SimiTree

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Revenue Cycle: The Transformation Underway

Why Managing the Revenue Cycle Is Becoming Much More Complex

As billing gets more complicated, here's a look at what's prompting the changes – and where we're headed.

Nearly a decade after U.S. Congress passed sweeping legislation to improve and unify Medicare's post-acute care services and how they are reported, billing departments are feeling the fallout, with more to come.

The Improving Medicare Post-Acute Transformation Act of 2014, known as the IMPACT Act, mandates the collection and reporting of standardized data across the post-acute care spectrum. It also emphasizes coordination and transitions of care, enacting standardization of data elements that allow for information to follow the patient from one health care setting to another, thereby improving outcomes.

New payment models have been game-changers for post acute care.

IMPACT's goals of standardized data collection and greater care coordination are part of an increasing customization of the health care experience that has laid a foundation for new and more complex post-acute care Medicare payment models.

Since 2019, we've seen the implementation of new payment models for post-acute care that are far more patient centric. Both the Patient-Driven Payment Model (PDPM) for skilled nursing facilities and the Patient-Driven Grouping Model (PDGM) for home health are coding driven to a degree not previously seen in the industry, and dependent upon a plethora of patient-specific variables impacting the amount of reimbursement.

New payment models have been game-changers for almost all the post-acute industry, forcing top-to-bottom organizational change to address cash flow shortages and protect margins. In some cases, business models have had to be entirely revamped to overcome the death knell of volume-driven therapy services.

Hospice is expected to move into the batter's box next with a new payment model of its own, and the Centers for Medicare and Medicaid Services (CMS) is currently exploring payment model options, including models that would include concurrent hospice and curative care.

Next up: Hospice. CMS is exploring payment models that would include concurrent hospice and curative care.

Together, all these changes are fully living up to the promise of "Transformation" set out in the name of the 2014 IMPACT Act.

Billing transformation

Nowhere is transformation more evident than in a post-acute care organization's billing department. Once largely a stand-alone function within an organization, post-acute billing has transformed into an interactive operation requiring intensive collaboration between intake, quality, medical records and other back office departments. Billing requires regulatory expertise, clinical documentation acumen and a sense of urgency on the part of all to meet shorter timeframes.

The billing process balances carefully on a seesaw where a problem with any of the other riders – compliance, coding, clinical and overall operational performance -- can cause cash flow to plummet, impacting profitability. In fact, it's almost impossible to achieve balance unless all the riders are working in tandem, from the moment the referral is made all the way through to cash posting.

And the transformation we've seen in recent years is nowhere near complete.

Medicare continues to push the revenue cycle to move faster and document better, capturing patient-centric details that determine the course of care, target the risk of rehospitalization and close the information gaps between health care settings.

A broad look at what's going on

It would be impossible to list here all the moving parts that are influencing and re-shaping the revenue cycle as Medicare continues to introduce new regulations and change existing regulations. Here is a broad overview of some of the important changes underway, some already upon us and some still to come, and a look at how they are expected to contribute to the increasing complexity of the post-acute revenue cycle.

1. Collection of patient information is becoming much more complex.

Beginning in 2023, the entire post-acute industry will see a major expansion complexity and specificity of the patient assessment as Medicare moves forward with IMPACT-mandated data collection. One of the goals set out in the Act is the streamlining of Transfer of Health (ToH) information when a patient transfers from one care setting to another. Coupled with Medicare's continued push for more patient centric care and services, enacting the IMPACT-mandated measures will require more detailed patient assessments that affect plans of care, quality of treatment, compliance, and reimbursement across the post-acute spectrum. Home health will lead the way with other segments of the industry following soon thereafter.

- **Home health:** In January 2023, CMS will implement what many consider the most extensive overhaul of the OASIS since its introduction in 1999: the OASIS-E for home health. The new assessment introduces several new categories of data collection for home health as part of standardized data collection efforts mandated by IMPACT. In addition to items designed to capture information about the patient's functional status and abilities, OASIS-E will add sections designed to assess patient cognitive patterns, behavior, and mood. Completion of the new, expanded assessment will continue to serve as an integral piece of reimbursement under PDGM.
- **Hospice:** CMS continues beta-testing for a new hospice patient assessment tool, the Hospice Outcomes and Patient Evaluation tool, or HOPE. While CMS has previously said the standardized patient assessment data elements for certain post-acute care providers required under IMPACT are not applicable to hospices, it said in the proposed hospice rule for FY2023 that some elements will apply. One of the primary uses for the tool will be data collection for payment refinements, according

to CMS. Hope will also be used to provide quality data for the Hospice Quality Reporting Program and to support survey and certification processes. It is widely expected to function in similar fashion to the OASIS, with requirements for completion at the beginning of the hospice episode as well as at additional timepoints.

