



2007 HIMSS Analytics Report: Care-Based Revenue Cycle Management

Sponsored by QuadraMed Corporation

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Introduction

Historically, revenue cycle management (RCM) has referred to the processes and associated suite of software applications required to manage the registration, charging, billing and payment collection tasks associated with a patient encounter. These applications typically include: patient scheduling, ADT/registration, master patient index, encoding, patient billing, electronic claims, managed care contract management and credit/collections.

Emerging regulatory changes will drive care delivery organizations to focus even more acutely on their RCM process and integration with clinical application systems. In particular, care delivery organizations will need to address:

- Recovery audit contractors (projected for 2007)
- Pay-for-performance (projected for 2007)
- Severity adjusted DRGs (projected for 2008)
- HIPAA claims attachment (projected for 2009)
- ICD-10-CM codes (projected for 2010)

These regulatory drivers will make it increasingly more important to monitor operational performance and quality indicators – many of which are driven by clinical data. Although only thirty percent of survey respondents reported the ability to currently report against these indicators real time or proactively via score cards or alerts, we believe this percentage will increase relative to the importance of addressing the impact of the drivers indicated above.

HIMSS Analytics joined forces with QuadraMed Corporation to examine how revenue cycle management is evolving as more hospitals are implementing more sophisticated clinical systems. **Effective RCM strategies will depend on next generation clinical and financial information systems to address RCM from a care-based perspective in order for organizations to fully realize their revenue potential as the paradigm of reimbursement continues to shift towards payment based on quality and performance.**

This report summarizes our findings from a survey of senior executives from healthcare organizations across the United States. Funding, for this research, was provided by QuadraMed Corporation.

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1. Executive Summary

When the Centers for Medicare & Medicaid Services (CMS) launched the Hospital Quality Initiative in 2005, a demonstration project was established to evaluate rewarding hospitals for superior performance based on certain measures of quality as well as reducing payment if hospitals fall below the clinical baseline set in the first year by the bottom 20 percent of hospitals. This, along with other federal initiatives such as The Tax Relief and Health Care Act of 2006 (requires CMS to use recovery audit contractors to identify Medicare payment errors), HIPAA claims attachment, severity adjusted DRGs, and ICD-10-CM coding drivers, will further challenge care delivery organizations as they strive to enhance patient care quality and manage their revenue cycle.

The broad objective of this research was to gain a better understanding as to how care delivery organizations (CDOs) are responding to new regulatory drivers and the need to collect and integrate quality and performance indicators, demonstrated by clinical data, into their RCM process. The majority of respondents, who indicated that CMS changes would have a significant impact on their RCM process, noted that it was very important to have key clinical elements support the organization's revenue cycle management process in the future.

Even though the majority of respondents indicated the importance of clinical indicators to their RCM process, only twenty percent of the respondents' vision for RCM included some aspect of clinical integration. This disconnect is most likely due to the fact that two-thirds of the organizations, who use different vendors for clinical and financial applications, reported limited exchange of clinical and financial data, and only 50 percent of those organizations that use the same vendor reported a seamless exchange of clinical and financial data. This inability to easily integrate clinical data is going to have a substantial impact on the healthcare information technology market since many care delivery organizations currently depend on legacy systems which have limited capability to adequately address these new demands for integration and proactive reporting.

In addition to addressing processes that impact improvements in service quality, patient safety and patient satisfaction there is also a growing awareness that additional integration of clinical and financial data will be critical to both timely and complete reimbursement. From a structural perspective, the majority of organizations have already established an RCM committee and the majority of these committees reported having clinical representation. This interdisciplinary approach to RCM issues supports the realization that RCM must be addressed from both a clinical as well as a financial perspective, and recognizes that there are numerous processes and components that require clinical and financial

integration to achieve overall process improvement. These organizations are beyond addressing the “low hanging fruit” of RCM and are now addressing the more complex challenges associated with workflow modifications and process improvements to improve the capture, management and collection of patient service revenue.

However, capturing and integrating the data required to report and act upon quality and performance metrics will be an ongoing and sizeable effort. Some organizations have succeeded in solving this problem. Nearly 30 percent of the respondents reported the ability to measure changes in key indicators either real-time or proactively via scorecards and alerts. These early adopters have overcome a number of challenges and could provide significant insight to other organizations facing the same long term battle.

This new emphasis on RCM strategies is also supported by the current curriculums found in seminars conducted on RCM topics by the Healthcare Financial Management Association (HFMA).¹

Other key survey findings include:

RCM Operational Drivers: Improving financial outcomes was identified as the **single** most important factor in driving RCM strategy. Also important is the patient experience both before and after discharge.

Benefits of RCM Process: Reducing claim denials, improving charge capture and improving coding accuracy are the top areas in which respondents reported that they have received benefit from their current RCM process.

