American HealthTech

Revenue Cycle Trends in 2016

Cut through the complexity with these insights

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Looking into 2016, skilled nursing organizations will increasingly focus their revenue cycle management attention on the shift towards a more value-based healthcare delivery model. This transition from a fee-for-service (FFS) reimbursement system to one based on value is one of the greatest financial challenges SNF revenue cycle and financial leaders will face.

This eBook outlines the top five trends that we see impacting skilled nursing revenue cycle operations in 2016. A well-run revenue cycle management (RCM) function is critical to the success of every skilled nursing organization: how effectively this process is carried out will determine the overall financial health of your organization. As healthcare delivery models change, skilled nursing providers will need to reshape their revenue cycle management process to stay on top of these trends while continuing to reduce operating costs, preserve cash flow and deliver good quality outcomes.

#1 Managed Care Administration

Medicaid expansion represents a growing market for Managed Care Organizations (MCOs), as with millions of new enrollees come aboard as a direct result of the Affordable Care in Act (ACA) implementation. Currently, there are 33 states that have expanded their Medicaid eligibility programs. The theme in 2016 for Medicaid managed care will be continued growth.

Medicare Advantage plans will be more prevalent in the future. SNF organizations should concentrate on the management of costs as well as quality. Medicare Advantage plan expansion will continue to explore innovative quality-based contracting and other mechanisms to manage costs.

#2 Shared Risk, Value-Based Care and Alternative Payment Models

SNF providers will increasingly be asked to test their business processes and ability to bear risk. The Centers for Medicare and Medicaid Services (CMS) has set goals and a specific timeline to attach an increasing proportion of Medicare fee-for-service (FFS) payment to quality or value through 2018. Regardless of the risk arrangement, health plans may consider oversight programs to ensure contracted providers manage risk appropriately. Some of these programs include bundled payments, collectively known as the Bundled Payments for Care Improvement (BPCI) Initiatives. One of these initiatives, BPCI Model 3: Retrospective Post Acute Care Only - now puts SNFs at the helm to manage payments among other healthcare providers for post-acute care. Medicare will continue to make FFS payments and the total expenditure for the episode of care will later be reconciled against a bundled payment amount. A payment or recoupment amount will then be made by Medicare reflecting the aggregate expenditures compared to the target price (bundled payment).

22% of SNFs are now participating the CMS bundled payment demonstration and more will be participating during the risk-bearing phase. Bundled payment models will continue to place a much higher premium on clinical efficiency and discipline, which will increase and strengthen partnerships between acute and post-acute providers.

#3 Reconciling Value-Based Payments in a Fee-for-Service Environment

Value-based payment contracts are in the early pilot stages and most are constructed according to a shared savings model. Arrangements differ, but there is one unifying source to provide incentives to providers to reduce the spend on a defined patient population: cost reduction, with a percentage of the net savings returned as a bonus to the provider.

Tracking shared savings reimbursements now requires SNFs to be more advanced in their accounting capabilities. Monitoring residents, the services they are receiving and the costs to manage their care all need to contribute to a profitable result. Lastly, monitoring financial performance against the contract is paramount for future contract negotiations.

#4 Optimizing Margins to Offset Drops in Revenue

Without an official 'transition date' from fee-for-service to value-based reimbursement, the focus to optimize margins will be important. A decrease in revenue might take place during this transition as the frequency with which providers are reimbursed will vary. To stay afloat in the midst of this transition skilled nursing organizations should do three things: effectively manage the shared savings programs, reduce operating costs, and increase resident referrals. This can be accomplished by qualifying for all possible bonuses, identifying costs, and improving quality outcomes to be the provider of choice (and beneficiary of more referrals) in your community.

#5 Automation of Revenue Cycle Management

Automation of your revenue cycle is more critical than ever. SNFs should make the changes necessary to achieve these efficiencies so that attention can be focused your attention on the managing costs to succeed in shared savings programs. Additionally, the automation of the RCM process allows you to focus on decisions that will help to improve financial performance.

Conclusion

As payment incentives are increasingly attached to patient care, skilled nursing organizations will be faced with increasingly complicated decisions regarding how they manage their financial performance and efficiency. For many years, fee-for-service reimbursement rewarded volume rather than value or quality. In 2016, there will be continued focus on - and momentum behind - pilots and demonstration programs testing new value-based payment models. Bundled payment programs require healthcare providers across all care settings to coordinate more effectively. Instead of a payer separately reimbursing for each healthcare service provided, that payer will issue a single payment for all services provided within 90 days of the hospital discharge. One outcome of all of these changes: post-acute care providers - and skilled nursing organizations in particular - will become increasingly valued partners to Accountable Care Organizations and Managed Care Organizations. The question for your organization: how ready are you to deliver this value and embrace these fundamental changes to how the care you provide is reimbursed?

Sources:

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-04-15.html

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Lorraine Lodigiani manages the Financial and Administrative Management and Revenue Cycle Management solutions for skilled nursing organizations at American HealthTech. Her articles have appeared in numerous healthcare financial news articles and blogs, including Provider, Caring, and McKnight's Long Term Care News, with a focus on the latest technology innovations, best practice revenue cycle management, and financial operations management.

About American HealthTech

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