appropriate financial counseling activities are initiated and completed prior to the completion of the information-gathering work. All consumers receive an electronic confirmation of their information and scheduled date and time of service. The maturity scale scoring criteria for the Information-Providing Process dimension of Consumer Interaction Channels is shown in Table 4.

Table 4. Maturity Scale for Information-Providing Process

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> The provider calls the consumer at least 2 days prior to the service date. <ul style="list-style-type: none"> Demographic information is collected or updated. Insurance information is requested and recorded in the preregistered account. Arrival and other instructions are provided based on the services scheduled.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> Price information is provided upon request. Uninsured individuals are flagged for financial counseling or rescheduled for a later date if a predetermined down payment cannot be made.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> Applying patient financial communications best practices, a price estimate is provided and resolved in advance of service. If account resolution cannot be completed, the account is flagged for financial counseling or rescheduled for a later date.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> The provider sends an electronic communication to the consumer at least 5 days in advance of the scheduled service. <ul style="list-style-type: none"> The communication allows consumers to access the provider portal, update insurance and demographic information, view their estimated out-of-pocket responsibility and make a payment. Individuals who do not log in to update their information are contacted by phone at least 2 days prior to the service date to update information. Payments may be made in advance via credit card, e-check, etc., or at time of service. If a payment cannot be made, the account is flagged for financial counseling or rescheduled for a later date.
5	<p>Incorporates all applicable aspects of the lower levels plus:</p> <ul style="list-style-type: none"> For known/returning individuals, a comprehensive patient-matching activity confirms their demographics using the most convenient electronic tools available, including online, mobile app or biometrics. It allows updates, as appropriate, to any demographic, insurance or other payer information. The health plan provides the status of the amounts owed as deductible, coinsurance or copayments, as of the current date. A price estimate is prepared and shared with the consumer, in accordance with patient financial communications best practices. Applicable benefits are confirmed, or the consumer is made aware of, and resolves any issues related to the applicability of the insurance benefits to the scheduled service.* For uninsured individuals, appropriate financial counseling activities are initiated and completed prior to the completion of the information-gathering work. Electronic confirmation of information and scheduled date and time of service is automatically provided. New patients are electronically guided through a series of streamlined questions designed to establish a master patient record and subsequently complete the balance of the preregistration activities outlined above. Chat options and a live transfer to a patient access representative is available as needed throughout this process. Other innovative ways or initiatives to improve the patient experience are sought.

* This activity occurs concurrently with, or immediately after the completion of, the scheduling activity and applies to all scheduled patients, regardless of the timing of the scheduling activity in relationship to the date and time of the service.

Authorization resolution: How the provider resolves needed authorizations for consumers

Consumers may or may not be enrolled in an insurance plan that requires preauthorization for testing, services and/or continued stay authorizations (for inpatient services). Consumers expect providers to identify these requirements and resolve them prior to, or at the time of, service, thus reducing service delays and potential payment denials. For inpatient stays, the provider’s care coordination team uses efficient and effective methods of communication to ensure that care is covered by the health plan, or, as appropriate, coordinate the movement of the individual into the medically necessary and appropriate service modality. At the most mature level, incentives are aligned for inpatient level of care and patient status through the use of mutually agreed upon third party resolution services.

The maturity scale scoring criteria for the Authorization Resolution dimension of Consumer Interaction Channels is shown in Table 5.

Table 5. Maturity Scale for Authorization Resolution

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Providers post charges on their website in machine-readable format for the 50 most common procedures. • For ambulatory services, the consumer is expected to identify and request resolution of any preauthorization requirements. • Case management staff identify and manage inpatient and observation requirements. • When a denial is received for lack of prior authorization, a retroactive authorization is requested by the provider.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • A list of the most common ambulatory services that require preauthorization is maintained and used to trigger preauthorization requests to the ordering physician’s office. • If a preauthorization is not completed by the date of service, the consumer is asked to sign an electronic advance beneficiary notice of noncoverage (ABN) and may be billed if the authorization issue is not resolved.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • For ambulatory services, after insurance is verified, a preauthorization is requested either by the physician or the hospital. • The preauthorization may be called, faxed or electronically sent to the payer’s authorization unit. • Routine follow-up to resolve the authorization may occur.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • Provider staff routinely and purposefully follow up to resolve the authorization, engaging the consumer and/or the physician as needed to resolve the issues prior to the date of service. • The consumer is routinely advised about outstanding issues and options.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Prior authorization requirements are electronically identified as a component of the automated insurance verification process and completed using the electronic prior authorization data set and the electronic health record (EHR) information provided by the ordering physician. • Incentives are aligned within the provider/health plan relationship. • Patient status decisions are determined by a third party and agreed upon by both health plan and provider. • There is clear and timely communication between the provider and the consumer to ensure that the consumer understands the process. If applicable, the consumer may be asked to assist with resolving health plan roadblocks. • Any failure to receive an authorization at least 2 days prior to the scheduled date of service is electronically referred back to the ordering physician for resolution; electronic ABN documents are completed, as appropriate. • Medical staff and provider rules apply to the rescheduling of elective cases failing to complete the authorization requirements. • Other innovative ways or initiatives to improve the patient experience are sought.

Price transparency: What consumers know about what they are expected to pay for services

The provider’s pricing strategy supports transparency and consumerism. As consumers are faced with increasing out-of-pocket financial responsibilities, they expect providers to provide reasonable estimates for services, even if the service is not currently scheduled. Providers apply the principles of HFMA’s [Patient Financial Communications Best Practices](#) throughout the access process. Providers use electronic tools designed to incorporate the total estimated price, which identifies what the health plan is expected to pay, and the balance expected from the consumer. This includes the application of contract or other reimbursement expectations and real-time status of the consumer’s benefits in order to achieve a reasonable estimate. Identification and consideration of in-network or out-of-network status is incorporated into the estimate. In accordance with HFMA’s [price transparency guidelines](#), the consumer should ultimately look to the health plan for plan-specific adjudication and patient responsibility information.

The maturity scale scoring criteria for the Price Transparency dimension of Consumer Interaction Channels is shown in Table 6.