Key Indicators for Measuring Patient Outcomes: Patient satisfaction scores and quality metrics are used almost universally to assess patient outcomes and organizational performance. In addition, the majority of respondents reported that their organization uses multiple indicators to measure outcomes. Over half of the respondents indicated that reporting on these key indicators is accomplished via retrospective reporting.

Responsibility for Initiating Action Regarding Patient Outcomes: One-third of respondents reported that the person responsible for initiating action, related to patient outcomes, was the person responsible for quality (e.g., Director of Quality Improvement, Director of Quality Management, Vice President of Quality).

Improvement in RCM Process: In the past year, respondents have seen improvement in a number of components of their RCM process, including accuracy in coding, cash flow, patient satisfaction, and accuracy of charge capture.

Integration of Clinical and Financial Data: Over half of the respondents indicated that they seamlessly exchange data between their clinical and financial applications. Only three percent of respondents indicated that they have no data exchange.

RCM Committee: Eighty-three percent of respondents noted that an RCM committee is in place at their organization. The CFO is the person who is most likely to sit on the

¹ HFMA website, Revenue Cycle Management Strategies (www.hfma.org)

committee. In addition, nearly two-thirds of these respondents reported that a physician or nursing executive sits on the committee.

Presence of RCM Manager: Only one quarter of the respondents have an individual who is solely responsible for RCM and the majority of respondents reported that they have no plans to hire a person for this role.

This report will explore the key business drivers and challenges that impact RCM; the benefits organizations achieve from the current RCM process; key indicators used for measuring patient outcomes; integration of clinical and financial data; the use of an RCM committee and future vision for RCM.

2. Methodology

HIMSS Analytics extended invitations to participate in this telephone-based survey to a wide variety of executives, including Chief Operating Officers, Chief Financial Officers, nurse executives, physician executives, and senior Information Technology (IT) executives. Invitations were also extended to Director level positions in the patient accounting and Health Information Management (HIM) departments. Only one individual per organization was invited to participate in the survey. A total of 300 respondents completed the survey, which was administered in December of 2006.

3. Profile of Survey Respondents

A specific respondent quota was used to achieve input from the varied perspectives of senior executive leadership including COOs, CFOs, CIOs, CMOs and CNOs. In addition, specific attention was given to achieve responses from a cross sampling of a number of major healthcare software vendors.

A summary of the title groups² surveyed included:

- Chief Operating Officer—16.70 percent;
- Director of Patient Accounting—16.70 percent;
- Health Information Management Director—16.70 percent;
- Chief Information Officer/VP of Information Technology—16.70 percent;
- Physician Executive — 8.30 percent;
- Nurse Executive — 8.30 percent;
- Senior Finance Executive —8.30 percent;
- Vice President/Director of Revenue Cycle Management —8.30 percent.

Respondents were asked to identify the strategic clinical vendor in place at their hospital. MEDITECH was most frequently identified (27 percent), followed by McKesson (20 percent), Cerner (nine percent), Siemens (eight percent) and Dairyland and CPSI (five

² In order to examine the data in more detail by position title, these respondents will be grouped into three categories. The first is clinical executives and includes COOs, physician executives and nurse executives. The second is HIM/IT executives and includes HIM directors and CIOs. The final group is finance executives and includes directors of patient accounting, senior finance executives and RCM executives.

percent each). Other vendors identified in the survey were: Epic, Eclipsys, GE/IDX, HMS and QuadraMed.

4. What is Revenue Cycle Management?

Respondents had a fairly traditional view of revenue cycle management. Most identified revenue cycle management at their organization as the processes and components behind the organization getting paid. Only a handful of respondents indicated that revenue cycle management includes a relationship between clinical and financial data.

Revenue cycle management (RCM) has been traditionally associated with the tasks related to ensuring payment for a patient encounter. As one respondent noted, “It’s how fast we get the charts coded and the reimbursement back into the hospital”.

Respondents were asked to validate their perception of RCM by providing a definition of RCM at their organization. An analysis of these responses suggests that there are several broad perceptions of RCM.

A number of respondents defined RCM as discreet components of a process, such as charge capture, reimbursement or coding—“My definition is scrubbing the bills and getting them out, coding and making sure the bills get out properly”.

Other respondents focused on RCM from more of a systems perspective and see RCM as a number of processes that have an end result in reimbursement for services rendered—“I think it means from front door to back door until the bill is collected and paid”. Another group of respondents defined the RCM process as having a direct link to the organization’s strategic and annual budget cycle. According to one respondent, “Revenue cycle management means showing that we meet our budget. We should have savings from previous purchases to make up for absences in the next budget. It’s all about managing the finances”.

