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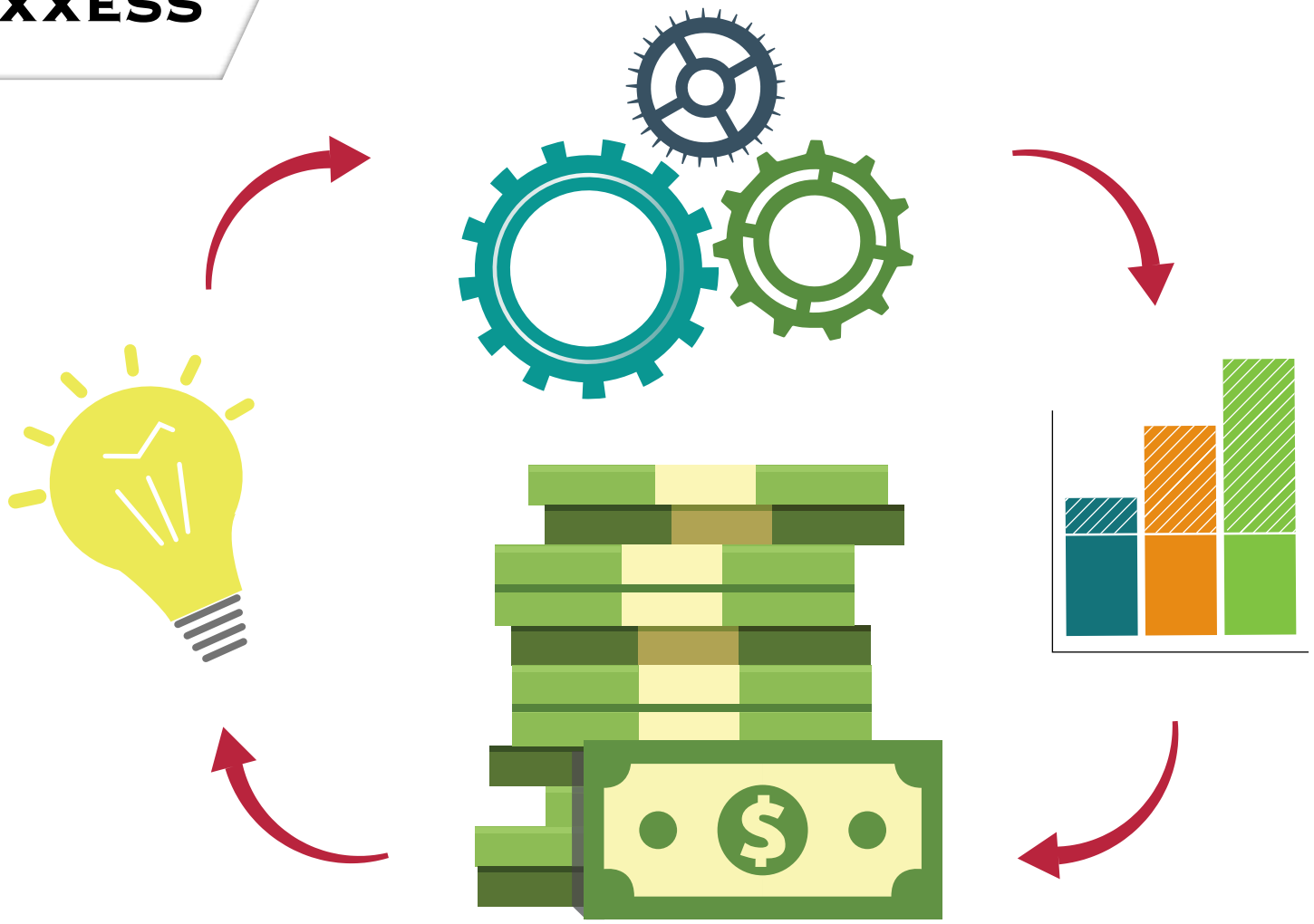

REVENUE CYCLE MANAGEMENT

Prepare your organization for change

An AXXESS White Paper

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Revenue cycle management may be the decade's hottest topic in the home care market. The industry is undergoing a complex web of changes that presents enormous operational and financial challenges to home health agencies. Now, more than ever, it's crucial that your agency has an effective revenue cycle management processes in place to be prepared for the current challenges and thrive in the future, as regulations and service models continue to evolve.