- **In-patient rehab:** Patient information collection is also intensifying beyond home health and hospice. While the COVID-19 public health emergency has delayed implementation of version 4.0 of the IRF-PAI for in-patient residential facilities, the instrument will introduce almost 300 new Quality Reporting (QRP) fields for providers to complete at the time of the patient's admission and discharge.
- **Skilled nursing facilities:** Implementation of an updated version of the Minimum Data Set (MDS) for skilled nursing facilities has also been delayed due to the COVID-19 public The MDS is an important component of the Resident Assessment Instrument, and like its post-acute care counterparts, will include new and expanded information collection elements to comply with IMPACT.

As I write this, no specific dates have been set for implementation of the new assessments for skilled nursing facilities and in-patient rehabilitation facilities. CMS has previously said implementation of both will occur at the beginning of the second fiscal year after the end of the COVID-19 public health emergency. For example, if the public health emergency ends at some point during 2022, the new and expanded assessments will be implemented on October 1, 2024.

2. New payment models are making profitability harder.

Three years and one pandemic into two of Medicare's new payment models for post-acute care, we're recognizing the major shakeup to industry margins. It's taking a while to sort out the full impact of COVID-19, and there's no way to know for certain what the final industry price tag will be for rising labor costs in an ongoing staffing shortage, inflation-related supply costs, costly infection control measures and other components of doing business in a public health emergency.

What is clear is that the payment models themselves have rewritten the former volume-of-service business model and introduced more complex considerations for serving higher acuity patients in shorter lengths of stay with services that are much more specific to the patient based on documented characteristics.

- **The Patient-Driven Grouping Model (PDGM)** implemented for home health in January 2020 ushered in 30-day billing periods, upped care coordination requirements, and intensified the need for coding & OASIS accuracy to determine the patient's clinical grouping and functional impairment, two of five key components for the new model. It also imposed upon home health organizations the need to examine their referrals more carefully, considering how well referral sources would cooperate to meet expedited timeframes for physician signatures and other documentation, as delays could prove to be costly under PDGM's shorter billing timeframes. Payment is based on a complicated methodology in which consideration must also be given to clinical factors such as potential impact of patient comorbidities, and the acuity level of care the patient has most recently been provided. Missteps in any part of the process can significantly impact reimbursement.

- **The Patient-Driven Payment Model (PDPM)** implemented for skilled nursing facilities in October 2019 completely changed financial incentives for skilled nursing facilities, replacing therapy-driven services with care based on patient-centric characteristics. The new model prompted overall changes in clinical and operational aspects for almost all facilities, impacting admission discharge and assessment practices. Some facilities tweaked their overall business models as well, moving to ventilator and dialysis services and other complex services to replace therapy. But the delivery of higher acuity care delivered its own set of complicated issues, and the COVID-19 public health emergency has shuffled all the pieces on the playing board for SNFs.

One important question that continues to be asked is whether we will see a unified payment system merged from the current post-acute care payment models, with different rules for payment, eligibility, coverage and performance measurement among home health, skilled nursing and inpatient rehab facilities, and long-term care hospitals. A unified system would address the main goals of IMPACT, forcing patient-centric care rather than setting-based care.

A better question than whether we will see a unified payment model may be when we will see it, in light of the pandemic. An attempt has been underway for several years now to develop such a model, with a government contractor undertaking research and development at the behest of CMS and answering to a panel of experts selected to participate in an advisory capacity. Momentum toward unification was growing, prior to the COVID-19 public health emergency.

But the unified model has come under fire for its shortcomings, including its construction from data collected between 2017 and 2020, before the game-changing implementation of PDPM in 2019 and PDGM in 2020. Since that data also predates the COVID-19 pandemic, its validity as a base for construction of the unified model has been challenged. Additional criticism surrounds the model's usage of inconsistent data elements, creating major inconsistencies in comparisons of diagnoses, case-mix levels, treatment needs and costs of care.

It is safe to predict that until these major flaws can be addressed, and work can begin on a model with sufficient data, we will not see a unified payment model.

In the meantime, both the PDGM and PDPM payment models cover much ground in better establishing patient specifics as the hub of our services. Implementation of OASIS-E as well as new patient assessment instruments in skilled nursing facilities and inpatient rehab facilities will carve out more ground in the areas of standardization necessary to move in the direction of one payment model.

The one certainty that we can count on is that patient characteristics, not service delivery, will continue to drive payment models.

3. Value-based care will pose additional billing challenges.

Medicare continues to incentivize cost reduction and quality improvement, moving forward with value-based care and supporting the expansion of Medicare Advantage.

- **Value-Based Purchasing.** Nationwide expansion of the Value-Based Purchasing Model gets underway in 2023, the first performance year for the program. All 50 states, the District of Columbia and territories will be required to participate in VBP, with a Total Performance Score made up of performance relative to peers in process and claims-based measures as well as some CAHPS survey measures. Providers will receive a positive or negative payment adjustment in 2025 based on 2023 scores.