Table 6. Maturity Scale for Price Transparency

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Providers post charges on their website in machine-readable format. • Consumers seeking specific price information are instructed to call for more information.
2	<ul style="list-style-type: none"> • Upon request, a charge estimate is provided for the 50 most common procedures. • Individual test charges are provided on the provider’s website. • Consumers are directed to contact their health plan for more specific information.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Specific price information, based on the provider’s average charges, the health plan and the individual’s benefits are provided upon request. • Copayment requirements are identified through the insurance verification process and requested at time of registration or service. • Deductibles and coinsurance status are provided, as available, from the health plan.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • HFMA’s consumer guide to understanding prices and consumer guide to avoiding surprise bills are readily available to consumers, in accordance with HFMA’s price transparency guidelines. • A dedicated price line is available to discuss procedure- or test-specific prices, based on the caller’s insurance information. The provider responds to all requests within 2 days of the request. • Patient financial communications best practices are used throughout the financial experience. • Price transparency guidelines are incorporated into the patient experience.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Consumers are able to obtain a current price estimate via a call, patient portal or mobile application. The technology has a one-touch link to all major health plans in the provider’s service area and uses the real-time status of the consumer’s benefits to develop a transparent price estimate. The price estimate indicates the average charges, total price and consumer’s responsibility for the requested service. • The health plan is viewed as the most accurate source of information regarding price. • Quality ratings based on the health plan’s specific quality rating system are also provided. • Estimates may be confirmed and guaranteed by the provider. • Other innovative ways or initiatives to improve the patient experience are sought.

Financial responsibility resolution: How consumers can understand and resolve financial responsibilities

Consumers may be insured, underinsured or uninsured. Providers must implement strategies designed to ensure that consumers have an understanding of their financial responsibilities prior to service or at the time of service in emergency situations. Application of HFMA’s [price transparency guidelines](#) and [patient financial communications best practices](#) as well as deployment of robust financial counseling, payment options and access to financial assistance are key components of these important strategies.

The maturity scale scoring criteria for the Financial Responsibility Resolution dimension of Consumer Interaction Channels is shown in Table 7.

Table 7. Maturity Scale for Financial Responsibility Resolution

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> Consumers are solely responsible for determining their own insured status and personal financial responsibility.
2	<ul style="list-style-type: none"> The financial counselor determines the consumer’s insured status through inquiry and insurance verification during preregistration for scheduled services or at initial registration for nonscheduled services (i.e., emergencies). No assistance is provided with financial responsibility or with a charity care application.
3	<ul style="list-style-type: none"> The financial counselor determines the consumer’s insured status through inquiry and insurance verification during preregistration for scheduled services or at initial registration for nonscheduled services (i.e., emergencies). For uninsured or underinsured consumers, the financial counselor assists the consumer or responsible party in completing a charity care application.
4	<ul style="list-style-type: none"> For insured individuals, the individual’s anticipated financial responsibility may be determined and communicated to them. For uninsured or underinsured individuals, the financial counselor assists them or the responsible party in completing a charity care application and may discuss payment plan options. Patient financial communications best practices are used throughout the financial experience. Price transparency guidelines are incorporated into the patient experience. In the event the patient has completed services and has a balance due, HFMA’s Best Practices for Resolution of Medical Accounts are followed.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> For uninsured or underinsured individuals, the financial counselor discusses payment plan options and offers comprehensive financial counseling services, as applicable. Online and mobile access for benefits and automated calculation of the individual’s out-of-pocket estimates are available via a self-service application or portal, or via telephone contact with the financial counselor. Payment plan options may be automated to enable consumers to self-select options and tools best suited to their needs. Technology such as Apple Pay or equivalent may be deployed by the provider. For individuals who need or want to consider applying for financial assistance, the mobile app or portal includes an automated financial assistance application. Other innovative ways or initiatives to improve the patient experience are sought.

Service arrival: What consumers should expect when they arrive for service

Consumers expect that arrival processing may be completed in advance, similar to the electronic key services provided through a mobile electronic check-in process at many hotels. Wayfinding tools are incorporated into this process, informing consumers where to park, which entrance to use and how far in advance to arrive. The mobile app also facilitates the electronic processing of any payment due at time of service. Providers are electronically notified of the patient’s arrival and thus able to promptly acknowledge their presence and initiate service. If there are delays, the consumer is notified via personal or electronic mechanisms, based on the individual’s identified preferences. These high-touch communications continue during the provision of service.

The maturity scale scoring criteria for the Service Arrival dimension of Consumer Interaction Channels is shown in Table 8.

Table 8. Maturity Scale for Service Arrival

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Consumers are given information over the phone (if they call and request) regarding what to bring and how to prepare. • A manual map or wayfinding page is mailed to the consumer. • No financial expectations or price estimates are provided unless specifically requested by the consumer.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Information is prepared and mailed to every patient based on the type of visit scheduled. Materials include facility map, parking information and preparation instructions. • Insurance eligibility is verified in advance and consumers are told of their expected out-of-pocket expense, but nothing is collected in advance and no financial counseling is available in advance of visit.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Consumers are provided an online website or portal where all information is available by visit type and location. Online site includes an electronic map of the facility. • Consumers are asked to preregister online and complete all paperwork, including electronic signature. • An out-of-pocket estimator is available, including links to the various health plan websites, so consumers can calculate their estimated cost.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • Consumers are provided with an online website or portal where all information about their visit is already populated. Location and driving directions are provided via a hyperlink that will be sent to their phone with one click. • Preparation instructions are available by procedure type and a calendar invite option is available to schedule any prep reminders (fasting, medications, etc.). • Price estimation is provided based on health plan and expected procedure code. • Patient financial communications best practices are used throughout the financial experience. • Price transparency guidelines are incorporated into the patient experience.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Consumers receive a text message or email upon scheduling with a link to a portal where all information about their visit is already populated. Location and driving directions are included and will automatically be replicated in a calendar appointment that will be sent to consumers via text. • Payment may be made in advance via a Google Pay-type feature. A payment plan may be set up and charged to a credit card automatically. • Consumers receive a “green card” electronic message that notifies them when all required forms are completed and payments are posted, advising them to proceed directly to the location of the procedure/visit upon arrival and bypass the registration desk. • Upon arrival, the consumer’s smartphone may sync up with the scheduling board, alerting the provider that they are ready. • A text directs the individual to the exam or treatment room to enter; biometrics may be used to confirm their identity. • Other innovative ways or initiatives to improve the patient experience are sought.

Postservice communications: How consumers receive postservice financial communications from providers

Consumers may choose the communications channels that best fit their individual and family needs and preferences. Providers who offer a wide range of options improve their opportunities to exceed the consumer’s expectations in the communication of financial matters on an ongoing basis.