Several years ago the primary focus was on automation. Today, the focus has shifted to deploying a holistic technology platform that prioritizes patient care *(especially with Final Rule 1625-F introducing the value-based payment model to home healthcare in 2016)*, ensures compliance, and improves cash flow while also growing revenue and eliminating revenue loss.

That's a lot to ask from a revenue cycle management technology platform. Even so, now is the time to invest in your agency's future. Unfortunately, not every revenue cycle management system available will meet all of your needs. That means you must choose wisely.

This white paper discusses the implications of the transition to ICD-10 coding, the growth of the patient-centered care model, and the move towards value-based purchasing for the revenue cycle management practices of home health agencies. It also highlights the comprehensive and measurable benefits of a fully integrated, web-based, and mobile revenue cycle management technology platform.

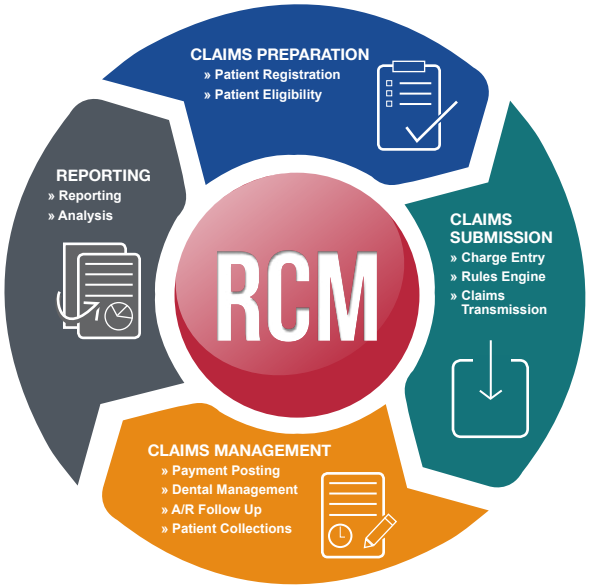


Diagram 1 & 2
Above: How Revenue Cycle Management (RCM) works.

Left: The benefits of an effective Revenue Cycle Management Program.

The home care market is facing a wide range of challenges. This $81.6 billion industry serves nearly 8 million people, and is experiencing levels of growth and transformation that threaten the success—and even the survival—of home health agencies that don't properly prepare for the future.

Three of the most pressing concerns for home health agencies during the ICD-10-CM transition are delayed and denied claims that disrupt cash flow, diminished patient care, and a reduction in productivity. These problems arise because the structure and purpose of ICD-10-CM codes are dramatically different from the ICD-9-CM codes that members of your staff have been using throughout their entire career. Consequently, your agency will have to make it through a steep learning curve.

CODING AND BILLING ERRORS

Coding and billing errors are to be expected during the transition. As your staff gains practical experience using ICD-10-CM codes, the number of errors should decrease. However, in the initial stages of the transition, errors will slow down your billing workflow and cause claims to be denied or delayed due to incorrect coding, threatening cash flow. Healthcare providers as well as government agencies will all be affected by the transition. "The likelihood that **Medicare will reject nearly one in five** of the millions of claims that go through our complex healthcare system each day represents an intolerable and unnecessary disruption to physician practices," American Medical Association President Robert M. Wah, M.D. wrote in a March 2015 letter to the Centers for Medicare and Medicaid Services. His letter was co-signed by 99 agreeing state and medical specialty societies. "Robust contingency plans must be ready on day one of the ICD-10 switchover to save precious healthcare dollars and reduce unnecessary administrative tasks that take valuable time and resources away from patient care."