- **Medicare Advantage.** CMS continues to support MA health plans that provide supplemental benefits designed to reduce costs and improve quality. The number of Medicare Advantage plans is growing -- and proposed legislation known as the Choose Home Care Act, under committee review in U.S. Congress at the time I am writing this, is expected to further accelerate the use of home health by MA beneficiaries. The proposed Act would establish a 30-day supplement to the existing home health benefit and cover expanded skilled nursing, therapy, personal care, telehealth services and more for approved Medicare beneficiaries with higher acuity health care needs who choose home-based care over facility care.

- **VBID for hospice.** Medicare Advantage is edging strongly into the hospice arena, too. CMS began testing a hospice component of the Value-Based Insurance Design (VBID) model earlier this year, VBID is a model CMS relies on to test the impact of supplemental benefits on select groups of chronically ill patients and socioeconomic groups. Since 2017, a growing number of states have been included in VBID testing models for diabetes, congestive heart failure, hypertension, rheumatoid arthritis, dementia, and many other chronic conditions. For plan year 2022, 13 of the 34 MAOs are participating in the hospice benefit component under VBID in 49 states, the District of Columbia and Puerto Rico.

The expansion of VBP, VBID and growing numbers of MA beneficiaries are bringing a much greater volume of work to billing departments. As an example, hospices serving a patient with an MA plan under VBID must send all notices and claims to both the participating MAO and their Medicare administrator contractor (MAC). Although the MAO will process the payment, the MAC will process claims for informational purposes so that CMS can track data.

Many operational questions are yet to be answered about increasing MA plans, VBP and VBID. Will new operational processes be needed for simultaneous claims processing? Will different billing expertise be required? Will different plans require different documentation to support eligibility? If so, how often?

These changes will continue to impact the complexity of billing, requiring greater expertise.

A healthy revenue process

As managing the revenue cycle becomes more complex, many organizations are realizing the difficulty in devoting full resources to handle the changes and stay on top of increasing demands for accuracy, efficiency, and compliance acumen.

Outsourced billing and coding services have long been an industry staple, but we're seeing explosive growth in outsourced services for full revenue cycle management, which includes all aspects of claims processing, from eligibility and insurance verification to document management, claims processing, submission and management, and cash posting.

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With the acquisition earlier this year of two additional companies, Imark Billing and Infinity, SimiTree has positioned itself to bring a healthy revenue cycle management process to clients of all sizes, from start-up to enterprise operations, and across all facets of the post-acute spectrum: home health, hospice and palliative care, facilities, behavioral health service providers and more. Multiple teams of expert coders & OASIS reviewers are ready to handle the complexities of coding for today's patient-centric reimbursement models.

We understand that all revenue cycle functions work together, to create peak performance. Our revenue cycle management is supported by financial consulting, operational and compliance improvement, along with a full complement of strategic growth and development services ranging from sales training to interim management and leadership development.

And our robust data analytics capabilities give us an edge in data tracking and benchmarking, allowing clients a comparative look at how they measure up against national data and more. Data analytics continue to play an increasing role in productivity and efficiency by tracking query response rates, physician engagement and care collaboration. Our proprietary software allows clients to target specific process points where problems occur, slowing the claims process.

We feel confident in our ability to meet our client needs as we move forward with the continuing transformation of the post-acute revenue cycle.

Technology will be one of the keys to success in tomorrow's revenue cycle.

The Future of RCM: Bots, Cash and Carry, more

Some of the toughest challenges for the revenue cycle are still to come, as our industry balances a patient-first approach driven by patient experience and better communication with the continuing need to shore up margins and maximize revenue.

Healthcare has been dubbed the "the new Cash and Carry Frontier," with growing numbers of payment-plans offered for private duty and co-payments, and our industry must work out its place in that mix.

Technology will be one of the keys to success in tomorrow's revenue cycle, with bots taking over many of repetitive claim status and prior authorization tasks now filling up the human workday. If a human can manually key in 40 accounts per day and a bot can work on 400 accounts in the same day, it makes sense to automate those repetitive and transactional tasks.

In doing so, we'll free up our greatest asset: the smart team members who put their expertise to work.

Need help with your revenue cycle?

SimiTree knows it can be challenging for your agency to stay abreast of the changes.

We'll provide the expertise and resources you need, handling the work for you with our full array of outsourced billing, collections, cash posting and revenue cycle management services.

With newly expanded resources, we're ready to deploy quickly, becoming a friendly extension of your own team. Our expanded resources enable us to field the expertise needed without long wait times, offering both outsourcing solutions and consulting services to help with cash flow, compliance, claims processing delays, and profitability.

Reach out to learn how SimiTree can help your agency and get a free quote on our outsourced billing and full revenue cycle management services. Use the form below to let us know how we can help.

Mike Freytag,
Managing Principal EVP Outsourced Services

SimiTree Principal Mike Freytag has an impressive history of operational, financial, managerial, revenue cycle and accountable receivable experience across the post-acute spectrum, from home health and hospice to ABA and behavioral providers. He often serves in interim management roles for SimiTree clients, helping providers increase revenue, improve operations and ensure accurate reimbursement.

Freytag holds a Bachelor of Science degree in Finance from Villanova University.

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