The maturity scale scoring criteria for the Postservice Communications dimension of Consumer Interaction Channels is shown in Table 9.

Table 9. Maturity Scale for Postservice Communications

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Statements are mailed to the guarantor monthly; hospital and physician accounts are not combined. • Guarantor has the option to pay via check, credit card or by telephone during normal business hours.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Statements are mailed to the guarantor monthly and are available online through the patient portal. • Payments may be made online using a credit card or check.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Guarantor has access to statements online, via the patient portal or on the mobile app. Detailed charge and payment information may be provided. • Payments may be made online or on the mobile app using a credit card or check. • Guarantor may opt out of paper statements and establish payment plans within established guidelines. • For patients who have balances due postservice, HFMA’s Best Practices for Resolution of Medical Accounts are followed.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • Detailed charge and payment information is provided for all accounts, as well as real-time balances. • Hospital and physician accounts may be combined. • Proxy access is available for family members to access and manage a relative’s account.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • An automated “track my claims” function automatically notifies guarantor any time activity is posted to an account; the function also provides tracking functionality for one or more accounts at the same time. • Health plans, providers and consumers collaborate to ensure accurate and timely communication among all parties. • Payments may be made via monthly scheduled automatic payments (EFT), online or on the mobile app using a credit card or check. • Guarantor may opt out of paper statements and establish payment plans within established guidelines. • Artificial intelligence tools are used to personalize each consumer’s propensity to pay and collections practices are synchronized with the propensity-to-pay scores. • Secure text messaging is used post-visit to immediately confirm any unpaid copayment responsibility and to initiate a payment request. • Guarantor and patient demographic and insurance information may be updated through online access, patient portal or mobile app. • Patient financial communications best practices are used throughout the financial experience. • Price transparency guidelines are incorporated into the patient experience. • Other innovative ways or initiatives to improve the patient experience are sought.

Quality & Accuracy

The Quality and Accuracy component of the Consumerism Maturity Model includes scoring on the following dimensions of consumerism: Medical Records; Bill Generation; Claims Submission; and Quality Information Access. Scoring criteria for each dimension are detailed in this section.

Consumer Interaction Channels

- Service Location Process
 - Appointment Scheduling
- Information-Providing Process
- Authorization Resolution
- Price Transparency
- Financial Responsibility Resolution
- Service Arrival
- Postservice Communications

Quality and Accuracy

- Medical Records
- Bill Generation
- Claims Submission
- Quality Information Access

Consumer Experience

- Quality Ratings Utilization
- Consumer Feedback Methods
- Digital Experience
- Inquiry Resolution
- Satisfaction Guarantee

MEASUREMENT

- Designated HFMA MAP Keys
 - Insurance verification rate
 - Service authorization rate
 - Cash collection as % of net patient service revenue
 - Aged Accounts Receivable (A/R) > 90 days
 - Discharged not submitted to payer (DNSP)
- HCAHPS “would recommend” score

Medical records: How available, accurate and complete the consumer’s medical records are

Consumers may access medical records from any provider at any time using an online portal or via a mobile app. Medical information is not provider- or system-limited, allowing the consumer to electronically share medical information across disparate systems. Total interoperability of the medical records with high levels of security and robust patient-matching tools support this capability. This availability of information across all platforms is essential to the elimination of duplicate testing and for the prompt identification of all medications and allergies, thus supporting patient safety.

The maturity scale scoring criteria for the Medical Records dimension of Quality and Accuracy is shown in Table 10.

Table 10. Maturity Scale for Medical Records*

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> Records are not available to consumers via online portal or mobile applications. Consumers must request, and often pay for, copies of records. Hospital or physician visit discharge instructions are limited to follow-up orders given to consumers on paper along with prescription(s) ordered after an encounter.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> Provider portal allows consumer to confirm and order prescription refills. Encounter listing is available. Detailed records of visits or encounters, including medical examination notes, diagnosis codes, etc., are not available online.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> Provider portal allows consumers to send messages to providers, as follow-up to visits, and schedule primary care appointments. Limited records of office visit encounters and some test results are available to consumers online or via mobile app.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> Records of all ambulatory visits and procedures are available for this provider online. Records cannot be transmitted or sent to providers (hospitals or physicians) outside this provider’s electronic health record (EHR) network.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> Records from other providers are available to consumers via this portal or mobile options based on appropriate authentication; consumers communicate with providers from diverse health systems through one portal. Communication from consumers is held in a secure section of the EHR for appropriate follow-up from provider. Documentation of all prescriptions ordered and used is available to all clinicians involved in an individual’s care, including recognition of medication interactions or excessive dosing (e.g., opioids). Consumers may choose to refer copies of this medical history to another provider not previously consulted; this information is also retained for future reference. Information from all providers is retained and available via one portal for consumers. Consumer’s electronic record portal includes and provides reminders for diagnostic or required annual visits based on the individual’s condition, and sends reminders to them, noting their preference for follow-up location. Diagnostic results are retained and available for consumers in provider’s medical records, and patient portal or mobile device. Mobile app or web portal accepts data from other health tracking devices (Fitbit, Apple Health, etc.); stores these data points for future medical visits. Provider’s EHR includes healthy options and recommendations for individuals based on their profile for health improvement; tracks individual’s health outside of encounters with healthcare providers. Consumers may review medical records at any time and request clarifying data to improve their understanding of medical conditions. All visits are available on patient portal (inpatient, ambulatory, post-acute, etc.) for their review. Other innovative ways or initiatives to improve the patient experience are sought.

* In all cases, it is assumed that the provider (hospital or physician) operates and documents on an electronic health record platform.

Bill generation: How accurately and promptly the consumer’s bill is generated

Consumers have a right to expect that the services provided will be accurately billed in a timely manner. Providers ensure the accuracy and completeness of the bill via the deployment of robust revenue integrity tools. Departmental controls are electronically deployed to edit for missing or inaccurate charges, as well as charge delays.

The maturity scale scoring criteria for the Bill Generation dimension of Quality and Accuracy is shown in Table 11.