REDUCTION IN PRODUCTIVITY

In addition to the cash flow disruption caused by delayed or denied claims, your agency will struggle through a reduction in productivity. Because the challenges raised by the ICD-10-CM transition can cause a ripple effect throughout your revenue cycle management processes, the greatest impact to productivity will be in the areas of coding, health information management, case management, and billing. The time staff members spend on learning the new codes as well as tracking, reworking, and reprocessing delayed and denied claims will reduce the amount of time they have to spend on their primary job functions. Naturally, this leads to a reduction in overall productivity.

Medicare will reject nearly **1** in **5** claims

DIMINISHED PATIENT CARE

The same factors that cause a reduction in productivity also lead to diminished patient care. When your staff is dealing with all of the additional administrative burdens caused by the ICD-10-CM transition, there is an increased likelihood that their focus on patient care will suffer. That's the exact opposite outcome that all of the changes in the healthcare market are designed to produce.

The questions you should be asking yourself today are:

- Can your agency meet payroll and handle all of its other operational costs if 20% of the claims your agency submits to Medicare are delayed or denied due to coding and billing errors?
- Is your agency able to survive a significant decrease in productivity?
- How will you maintain the level of attention and care your patients need with the added administrative burden during the transition?
- Are your current revenue cycle management processes capable of preventing or diminishing the impact of the anticipated financial disruptions and administrative burdens?

Now that ICD-10-CM is here, if you aren't satisfied with your answers to these questions, the survival of your agency is at risk.

Whether it's referred to as value-based purchasing or pay-for-performance a broad set of payment strategies that link financial incentives to performance, is on the horizon for home health agencies.

THE NEW VALUE-BASED PURCHASING PROGRAM

In accordance with the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) issued Final Rule CMS-1625-F in October 2015, which introduces a value-based purchasing program to reward home health organizations based on the quality of care they provide to Medicare patients, adherence to best clinical practices, and how well the clinician enhances patient experience. The overarching goal is to improve the value of healthcare services at an affordable cost, improve patient outcomes, and return attention to patient-focused care instead of the volume of services provided.

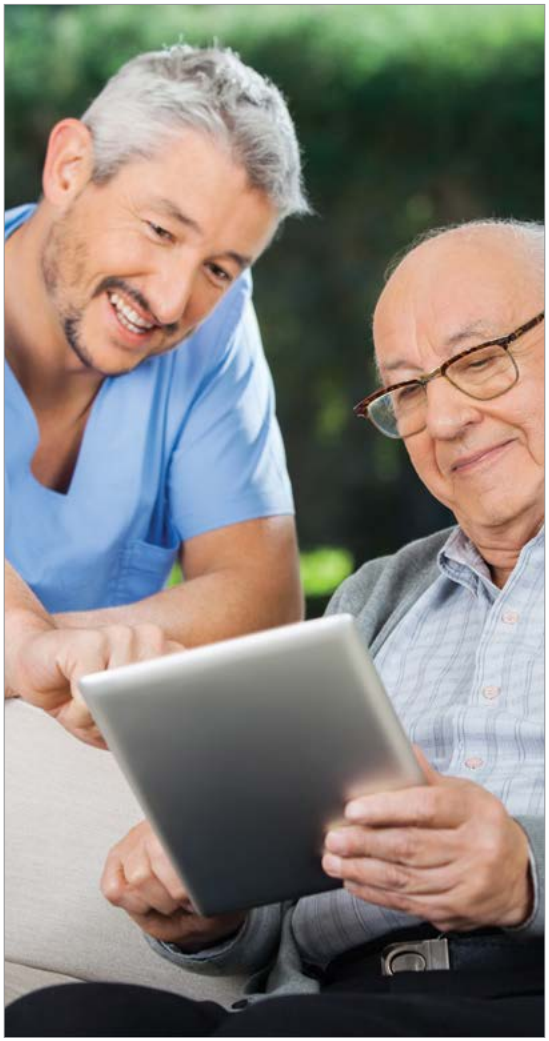
IMPLICATIONS FOR HOME HEALTH AGENCIES

The pilot home health value-based purchasing program will have the following impacts on home health agencies serving patients in these nine initial states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee:

- **Potentially Lower Medicare Reimbursement Rates –** The program will either reduce or increase Medicare payments in a range of 5% to 8%. CMS projects that 10% of agencies will experience payment reductions ranging from 2.26% to 3.3%.
- **New Performance Measures –** The level of your payment increases or reductions will depend on whether your agency falls below, meets, or exceeds performance standards based on a range of quality and efficiency metrics that will likely differ from your existing internal performance measures
- **Improved Integration with other Providers –** Home health agencies must improve their integration of care practices with other providers—including hospitals—to improve patient access to care and health outcomes.