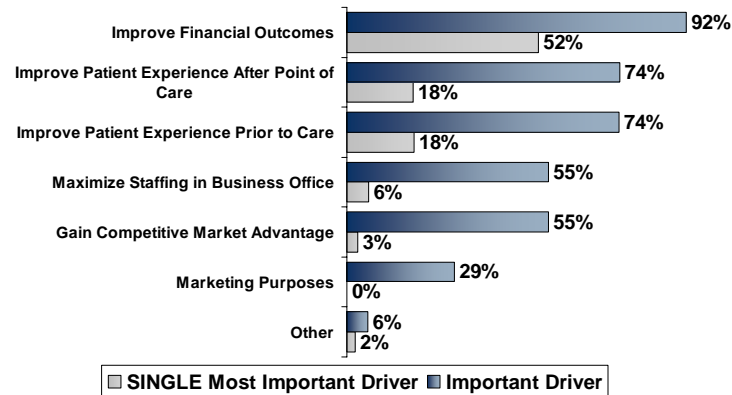
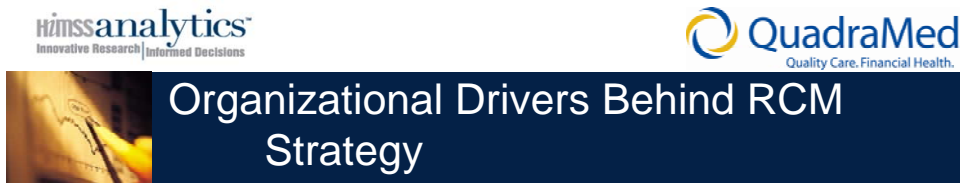
Finally, a small handful of respondents see a direct tie between RCM and clinical processes. For example, “I’d define it as the management of our clinical systems, anything that’s clinical. To make revenue, you have to manage your clinical department”. Another respondent directly linked financial and clinical processes. “My definition of revenue cycle management is ensuring that we produce the highest revenue as quickly as possible through the use of financial and clinical processes”.

5. RCM Operational Drivers and Challenges

Improving financial outcomes is a key component of RCM strategy for nearly all of the respondents in this study; and half identified it as the single most important factor driving RCM strategy. However, improving the patient experience, both prior to and after patient care, is also an important component of RCM strategy for three-quarters of respondents.

Respondents were asked to identify the top operational drivers behind their organization’s RCM strategy. Nearly all respondents indicated that improving financial outcomes (i.e., reduced days in accounts receivable, cleaner coding and improved cash

collections), is a key element. In fact, approximately half of the respondents indicated that this was the **single** most important factor driving their RCM strategy.



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Improvement of the patient experience is also important. Three-quarters of respondents indicated that improving the patient experience at the conclusion of care (i.e. making it easier for final billing) was a key driver that impacts the RCM process; another three-quarters of the respondents identified improving the patient’s experience prior to care (i.e. making it easier for patients to register or checking patient eligibility). Respondents also noted that behind improving financial outcomes, these two items were among the **single** most important drivers behind organizational RCM strategy. Each of these items was selected by 18 percent of respondents as a single top driver.

Respondents were least likely to identify marketing purposes as a factor that drives their organization’s revenue cycle management strategy. This response was selected by only 29 percent of respondents (and only one respondent noted that it was the **single** most important factor behind their RCM strategy).

An examination of the data with regard to position title indicates that IT/HIM and finance executives are more likely to identify “maximizing staffing and stability in the business office” as a top driver behind organizational RCM strategy than are clinical executives. No additional statistical associations can be drawn.

Respondents were asked to identify the areas of their RCM process that were most challenging. Most frequent responses included:

- Collecting Payment on Overdue Accounts/Collecting Bad Debts;
- Timeliness and Accuracy of Coding;
- Timeliness and Accuracy of Charge Capture;
- Claim Denial Management;
- Hiring and Keeping Appropriate Staff;

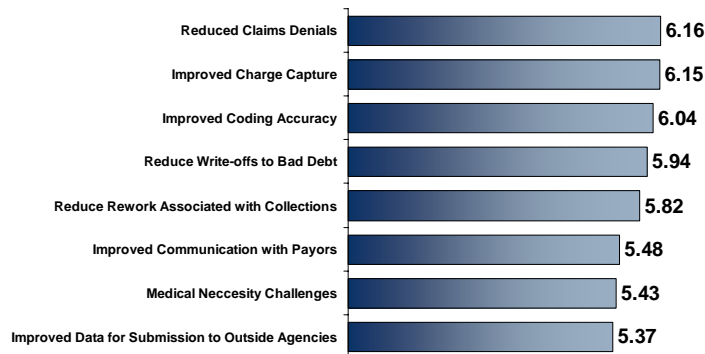
- Maintaining a Positive Patient Experience.

Finally, a number of respondents identified challenges in dealing with insurance companies. These challenges ranged from linking to payers for claims processing to linking to payers to verify eligibility and authorization to keeping up with changes in the requirements that insurance companies mandate for payment of service.

6. Benefits from Current RCM Process

Reducing claim denials, improving charge capture and improving coding accuracy were the top areas in which respondents reported that they receive benefit from their current RCM process. Two-thirds of respondents also reported that coding accuracy at their organization had improved over the course of the past year.