Table 11. Maturity Scale for Bill Generation

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> Everything is manual. Charges are captured on paper. Coding is completed by reviewing records and selecting the appropriate services for billing. Claims are generated with manual editing of the claim values prior to submission.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> Charges are primarily captured on paper, with some electronic charge feeds for limited services. Billing data is processed through a claims scrubber to detect inconsistencies and errors that would result in a denial. Errors are corrected and claims released.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> Charges are primarily captured electronically, with paper processes used for peripheral areas. Integrated or bolt-on coding tools are used to increase speed and accuracy of coding. Clinical documentation improvement (CDI) efforts are decentralized with limited documentation of policies, procedures and metrics.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> Charges are primarily captured electronically, including interfaces with peripheral systems. Integrated billing edits identify missing and incorrect data before claims generate. Errors are corrected in the revenue management system before claims are created. Final claims submitted through a claims scrubber are 99+% clean. CDI programs are standardized to enforce policies and procedures.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> Computer-assisted coding is used to optimize speed and accuracy of coding. Charge data reports and errors are electronically routed to responsible service lines for review and timely correction. CDI programs are standardized and routinely tested to confirm compliance and enforce policies and procedures. Metrics are established and measured regularly. Other innovative ways or initiatives to improve the patient experience are sought.

Claims submission: How providers ensure that the consumer’s claim is submitted to the right carrier and plan

Consumers have a right to expect that providers will correctly identify their insurance carrier and plan for all services provided. In some cases, this may involve responsibility for the correct sequencing of multiple plans for individual services. Providers ensure that any coverage and eligibility issues are fully resolved before any primary or secondary claims are electronically submitted to health plans.

The maturity scale scoring criteria for the Claims Submission dimension of Quality and Accuracy is shown in Table 12.

Table 12. Maturity Scale for Claims Submission

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Claims are manually reviewed for correct health plan identification. • Claims with missing or incorrect health plan information are sent to the patient for correction.
2	<ul style="list-style-type: none"> • Primary health plan identification is based on the results of any insurance verification work completed prior to, or at the time of, service. • Any edit failures for incomplete patient identification with the health plan require manual intervention. The result is that the claim is sent to the patient for additional information.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Any edit failures based on the health plan’s inability to identify the patient are automated, so the claim is immediately reclassified as a self-pay claim and sent to the patient for resolution. • Documentation is automatically included with the claim sent so the patient may identify how to resolve the claim with the health plan and the provider.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • All health plan identification edit failures are automated, including reverification routines triggered based on the use of artificial intelligence applications. • The results of the automated patient contact are recorded and used to trigger additional steps, as appropriate. These claims are held in a pending status and routinely routed to assigned staff on a preset timing sequence for additional interventions.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • As part of the prebilling routines, all claims are scrubbed to ensure accurate and complete identification and sequencing of health plans. • Reverification is automated and conducted based on the type of edit failures identified through the claim scrubbing processing. • Manual intervention is minimized through the automated claim flow and editing based on scrubber results. • Other innovative ways or initiatives to improve the patient experience are sought.

Quality information access: How consumers access comparative provider quality ratings

Consumers may access information about quality ratings from health plan and governmental sources. Insured individuals are encouraged to use their health plan’s website or mobile app to identify high-quality providers. Likewise, the “Compare” ratings from CMS for all types of healthcare providers are available from the CMS [home page](#) and may be used to compare a variety of quality ratings. Providers may also use independent survey organizations to routinely survey patients and potentially post those results to their websites as well.

The maturity scale scoring criteria for the Quality Information Access dimension of Quality and Accuracy is shown in Table 13.

Table 13. Maturity Scale for Quality Information Access

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> Quality data is not routinely provided on the provider’s website, patient portal or mobile app. Consumers are referred to the state hospital association website, and/or to CMS Compare websites for information.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> Consumers are referred to their health plan or the CMS website for quality information. The provider only lists high-level, summary information from the most recent annual survey or CMS report.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> The provider acknowledges the importance of the consumer’s ability to compare quality results for both the facility and individual provider services. Basic information such as CMS star ratings, readmission rates, hospital-acquired infection rates, etc., are routinely posted to the provider’s website and updated at least annually. Contact information is provided to allow the consumer to obtain additional information about the quality information posted.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> Provider-specific quality ratings from CMS and private ratings (e.g., Press Ganey, etc.) are available on the provider’s website, patient portal and mobile app. Searchable tools allow consumers to easily compare hospitals, physicians and services within a healthcare system and with other healthcare systems.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> Pricing information is provided from the provider’s price estimation tool once a service and/or provider are identified. The consumer’s insurance information and preferences are securely stored to streamline additional inquiries, either concurrently or at a later time. A link to the provider’s scheduling tools is also available as part of an automated scheduling tool. Patient financial communications best practices are used throughout the financial experience. Price transparency guidelines are incorporated into the patient experience. HFMA’s Best Practices for Resolution of Medical Accounts are incorporated into the patient experience. Other innovative ways or initiatives to improve the patient experience are sought.

Consumer Experience

The Consumer Experience component of the Consumerism Maturity Model includes scoring on the following dimensions of consumerism: Quality Ratings Utilization; Consumer Feedback Methods; Digital Experience; Inquiry Resolution; and Satisfaction Guarantee. Scoring criteria for each dimension are detailed in this section.

Consumer Interaction Channels

- Service Location Process
 - Appointment Scheduling
- Information-Providing Process
- Authorization Resolution
- Price Transparency
- Financial Responsibility Resolution
- Service Arrival
- Postservice Communications

Quality and Accuracy

- Medical Records
- Bill Generation
- Claims Submission
- Quality Information Access

Consumer Experience

- Quality Ratings Utilization
- Consumer Feedback Methods
- Digital Experience
- Inquiry Resolution
- Satisfaction Guarantee

MEASUREMENT

- Designated HFMA MAP Keys
 - Insurance verification rate
 - Service authorization rate
 - Cash collection as % of net patient service revenue
 - Aged Accounts Receivable (A/R) > 90 days
 - Discharged not submitted to payer (DNSP)
- HCAHPS “would recommend” score

Quality ratings utilization: How consumers use publicly available ratings of providers and patient experience

Consumers have access to a variety of ratings, including health plan ratings, government comparative scores, and specialty and general use mobile apps, such as Yelp or ZocDoc, to name a few examples. Internally generated provider ratings should also be provided to supplement the publicly available data. The goal is to provide the most comprehensive view possible of patients’ experiences with the identified healthcare providers. These ratings help consumers identify providers and allow trending of real patient ratings over time. Provider websites and social media home pages are other sources of patient experiences and ratings.

The maturity scale scoring criteria for the Quality Ratings Utilization dimension of Consumer Experience is shown in Table 14.