CMS: 10% of agencies will experience payment reductions ranging from **2.26%** to **3.3%**

Fortunately for home health agencies, the value-based purchasing program is designed by CMS to coordinate with current home health requirements to minimize the burden of implementation. Even so, to survive the transition from fee-for-services to value-based purchasing, home health agencies must deploy innovative, integrated technology solutions that improve efficiency, increase accuracy, simplify reporting, and support better patient outcomes.



For the most part, healthcare providers still work in a provider-centered system. This means that the type of care patients receive is defined by established guidelines and procedures without much input from the patient. In contrast, the patient-centered care model focuses on improving provider-patient interaction through the use of skills and behaviors that are responsive to the needs and values of each individual patient.

THE VALUES UNDERLYING THE PATIENT-CENTERED CARE MODEL

In action, patient-centered care means that patients are listened to, informed, respected, and involved in their care. Additionally, care providers prioritize honoring the wishes of their patients.

The effectiveness of the patient-centered care model is based on the understanding that patients know best how well their health providers are meeting their needs. Home health agencies—as well as other providers—that practice patient-centered care tend to improve their patients' health outcomes and level of satisfaction simply by improving the quality of the provider-patient relationship. There is also typically a reduction in expensive diagnostic testing, prescriptions, hospitalizations, and referrals.

IMPLICATIONS FOR HOME HEALTH AGENCIES

Agencies that successfully undergo a culture change that prepares for and embraces the ICD-10-CM transition, value-based purchasing, effective coordination of care with other healthcare settings, and patient-centered care have the best chance of thriving in this new service era. That's because each of these developments directly impact your bottom line.

To maximize reimbursement, your agency must excel during the ICD-10-CM transition while also improving patient outcomes. Adopting a patient-centered care model keeps your staff focused on the types of activities and behaviors that recent and future changes in the healthcare system value.

The downside of the patient-centered model for your agency is the trade-off between spending more time with patients and patient volume. Your agency might provide fewer services, and that can have a negative impact on your agency's cash flow.

You can expect the healthcare system to continue focusing more and more on the patient. With this growing movement in mind, you must take a holistic approach to your revenue cycle management.

Essentially, revenue cycle management is a term that describes everything involved with the management of your agency's cash flow. That includes all of the administrative and clinical functions that contribute to the management and collection of patient service revenue.

Effective revenue cycle management streamlines these processes. When you get it right, your agency and your patients experience valuable benefits.

BENEFITS FOR THE HOME HEALTH AGENCY

The goal of revenue cycle management is to track and facilitate the claims process at every point throughout the revenue cycle. When this is done effectively, cash flows smoothly and predictably, allowing you to comfortably handle your agency's financial obligations and use the capital you've earned to grow your business. Additionally, effective revenue cycle management enables your agency to enjoy a reduction in the cost of collection and avoid reimbursement losses.

The benefits of revenue cycle management go beyond creating a reliable cash flow, preventing lost reimbursement, and reducing the cost to collect. A properly managed revenue cycle also improves compliance.

That's because revenue cycle management processes for home health agencies naturally align with compliance processes. All of the effort that goes into insurance eligibility verification, scheduling, documenting, coding, claims submission, and other processes forms a solid foundation for compliance. When each revenue cycle management step is performed correctly and efficiently, not only will claims will be paid in a timely manner, your agency will also be operating in compliance.

BENEFITS FOR PATIENTS

The benefits that patients experience flow from the same source as the benefits your agency experiences. When your staff spends less time on administrative functions involving coding, billing, insurance reimbursement, Medicare reimbursement, debt collection, and compliance, they have more time to spend on providing high-quality care to patients.