Respondents were asked to identify the level of benefit that they currently receive from their RCM process³. On average, respondents were most likely to indicate that their current RCM process affords them the benefit of reduced claim denials (6.16). Reduced claim denials has a statistically significant relationship in several areas, including charge master maintenance/ownership, patient satisfaction, provider satisfaction and accurate charge capture. In all four areas, respondents who reported an increase in benefits were also most likely to identify a reduction in claim denials.



Data is on a seven-point scale.

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This is followed by improved charge capture (6.15) and improved coding accuracy (6.04). While there are no statistically significant relationships between improved charge

³ Individuals were asked to base their response to this question on a one to seven scale, where one is no benefit and seven is “absolutely a benefit”.

capture and the past year's RCM process, those respondents who reported that their charge capture and RCM accountability improved in the past year also had the highest average with respect to the benefit afforded to their organization by improved coding accuracy. Furthermore, those who reported that their bad debt collection had either improved or stayed the same were more likely to report a higher average level of benefit with respect to coding accuracy.

Respondents were least likely to indicate that their present RCM process has an impact on their billing audits (4.79). Individuals who reported that their charge capture or RCM accountability had improved in the past year were more likely to report a higher level of benefit in this area, when compared to those who noted a decline in this area.

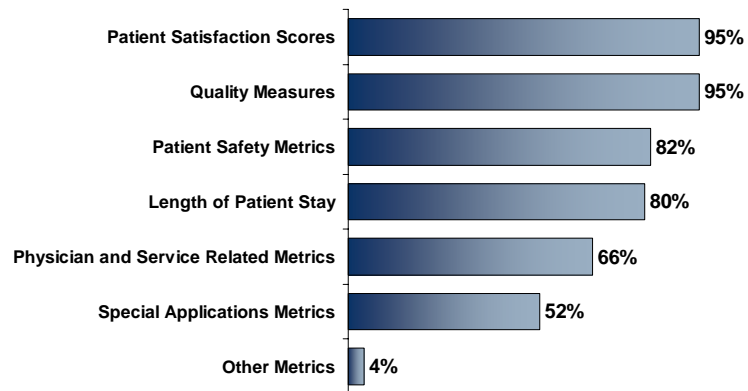
7. Key Indicators for Measuring Patient Outcomes

Patient satisfaction scores and quality metrics are used almost universally to assess patient outcomes and operational performance at the organizations in this sample. In addition, the majority of respondents report that their organization uses multiple indicators for assessing patient outcomes and performance. Over half of the respondents indicated that reporting on these key indicators is done via retrospective reporting.

As part of their mission “to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations”, JCAHO requires hospitals to measure patient outcomes and performance related to quality of care. With the exception of one respondent, all of the individuals in this survey noted that they use at least one metric to measure patient outcomes and operational performance. The most frequently identified metrics that organizations use are patient satisfaction scores and quality measures such as those identified by AHRQ or CMS. Both of these options were selected by 95 percent of respondents.



Key Indicators Used to Measure Patient Outcomes and Performance



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Two-thirds of respondents (67 percent) reported that they track on at least five of the quality metrics that have been identified in this report. Only eight percent of the respondents identified that they report on only one or two of the quality metrics identified in this report.

In all areas in which a statistically significant relationship exists between the title of the respondent and the benefit received from the key clinical indicators identified in this report, IT/HIM executives were more likely than the other title groups to identify that a benefit exists. This statement is applicable for the following areas:

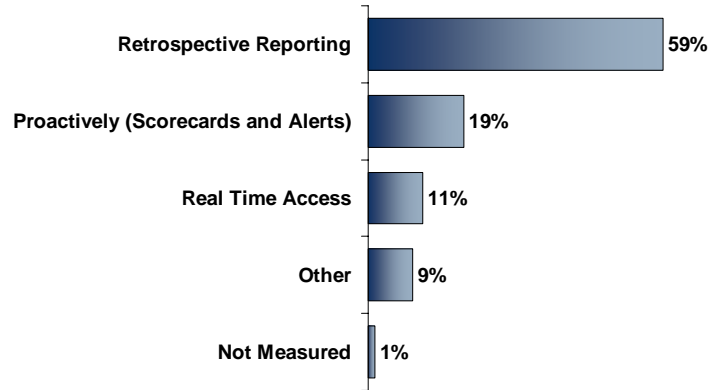
- Improved communication with payers;
- Improved maintenance capabilities for the charge master;
- Improved data for submission to outside agencies (i.e., CMS);
- Medical necessity changes;
- Reduced billing audits.

In addition, respondents who reported that they have an RCM Committee in place at their organization were somewhat more likely to report that they use patient satisfaction scores as a key indicator—97 percent of organizations that have an RCM Committee use patient satisfaction scores as a measure of performance; 88 percent of hospitals that don't have a committee do the same.