Table 14. Maturity Scale for Quality Ratings Utilization

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> The provider does not encourage or respond to the publicly available rating applications.
2	<ul style="list-style-type: none"> The provider monitors the publicly available rating applications and responds, as appropriate.
3	<p>Level 2 plus:</p> <ul style="list-style-type: none"> The provider identifies the most common public rating applications on their website, patient portal and mobile app. Consumers are encouraged to use these tools, although they are not linked to the provider’s systems or applications.
4	<p>Level 3 plus:</p> <ul style="list-style-type: none"> Usage is routinely monitored. Comments from consumers are monitored and shared internally.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> Direct links to the most common public rating and scheduling tools are provided on the provider’s website, patient portal and mobile app. Consumers are encouraged to use these tools, which include direct access to provider information, availability of services and scheduling tools. Comments from consumers are responded to as appropriate, preferably within 24 hours or less from the day of service. Other innovative ways or initiatives to improve the patient experience are sought.

Consumer feedback methods: How consumers provide feedback on their experience

Consumers may receive routine surveys, including customized, instant one- or two-question surveys, participate in structured focus group activities or serve on a patient advisory council. The provider’s commitment to improving the patient experience is evidenced by the variety of, and attention to, interactions with patients to learn more about their experiences with the provider organization. The deployment of mobile tools to obtain responses is an essential component of any experience rating strategy.

The maturity scale scoring criteria for the Consumer Feedback Methods dimension of Consumer Experience is shown in Table 15.

Table 15. Maturity Scale for Consumer Feedback Methods

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Survey activities are limited to infrequent postservice surveys administered by a third party or internal research operation. • Results are shared with department leadership. • Corrective action plans are developed and implemented as necessary.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Survey activities are administered following a routine and planned process by a third party or internal research operation to a random sample of consumers on a postservice basis. • Customized surveys are deployed to compile additional information on specific trends.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Survey activities are expanded beyond those administered by a third party or internal research operation to a random sample of consumers on a postservice basis to parallel the survey results produced by CMS through their survey activities.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • A variety of survey tools and approaches are used, including, but not limited to, one-question post-contact surveys (telephone, website, patient portal or mobile). • Patient advisory councils may be used specifically in revenue cycle operations when deploying new statement models, payment options or other new services.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Comprehensive survey tools are also used and deployed, based on identified patient preferences. • All aspects of services are randomly surveyed. • High tech electronic suggestion boxes are also deployed throughout the organization. Results are compiled and distributed real-time as well as on a monthly, quarterly and annual basis, as appropriate. • Surveys are supplemented by the use of patient advisory councils in both clinical and revenue cycle operations. • Social media are routinely monitored, and trends compiled. • Compliance with key principles of HFMA’s consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the survey questions. • Other innovative ways or initiatives to improve the patient experience are sought.

Digital experience: How complete is the consumer’s digital experience with the provider?

Providers create a patient portal that gives consumers a one-stop shop for most of their needs or inquiries. Consumers may search for care that is geographically convenient, request appointments, get appointment reminders via text/calendar invitation, view lab results, contact their provider, view billing statements and pay online. In a fully mature model, these options and more would be available to consumers via mobile or desktop.

The maturity scale scoring criteria for the Digital Experience dimension of Consumer Experience is shown in Table 16.

Table 16. Maturity Scale for Digital Experience

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Consumers may access, via a desktop application, provider information that includes location, hours of operation and quality ratings. • Consumers may call to speak with a representative for additional questions. • Health plan websites may also provide subscriber-specific information to consumers.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Using a desktop application, consumers may request appointments. • Consumers may view bills online. • Consumers may make profile information updates.
3	<p>All applicable items in Level 2 plus:</p> <ul style="list-style-type: none"> • Using a desktop application, consumers may access billing information and pay online, request medical history and view lab results. • FAQs for the most common inquiries are provided. • Automated emails are deployed to acknowledge the consumer’s inquiry.
4	<p>All applicable items in Level 3 plus:</p> <ul style="list-style-type: none"> • Using a desktop application, consumers may request appointments and reminders via call or text. • Consumers may call in to speak with a qualified representative for additional questions or chat with a bot to answer general questions. • Response times are monitored, and additional resources used, during periods of high call volume.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Based on their customized preferences, consumers may access the provider’s digital experience via desktop or mobile. • Consumers may submit insurance information in advance of an appointment and request appointment reminders via text or direct to calendar. • Providers are able to electronically push address information links to map utilities, calculation of travel time, etc., directly to the consumer’s mobile device. • When an insurance card is uploaded, the patient’s copayment, deductible and related information are displayed on the screen for patients. • Consumers may access live billing information, pay bills online, and view medical history and lab results. • Consumers may make profile information updates. • Consumers may live chat with a live service representative or call in to speak with a representative – if there is a wait time, the consumer will be offered an auto-call back without losing their place in the queue. • Emphasis is placed on a system of immediate, personalized follow-up to all consumer inquiries. • Key principles of HFMA’s consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the patient experience. • Other innovative ways or initiatives to improve the patient experience are sought.

Inquiry resolution: How timely and completely are consumer questions resolved?

Consumers may contact a provider for a variety of reasons. Ease of contact with the appropriate area is important, but so is the staff's ability to accurately identify the issue involved and promptly resolve it to the consumer's satisfaction. Various resolution tools are deployed, including an escalation process to ensure that the consumer's needs are met quickly and efficiently.

The maturity scale scoring criteria for the Inquiry Resolution dimension of Consumer Experience is shown in Table 17.