With more time centered on the patient, your staff can improve health outcomes, enrich the provider-patient relationship, and increase the level of patient satisfaction.

When you get it right, your agency and your patients experience valuable benefits

A HOME HEALTH TECHNOLOGY PLATFORM OPTIMIZES RCM

The best way to achieve effective revenue cycle management is to deploy a purpose-built, fully integrated technology platform that optimizes every process. This solution makes it easier for you and your staff to keep a finger on the financial pulse of the agency while also providing top-quality patient care.

When searching for a home health technology platform, it's crucial you select one that provides all—not just a few—of the following benefits:

Determine Medicare Eligibility: Because primary payer sources for Medicare patients change frequently, it's important to have access to current eligibility data. Avoiding eligibility errors early in the revenue cycle management process avoids problems when claims are submitted. If an eligibility mistake is made, the right solution can easily identify the problem and quickly correct it.

Improve Cash Flow: Real-time access to billing, automated claims processing, and detailed payment status means that your agency will get paid faster, improve its cash flow, and increase productivity.

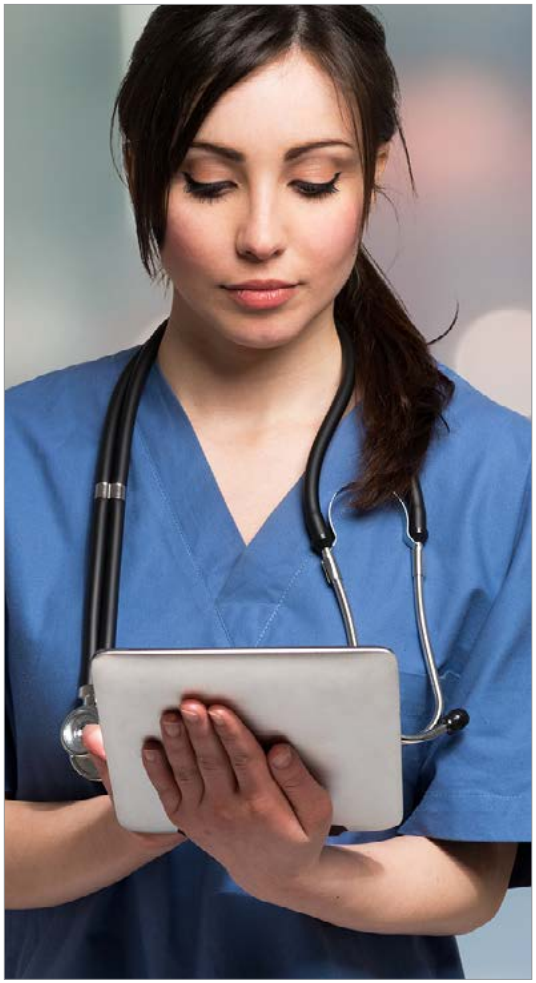
Eliminate Revenue Loss: The ability to process, track, and fix rejected claims in real time allows your agency to capture all earned revenue while eliminating costly, time-consuming processes.

Simplify Financial Reporting: To operate and grow your business, you need accurate projections for upcoming payments and deposits. Powerful and flexible reporting capabilities enable you to manage budgets and know that money will be available for payroll and other financial obligations.