Reporting on these metrics can take place in three primary ways—retrospective reporting, real time access/viewing, or proactively via scorecards and alerts. Over half of the respondents (59 percent) indicated that their sole method of reporting is via retrospective reports. Another 11 percent reported that they measure the above indicators via real time access and viewing and 19 percent reported that they are using a more proactive means of measuring indicators via scorecards and alerts. The remaining

nine percent of respondents indicated that they use a combination of retrospective reports and either real time access, scorecards or alerts.

Primary Means of Reporting Changes in Key Patient Outcomes Indicators

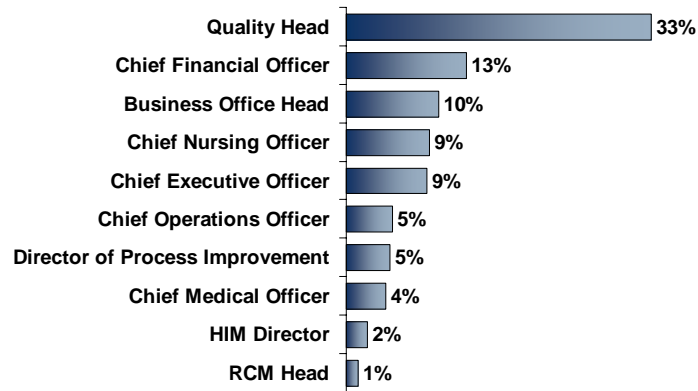


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Respondents were also asked to identify the person within their organization who has responsibility for initiating action with regard to changes in these key indicators. One-third of respondents (33 percent) reported that the person initiating action was the individual responsible for quality (e.g., Director of Quality Improvement, Director of Quality Management, Vice President of Quality). Other groups that were identified as being responsible for measuring key quality metrics are the Chief Financial Officer (13 percent), Patient Accounts Director/Business Office Manager (10 percent), Chief Nursing Executive (nine percent) and the Chief Executive Officer (nine percent).



Person Responsible for Initiating Action with Regard to Patient Outcomes Indicators



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Even though nearly one-quarter of respondents indicated that they have someone at their organization who holds a title similar to Manager or Vice President of Revenue Cycle Management, this person is not identified as the individual responsible for initiating action with regard to changes in key indicators. Instead, the types of individuals responsible for initiating action with regard to changes in key indicators are similar to that of the entire study, including quality heads, the CFO and the CEO.

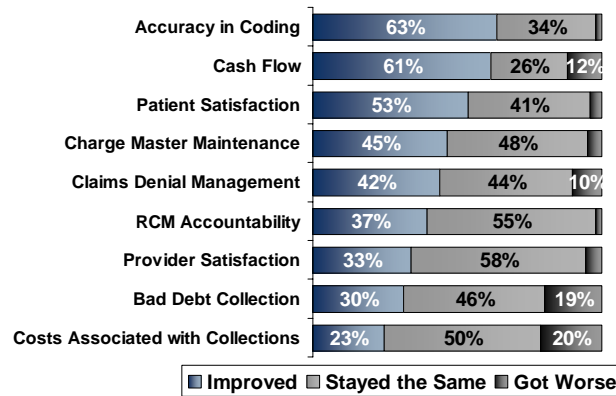
8. Change in Components of RCM Process

Respondents noted that in the past year, their organization has seen improvement in a number of components of their RCM process, including accuracy in coding, cash flow, patient satisfaction, and accuracy of charge capture.

Respondents were asked to identify how several components of their RCM process have changed over the course of the past year. In the areas of accuracy in coding, cash flow, patient satisfaction, and accuracy of charge capture, respondents were most likely to identify that their process had improved over the course of the past year. In the area of charge master maintenance, claims denial management, RCM accountability, provider satisfaction, bad debt collection and costs associated with collecting payments, respondents were most likely to report no change.



Change in Key Components of the RCM Process in the Past Year



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When these items are examined in relation to a respondent's title type, there were statistically significant differences in several areas:

- **Claims Denial Management**—financial executives were more likely than other executives to perceive that the management of claim denials had worsened at their organization in the past year
- **Costs Associated with Collecting Payments**—individuals in all title groups were most likely to indicate that this area had stayed the same over the past year; clinical executives were more likely than the other groups to report that these costs had gotten worse
- **Patient Satisfaction**—while individuals across all three groups were most likely to report that patient satisfaction had improved in the past year, IT/HIM executives were more likely than the other groups to report that patient satisfaction had improved in the past year; clinical executives were more likely than the other groups to report that patient satisfaction had decreased
- **Provider Satisfaction**—while all groups were most likely to report that provider satisfaction had not changed in the past year, clinician executives were nearly three times as likely to report that provider satisfaction had decreased in the past year
- **Bad Debt Collection**—while individuals in all three title groups were most likely to identify that bad debt collection had stayed the same in the past year, financial executives were more likely than the other groups to identify that bad debt collection had gotten worse in the past year
- **Accurate Charge Capture**—clinical and IT/HIM executives were most likely to report that accurate charge capture had improved in the past year; financial executives were most likely to report that this had stayed the same

Additionally, those who reported that their coding accuracy had improved in the past year were also more likely to report reduced rework as a benefit of RCM (when compared

to those who noted that coding accuracy stayed the same or got worse). Ironically, those who noted that their medical necessity challenges had gotten worse in the past year also were more likely than other groups to note that accuracy in coding was a benefit of RCM. This was also the case for those who reported a decline in RCM accountability.