Table 17. Maturity Scale for Inquiry Resolution

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Provider does not use a consumer management platform. • Each unit has its own contact information and resolution team; resolution is independent and not shared with others involved in the consumer's care or stored for future reference.
2	<p>All applicable items in Level 1 plus:</p> <ul style="list-style-type: none"> • Consumer is required to present diverse or complex inquiries multiple times and navigate a complex system without significant assistance from the provider.
3	<p>Level 2 plus:</p> <ul style="list-style-type: none"> • Provider uses more than one consumer management platform; each business unit uses its own platform to intake consumer relationship issues that impact this business unit's processing. • There is no coordination on resolution with more than one department. When the consumer has more than one inquiry or has inquiries that cross over multiple providers, resolution is fragmented, leading to consumer dissatisfaction.
4	<ul style="list-style-type: none"> • Provider uses a single, integrated consumer management platform to intake all consumer relationship issues. • Provider then refers the consumer to the most appropriate resource for resolution. • Performance on consumer interaction is not tracked, as resolution management is decentralized. • Diverse methods or channels used by the consumer to communicate with the provider are not directed to one central location for continuity and clarity in communication; inquiry is often repeated by the consumer.
5	<ul style="list-style-type: none"> • Provider uses a single, integrated consumer management platform to manage all consumer relationship issues. This platform is available and integrated with patient billing, telephone and web portals to ensure accurate communication is provided to the consumer via appropriate authentication, and communication is not repeated unnecessarily. • Questions are directed to consumer management representatives via a sophisticated algorithm that connects the consumer with the right resource the first time, without need for call transfers or delegation to others. • Provider uses artificial intelligence tools to generate generalized responses as well as the appropriate routing of more complex issues to the appropriate representative. • Provider acknowledges consumer inquiries and responds timely. • Provider tracks % of completion for same-day inquiry, whether via portal, online, mobile device, phone or in person. • If inquiry or dispute cannot be resolved same day (or same call), the provider sets expectations for resolution with the consumer, and provides resolution within agreed time frame. • Consumer management representatives identify additional opportunities for improvement or provide patient resources for additional clarity regarding medical care, billing and quality data for providers, including external data, e.g., CMS.gov, state agencies or health plan portals. • Provider accepts the burden of resolution for the consumer. • Key principles of HFMA's consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the patient experience. • Other innovative ways or initiatives to improve the patient experience are sought.

Satisfaction guarantee: Consumer satisfaction with services received is guaranteed

Consumers are trusted to appropriately identify situations where their expectations for high quality, efficient and effective service were not met. The provider has implemented a process whereby dissatisfied consumers are able to request a refund for part or all of a service. Payouts are monitored, root causes identified and necessary changes to processes developed and implemented.

The maturity scale scoring criteria for the Satisfaction Guarantee dimension of Consumer Experience is shown in Table 18.

Table 18. Maturity Scale for Satisfaction Guarantee

SCORE	SCORING CRITERIA
1	<ul style="list-style-type: none"> • Provider does not have a centralized unit empowered to resolve patient satisfaction issues. • Dissatisfied patients may resort to external communication (media) to highlight variances between expected care, quality or effectiveness of service.
2	<ul style="list-style-type: none"> • Provider has dedicated resources empowered to resolve patient satisfaction issues. • Patient feedback is decentralized.
3	<p>Level 2 plus:</p> <ul style="list-style-type: none"> • Provider has developed a model standard of minimum behavior and communication requirements to ensure patient satisfaction with every interaction with provider staff – clinical and nonclinical.
4	<p>Level 3 plus:</p> <ul style="list-style-type: none"> • The model standard becomes a key performance management attribute measured, with feedback provided to all staff. • Patients can provide feedback through surveys (e.g., Press Ganey) or online directly to clinician or staff. • Key principles of HFMA's consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the patient experience.
5	<p>All applicable items in Level 4 plus:</p> <ul style="list-style-type: none"> • Provider has dedicated resources empowered to resolve consumer satisfaction issues. • Consumers may provide feedback through diverse survey channels, including mobile or portal applications, for any specific encounter. • Consumers may request a refund or a balance waived based on an encounter not having met their expectations for quality, efficient or effective compassionate care. • Provider tracks all consumer feedback for root cause and improvement purposes, including how the program may impact HCAHPS scores. • Management of patient experience is centralized; all employees are empowered to resolve consumer dissatisfaction as close to the encounter as possible. • A centralized team creates a partnership between clinical and nonclinical teams charged with responsibility for promoting a positive patient experience throughout an encounter. • Issues are resolved within 7 days, or, the consumer is contacted to explain a longer delay. • Other innovative ways or initiatives to improve the patient experience are sought.

Measurement

Consumer Interaction Channels

- Service Location Process
 - Appointment Scheduling
- Information-Providing Process
- Authorization Resolution
- Price Transparency
- Financial Responsibility Resolution
- Service Arrival
- Postservice Communications

Quality and Accuracy

- Medical Records
- Bill Generation
- Claims Submission
- Quality Information Access

Consumer Experience

- Quality Ratings Utilization
- Consumer Feedback Methods
- Digital Experience
- Inquiry Resolution
- Satisfaction Guarantee

MEASUREMENT

- Designated HFMA MAP Keys
 - Insurance verification rate
 - Service authorization rate
 - Cash collection as % of net patient service revenue
 - Aged Accounts Receivable (A/R) > 90 days
 - Discharged not submitted to payer (DNSP)
- HCAHPS “would recommend” score

Calculation of the maturity model score

Each maturity model section is scored on a scale of 1 to 5, reflecting the maturity level reported by the provider. For the same period (need to specify quarterly, semiannually or annually) the numeric scores are added to produce the maturity model component of the Index. The results of the individual financial KPIs/calculations are captured for the same period as the maturity model levels' scoring and plugged into the correlation formula to create an index rating score.

The Maturity Model score is based on the level assigned by the provider to each category. The maximum score, indicating a level 5 status for every category, is 85 (17 categories x 5, the top-level score) and the lowest score is 17.

A sample worksheet illustrating how an individual organization might score is shown in the [Appendix](#).

Components of the measurements needed to calculate the CMIS are the maturity model score plus the KPIs listed in Table 19.

Table 19. Key Performance Indicators (KPIs) Used to Calculate the CMIS

METRIC	DIMENSION OF CONSUMERISM
Insurance verification rate	How effectively have you verified consumer coverage for services?
Service authorization rate	How effectively have you received authorization for consumer services?
Cash collection as % of net patient service revenue	How effectively have you communicated to and collected payment on behalf of consumers?
Aged accounts receivable > 90 days	How effectively have you resolved consumer accounts in a timely manner?
Discharged not submitted to payer	How effectively has your information-gathering process worked on behalf of consumers?
HCAHPS "would recommend" score	How likely are consumers to recommend your organization or practice to others?

Maturity model rating scale

Once an organization has used the self-assessment to rate where it falls within the categories, the overall score is tabulated by the spreadsheet-based tool and then correlated against the overall scale, as shown below. The color and level attained are also assigned automatically. In the example shown in the [Appendix](#), the overall score is 60, which equates to an Emerging level in the Maturity Model.