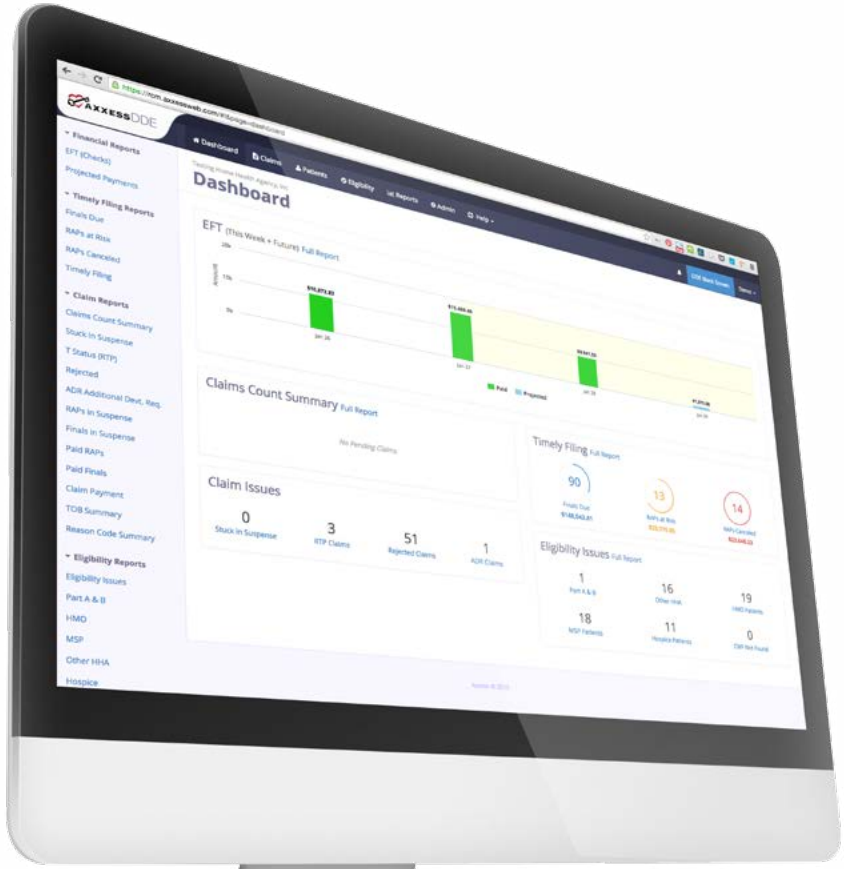
Ensure Compliance: Because compliance is always a moving target, the best revenue cycle management platform will be kept current by the provider as new regulations go into effect to ensure consistent compliance.

Access Anytime, Anywhere: Your staff can work from wherever they are and whenever they choose with a cloud-based platform. There is no software to install and upgrade, so your ongoing administrative costs are lower.

Grow Your Business: The most efficient solution is a fully integrated solution. That means it contains all of the required clinical and administrative software components in one secure location, allowing users to easily view, enter, and update data as well as identify and correct issues that may cause payment delays. Powerful reporting dashboards allow your staff to monitor operations.



INVEST IN AN EFFECTIVE RCM SOLUTION AND BILLING SERVICES



Preparing for the future requires more than mere automation. It's crucial that you invest in a revenue cycle management solution that ensures your agency will be prepared to handle the challenges it will face in the coming years.

The best way to provide the highest level of patient care while also optimizing your business process is to implement a user-friendly, fully-integrated, cloud-based home care revenue cycle management solution, and entrust your billing services to a partner that will maximize your revenue. With this technology in place, you will be able to maintain and grow an efficient, profitable, and compliant home healthcare business that is focused on patient care.

Axxess understands your agency's needs and has developed **AxxessDDE**, a comprehensive revenue cycle management tool, and **AxxessBilling**, our complete billing services to give you all of the benefits you need to succeed. To learn more about **AxxessDDE** and its comprehensive billing services visit **Axxess.com**. While there, you can schedule a personalized demo with industry experts and consultants who are eager to assist you, and ***Sign Up for a free 60-day trial***.

Axxess is a healthcare technology and solutions company with roots firmly embedded in consulting and software development. Established in 2007 as a consulting firm specializing in the home healthcare industry, Axxess identified an unmet need for software that is comprehensive, fully integrated, user friendly, and scalable.

After assembling a multidisciplinary team of technology experts, home health agency veterans, physicians, nurses and therapists, Axxess launched **AgencyCore** and **AxxessDDE**. Available as web-based software, **AgencyCore**, **AxxessDDE** and **AxxessBilling** help home health agencies run their businesses efficiently.

A nationwide leader in providing integrated software to home health agencies, Axxess is the first and only home health software provider accredited by the American Nurses Credentialing Center, a subsidiary of the American Nurses Association.

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