While there is no statistical relationship between cash flow and the level of perceived benefit, statistical relationships do exist between both patient satisfaction and accurate charge capture in a number of areas. For example, those who noted a reduction in claim denials in the past year also reported a higher level of patient satisfaction as a benefit from their RCM process. The same is true for support for electronic medical legal requirements and reduced write-offs to bad debt. However, those who reported that reduced rework associated with collections stayed the same in the past year were more likely to see a benefit in patient satisfaction than were those who saw an increase or decline. Those who saw a decline in case mix stability were most likely to note a benefit with regard to patient satisfaction as a result of their RCM process.

Those who noted that coding accuracy improved in the past year also reported a higher level of benefit with regard to accurate charge capture. This was also the case for reduced claim denials, reduced rework associated with collection, medical necessity challenges, case mix stability and reduced billing audits. Those who reported a decline with support for electronic legal medical records requirements were more likely than other groups to note that charge capture was a benefit of RCM for their organization.

9. Integration of Clinical and Financial Data

Over half of the respondents indicated that they seamlessly exchange data between clinical and financial data applications. Only three percent of respondents indicated that they have no data exchange between their clinical and financial applications.

About half of the respondents (52 percent) reported that their organization uses the same vendor for their core clinical and financial applications. Another 40 percent of respondents reported that their organization uses different vendors for clinical and financial applications.

Among those respondents who indicated that they used the **same vendor** for both of their clinical and financial applications:

- Almost half reported that data flows seamlessly between the clinical and financial applications as a consequence of using a single vendor solution
- Another 29 percent of respondents indicated that there is a seamless data exchange between financial and clinical systems, solely because the IT department at the organization has specifically worked to achieve data sharing between applications
- The remaining 22 percent of respondents indicated that there is only a limited exchange of data between their organization's clinical and financial applications.
- One respondent indicated that there is no exchange of data between clinical and financial applications.

Among the respondents who indicated that they used **different vendors** for their clinical and financial applications:

- Two-thirds reported that there is limited data exchange between clinical and financial applications;
- Another five percent of respondents indicated that there is no data exchange between the applications;
- Only 28 percent of respondents reported that there is a seamless exchange between the two applications.

In their own words, respondents who reported that there was absolutely no data exchange between their clinical and financial systems were most concerned that there is the opportunity to make a mistake in interpreting the data, either because the data is incomplete or the data is transmitted so slowly. As characterized by one respondent “The information moves a lot slower and you don’t know if everything is getting captured”. Another respondent identified the importance of seamless integration in the following statement “I’m interested and in the middle of a fully integrated electronic record, where the data will see the revenue merging with the profits. It’s something a lot of people want but don’t have because of integration issues”.

Respondents indicated that the exchange of clinical and financial data is critical. On a scale of one to seven, an average score of 6.07 was recorded in response to the question “what is the current value of having key clinical elements support your revenue cycle management process”. Respondents were even more firm in their belief that clinical elements will be important in the future. An average score of 6.48 was recorded in response to the question “how important is it to have key clinical elements support your revenue cycle management process in the future”.

Respondents who reported that they have achieved a seamless level of integration are already identifying benefits with respect to their RCM process. A number of respondents reported that they have achieved benefit in some of the key operational components of the RCM process, such as improved coding, lower days in AR or lower rates of claim denials. As one respondent commented “we’ve seen reduced length of stay, reduced claim denials, and an improvement with the charge master”. Others mentioned that their sole benefit is improved collections and finances. One respondent noted that “we’ve seen increased revenue and a decrease in write offs”.

Others reported that their entire RCM process has become more efficient. “We’ve received cost and information efficiencies, but its mostly just efficiency”. Other respondents reported that an integrated process allows them to have improved reporting on data. One respondent said “**We’ve experienced better reporting of outcomes and better tracking and monitoring of those. We’ve eliminated a great deal of mistakes**”.