The levels are defined as follows:

- **Consumer Centric (above 75):** The organization has mastered capabilities needed for meeting and exceeding consumer expectations related to the financial experience.
- **Emerging (60-75):** The organization has demonstrated a commitment to improving the consumer's financial experience and has made significant progress toward development of the requisite organizational capabilities.
- **Initiating (50-59):** The organization has begun the process of developing organizational capabilities for improving the consumer's financial experience.
- **Undeveloped (below 50):** The organization has yet to demonstrate that it is developing organizational capabilities for improving the consumer's financial experience.

Calculation of CMIS

Once the maturity model score is calculated and rated, it is then converted to a percentage score. Following the example in the [appendix worksheet](#), where the organization attained a score of 60, dividing that into the total possible score of 85 yields a 71% score, as shown in the top row of Table 20. Then, using the additional KPIs in Table 19 and converting them to a percentage based on the Maturity Model Rating Scale results in a scaled score for each metric and for the organization's overall CMIS, as shown in Table 20.

Table 20. Sample Consumerism Maturity Index Score (CMIS)

KEY PERFORMANCE INDICATORS (KPIs)	RATING
Consumerism self assessment	71%
HCAHPS "would recommend" score	72%
Cash collection as a percentage of net patient service revenue	90%
Aged accounts receivable (A/R) > 90 days (normalized)	70%
Discharged not submitted to payer (DNSP) (normalized)	91%
Authorization rate (inpatient and outpatient)	96%
Insurance verification rate	87%
CMIS	82%

CMIS rating scale

Once an organization has used the self-assessment to rate where they fall within the categories, and entered their performance into the CMIS, the overall score is tabulated and then correlated against the overall scale, shown below in Table 21. In the example shown above, the CMIS is 82%, which equates to an Emerging level in the Maturity Model.

Table 21. Consumerism Maturity Index Score Rating Scale

LEVEL ATTAINED	INDICATOR	OVERALL SCORE
Consumer Centric		90% and above
Emerging		Between 70 and 89%
Initiating		Between 60 and 69%
Undeveloped		Below 60%

Appendix

Sample scoring worksheet

CONSUMER INTERACTION CHANNELS	RATING
<p>Service location process: How consumers locate and receive services</p> <ul style="list-style-type: none"> • The health plan provides online access to its provider enrollment information, office locations and hours, as well as quality ratings for providers (i.e., physicians and hospitals). • Providers may provide links from their websites to participating health plan websites. • Price information for the most common services from in-network providers may be available from the providers. • Ability to accept new patients is identified. 	4
<p>Appointment scheduling: How consumers schedule services</p> <ul style="list-style-type: none"> • Consumers may call or use a patient portal to request services. • Scheduling is primarily initiated by physician offices. • Confirmation of the scheduling request is usually available within 2 or more days of the request. • Schedules are updated and electronically distributed to the preservice team and service departments. • Preregistration information is collected but not validated with consumers until they arrive for service. • If provided, insurance information is verified. • Additional calls from providers to the consumer are needed to complete the preregistration and financial clearance processes. • Orders may be received via fax, hardcopy or electronically and incorporated into the EHR. • Required orders are distributed electronically within the health system or via fax to external provider organizations by the ordering physician. 	3
<p>Information-providing process: How consumers provide comprehensive information prior to service</p> <ul style="list-style-type: none"> • The provider calls the consumer at least 2 days prior to the service date. <ul style="list-style-type: none"> — Demographic information is collected or updated. — Insurance information is requested and recorded in the preregistered account. — Arrival and other instructions are provided based on the services scheduled. • Applying patient financial communications best practices, a price estimate is provided and resolved in advance of service. • Uninsured individuals are flagged for financial counseling or rescheduled for a later date if a predetermined down payment cannot be made. 	3
<p>Authorization resolution: How the provider resolves needed authorizations for consumers</p> <ul style="list-style-type: none"> • Providers post charges on their website in machine-readable format for the 50 most common procedures. • A list of the most common ambulatory services that require preauthorization is maintained and used to trigger preauthorization requests to the ordering physician's office. • When a denial is received for lack of prior authorization, a retroactive authorization is requested by the provider. • If a preauthorization is not completed by the date of service, the consumer is asked to sign an electronic advance beneficiary notice of noncoverage (ABN) and may be billed if the authorization issue is not resolved. • Case management staff identify and manage inpatient and observation requirements. 	2

(continued)

CONSUMER INTERACTION CHANNELS (CONTINUED)	RATING
<p>Price transparency: What consumers know about what they are expected to pay for services</p> <ul style="list-style-type: none"> • Providers post charges on their website in machine-readable format. • Individual test charges are provided on the provider’s website. • Consumers seeking specific price information are instructed to call for more information. • Specific price information, based on the provider’s average charges, the health plan and the individual’s benefits are provided upon request. • Consumers are directed to contact their health plan for more specific information. • Copayment requirements are identified through the insurance verification process and requested at time of registration or service. • Deductibles and coinsurance status are provided, as available, from the health plan. 	3
<p>Financial responsibility resolution: How consumers can understand and resolve financial responsibilities</p> <ul style="list-style-type: none"> • The financial counselor determines the consumer’s insured status through inquiry and insurance verification during preregistration for scheduled services or at initial registration for nonscheduled services (i.e., emergencies). • For insured individuals, the individual’s anticipated financial responsibility may be determined and communicated to them. • For uninsured or underinsured consumers, the financial counselor assists the consumer or responsible party in completing a charity care application and may discuss payment plan options. • Patient financial communications best practices are used throughout the financial experience. • Price transparency guidelines are incorporated into the patient experience. • In the event the patient has completed services and has a balance due, HFMA’s Best Practices for Resolution of Medical Accounts are followed. 	4
<p>Service arrival: What consumers should expect when they arrive for service</p> <ul style="list-style-type: none"> • Insurance eligibility is verified in advance and consumers are told of their expected out-of-pocket expense. Consumers are asked to preregister online and complete all paperwork, including electronic signature. • Preparation instructions are available by procedure type and a calendar invite option is available to schedule any prep reminders (fasting, medications, etc.). • Consumers receive a text message or email upon scheduling with a link to a portal where all information about their visit is already populated. Location and driving directions are included and will automatically be replicated in a calendar appointment that will be sent to consumers via text. • Price estimation is provided based on health plan and expected procedure code. • Payment may be made in advance via Google Pay-type feature. A payment plan may be set up and charged to credit card automatically. • Patient financial communications best practices are used throughout the financial experience. • Price transparency guidelines are incorporated into the patient experience. • Consumers receive a “green card” electronic message that notifies them when all required forms are completed and payments are posted, advising them to proceed directly to the location of the procedure/visit upon arrival and bypass the registration desk. • Upon arrival, the consumer’s smartphone may sync up with the scheduling board, alerting the provider that they are ready. • A text directs the individual to the exam or treatment room to enter; biometrics may be used to confirm their identity. • Other innovative ways or initiatives to improve the patient experience are sought. 	5
<p>Postservice communications: How consumers receive postservice financial communications from providers</p> <ul style="list-style-type: none"> • Guarantor has access to statements online, via the patient portal or on the mobile app. Detailed charge and payment information may be provided. • Guarantor may opt out of paper statements and establish payment plans within established guidelines. • Payments may be made online or on the mobile app using a credit card or check. • For patients who have balances due postservice, HFMA’s Best Practices for Resolution of Medical Accounts are followed. 	3

(continued)

QUALITY & ACCURACY	RATING
<p>Medical records: How available, accurate and complete the consumer's medical records are</p> <ul style="list-style-type: none"> • Hospital or physician visit discharge instructions are limited to follow-up orders given to consumers on paper along with prescription(s) ordered after an encounter. • Limited records of office visit encounters and some test results are available to consumers online or via mobile app. • Provider portal allows consumer to confirm and order prescription refills. • Provider portal allows consumers to send messages to providers, as follow-up to visits, and schedule primary care appointments. 	3
<p>Bill generation: How accurately and promptly the consumer's bill is generated</p> <ul style="list-style-type: none"> • Charges are primarily captured electronically with paper processes used for peripheral areas. • Integrated or bolt-on coding tools are used to increase speed and accuracy of coding. • Billing data is processed through a claims scrubber to detect inconsistencies and errors that would result in a denial. Errors are corrected and claims released. • Clinical documentation improvement efforts are decentralized with limited documentation of policies, procedures and metrics. 	3
<p>Claims submission: How providers ensure that the consumer's claim is submitted to the right carrier and plan</p> <ul style="list-style-type: none"> • Primary health plan identification is based on the results of any insurance verification work completed prior to, or at the time of, service. • Any edit failures based on the health plan's inability to identify the patient are automated, so the claim is immediately reclassified as a self-pay claim and sent to the patient for resolution. • Documentation is automatically included with the claim sent so the patient may identify how to resolve the claim with the health plan and the provider. 	3
<p>Quality information access: How consumers access comparative provider quality ratings</p> <ul style="list-style-type: none"> • Provider-specific quality ratings from CMS and private ratings (e.g., Press Ganey, etc.) are available on the provider's website, patient portal and mobile app. • Searchable tools allow consumers to easily compare hospitals, physicians and services within a healthcare system and with other healthcare systems. • Contact information is provided to allow the consumer to obtain additional information about the quality information posted. 	4
EXPERIENCE	RATING
<p>Quality ratings utilization: How consumers use publicly available ratings of providers and patient experience</p> <ul style="list-style-type: none"> • The provider identifies the most common public rating applications on their website, patient portal and mobile app. • Consumers are encouraged to use these tools, although they are not linked to the provider's systems or applications. • Usage is routinely monitored. • Comments from consumers are monitored and shared internally. 	4
<p>Consumer feedback methods: How consumers provide feedback on their experience</p> <ul style="list-style-type: none"> • A variety of survey tools and approaches are used, including, but not limited to, one-question post-contact surveys (telephone, website, patient portal or mobile). • Comprehensive survey tools are also used and deployed based on identified patient preferences. • All aspects of services are randomly surveyed. • Compliance with key principles of HFMA's consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the survey questions. • High-tech electronic suggestion boxes are also deployed throughout the organization. Results are compiled and distributed real-time as well as on a monthly, quarterly and annual basis, as appropriate. • Social media are routinely monitored, and trends compiled. • Results are shared with department leadership. • Corrective action plans are developed and implemented, as necessary. • Surveys are supplemented by the use of patient advisory councils in both clinical and revenue cycle operations. • Other innovative ways or initiatives to improve the patient experience are sought. 	5

(continued)

EXPERIENCE (CONTINUED)	RATING
<p>Digital experience: How complete is the consumer’s digital experience with the provider?</p> <ul style="list-style-type: none"> • Consumers may access, via a desktop application, provider information that includes location, hours of operation and quality ratings. • Using a desktop application, consumers may access billing information and pay online, request medical history and view lab results. • Using a desktop application, consumers may request appointments. • Consumers may make profile information updates. • FAQs for the most common inquiries are provided. • Consumers may call to speak with a representative for additional questions. • Automated emails are deployed to acknowledge the consumer’s inquiry. • Health plan websites may also provide subscriber-specific information to consumers. 	3
<p>Inquiry resolution: How timely and completely are consumer questions resolved?</p> <ul style="list-style-type: none"> • Provider uses more than one consumer management platform; each business unit uses its own platform to intake consumer relationship issues that impact this business unit’s processing. • There is no coordination on resolution with more than one department. When the consumer has more than one inquiry or has inquiries that cross over multiple providers, resolution is fragmented, leading to consumer dissatisfaction. 	3
<p>Satisfaction guarantee: Consumer satisfaction with services received is guaranteed</p> <ul style="list-style-type: none"> • Consumers may provide feedback through diverse survey channels, including mobile or portal applications, for any specific encounter. • Consumers may request a refund or a balance waived based on the encounter not having met their expectations for quality, efficient or effective compassionate care. • Issues are resolved within 7 days, or, the consumer is contacted to explain a longer delay. • Management of patient experience is centralized; all employees are empowered to resolve consumer dissatisfaction as close to the encounter as possible. • A centralized team creates a partnership between clinical and nonclinical teams charged with responsibility for promoting a positive patient experience throughout an encounter. • Provider has dedicated resources empowered to resolve consumer satisfaction issues. • Provider tracks all consumer feedback for root cause and improvement purposes, including how the program may impact HCAHPS scores. • Provider has developed a model standard of minimum behavior and communication requirements to ensure patient satisfaction with every interaction with provider staff – clinical and nonclinical. • The model standard becomes a key performance management attribute measured with feedback provided to all staff. • Key principles of HFMA’s consumerism best practices, including patient financial communications and medical account resolution best practices and price transparency guidelines, are incorporated into the patient experience. • Other innovative ways or initiatives to improve the patient experience are sought. 	5
TOTAL SCORE (OUT OF 85)	60

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