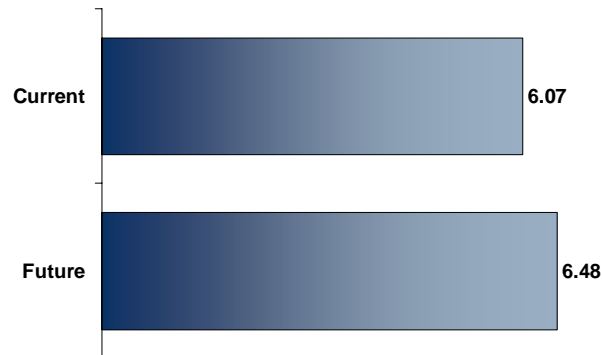
Finally, some respondents reported that they have begun to achieve some benefit from a clinical or patient care perspective. A sample of responses included:

- We can put a **dollar value** on clinical outcomes and we can make better decisions;
- The **physicians are happier** so they document more, and are more cooperative with us;
- We've experienced more accurate clinical information so we **receive higher reimbursement**.

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Value of Exchanging Financial and Clinical Data



Data is on a seven-point scale.

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For the most part, respondents were aware that CMS changes and regulations (i.e. pay-for-performance) have the potential to impact the RCM process. When respondents were asked if they understood the impact that such CMS changes could have at their organization, the average response was 5.62⁴. There are no statistically significant differences in the way in which clinical, financial and IT/HIM executives answered this question. However, there is an association between the perceived impact of CMS on RCM processes and the value placed on the exchange of clinical and financial data in the RCM process. For instance, 53 percent of the individuals who indicated that CMS changes would have a significant impact on the RCM process (rating of seven) also noted that it was very important (rating of seven) to have key clinical elements support the organization's revenue cycle management process in the future.

10. Future Vision for Revenue Cycle Management

While most respondents noted that they would like their RCM process to improve or become more efficient in the future, there is an increasing

⁴ Individuals were asked to base their response to this question on a one to seven scale, where one is no impact and seven is substantial impact.

awareness that the integration of clinical and financial data will be critical to being reimbursed in a timely fashion, providing quality care and having satisfied patients.

A number of themes emerged with respect to where individuals would like their RCM process to move in the future. First, a number of respondents simply stated that they would like to see their process move forward in a more efficient manner. As one respondent stated—“Our vision is to achieve the most effective and efficient revenue cycle with the least amount of resources possible”. Another group of respondents were focused on their organization’s bottom line—“My vision is just to make sure that we collect all of the bad debt and better coding so that we can get paid what we need to get paid”.

When compared with their current RCM process, individuals were much more likely to indicate that integration between clinical and financial processes will be critical to RCM processes in the future. Nearly twenty percent of respondents indicated that it is critical to have integration between these areas. According to one respondent, “The vision is that the documentation is an inherent part of the care, not one that comes later. That way it flows seamless”. Another respondent noted, “my vision is to have clinical information flow seamless to revenue management or vice versa to have revenue data flow to clinical so the appropriate procedure can be done to maximize our revenue”.

11. Revenue Cycle Management Decision Making Process

Eighty-three percent of respondents noted that a revenue cycle management committee is in place at their organization. The Chief Financial Officer is the person who is most likely to sit on this committee. In addition, nearly two-thirds of these respondents reported that a clinical executive sits on the committee as well.

Respondents were asked to identify how revenue cycle management decisions are made at their organization. Eighty-three percent of respondents indicated that there is a revenue cycle management committee in place. Among those organizations that do have an RCM committee in place, the person that is most likely to sit on the committee is the Chief Financial Officer. Nearly three-quarters of respondents noted that a CFO sits on their committee. This is followed by the HIM/Medical Records department head (64 percent).

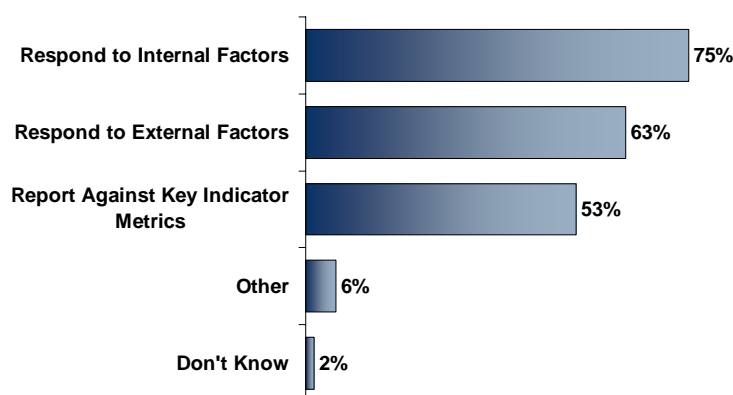
However, two-thirds of the respondents, who have a committee in place, noted that a clinical representative sits on their committee. Specifically, a nurse executive sits on the RCM committee at 49 percent of the respondent’s organizations included in this sample, while a physician executive was identified as a member by 28 percent of the respondents.

Also well represented on the committees are senior IT executives (40 percent) and COOs (35 percent).

Three-quarters of the respondents who reported that their organization has an RCM committee reported that the committee is responsible for responding to internal factors, such as failed advanced beneficiary notice (ABN) processes, that impact their RCM

process. Nearly two-thirds of respondents (63 percent) reported that the RCM committee is responsible for responding to external factors that impact the RCM process. Such external factors might include identifying payers who are not paying according to contract. Finally, just over half of the respondents reported that their committee routinely reports against key indicator metrics such as discharged-not-final-billed (DNFB).

Functions of Revenue Cycle Management Committee



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Organizations that do not use an RCM committee to address RCM issues handle matters in two primary ways. First, a number of respondents reported that this task is handled regularly by another committee at their organization. Second, a number of respondents reported that these tasks are taken care of by the organization's executives, but that there is no forum for consistent reporting. As one respondent notes, "The business office manager, CFO, Administrator, and Director of Nursing make the decisions".

12. RCM Manager

Only one quarter of the respondents in this survey reported that there was an individual who is solely responsible for RCM at their organization. The majority of respondents also reported that their organization has no plans to create a position that will be solely responsible for RCM.

One way that organizations are addressing accountability for the RCM process is to create a position of leadership responsible for RCM. In this survey, 22 percent of respondents indicated that their organization currently has a person in place that has a title similar to Vice President of Revenue Cycle Management and another six percent reported that their organization would like to create a position with this title in the near future. However, 71 percent of respondents reported that their organization does not have a VP of RCM and there is no plan to create a position with this title in the future.

From a statistical perspective, it appears as though having a person within the organization identified as a RCM head has very little impact on the way in which organizations think about the RCM process. However, it is necessary to keep in mind that less than one-third of the organizations in the sample have an RCM head. Any difference that may result from having this type of person in place may not be apparent due to the small population of hospitals in this sample that currently have an RCM head.

13. Conclusion

The Tax Relief and Health Care Act of 2006 was signed into law in December and requires CMS to use recovery audit contractors to identify Medicare payment errors. This, along with pay-for-performance, HIPAA claims attachment, severity adjusted DRGs, and ICD-10-CM coding drivers, will further challenge care delivery organizations as they strive to enhance patient care quality and manage their revenue cycle.

RCM can no longer be defined from a purely financial transaction perspective. Every patient care and ancillary clinical department application has an RCM component that ties the procedure codes, associated with treatment and service, to the coding for medical records and to the coding that is required for billing. As one respondent stated—“my vision is that there would be a seamless exchange between clinical and financial systems to improve the revenue cycle process”. Another respondent was more specific—“**the ultimate goal would be to have orders automatically generate charges so there wouldn’t be manual coding at all. My vision would also be to see bills automatically generated without much manual intervention and doctors would complete charts the same day through a total electronic medical record**”.

Based on the data collected from 300 healthcare leaders in this survey, the importance of incorporating clinical data into the RCM process is gaining momentum. The majority of organizations represented in this sample have established the necessary management structure and are incorporating non-traditional business units (i.e., Health Information Management, nursing and physician executives) onto their RCM committees. With this structure in place, organizations are now addressing the limitations associated with legacy information systems and the difficulties with incorporating clinical data into their RCM process.

This emphasis on clinical data goes beyond the findings of this survey. The Healthcare Financial Management Association (HFMA), which conducts seminars on RCM strategies, emphasizes this type of integration. According to their literature, “You’ll learn to integrate financial and clinical departments into a unified revenue cycle operation”.⁵

With this enlightened view of RCM, new requirements for improved feedback and concurrent reporting against performance indicators will continue to strain the capabilities of legacy clinical and financial systems. **Next generation clinical and financial information systems must address RCM from a care-based perspective in order for organizations to fully realize their revenue potential as the paradigm of reimbursement shifts to payment based on quality and performance.**

⁵ HFMA website, Revenue Cycle Management Strategies (www.hfma.org)

14. Survey Sponsors

About HIMSS Analytics

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HIMSS Analytics supports improved decision-making for healthcare delivery organizations, as well as healthcare IT companies, state governments, financial companies, pharmaceutical companies, and consulting firms, by delivering high quality data and analytical expertise. The company collects and analyzes healthcare data related to IT processes and environments, products, IT department composition and costs, IT department management metrics, healthcare trends and purchasing related decisions. It is a wholly owned not-for-profit subsidiary of the Healthcare Information and Management Systems Society (HIMSS).

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15. How to Cite This Study

Individuals are encouraged to cite this report and any accompanying graphics in printed matter, publications, or any other medium, as long as the information is attributed to the **2007 HIMSS Analytics Report: Care-Based Revenue Cycle Management Report**, sponsored by QuadraMed Corporation.

16. For more information, contact:

HIMSS Analytics

Amy Bergau
Marketing Manager
HIMSS Analytics
312/915-9525
abergau@himss.org

QuadraMed Corporation

Steven Russell
Senior Vice President, Corporate Development
QuadraMed Corporation
703-709-2340
srussell@quadramed.com