Medicare PPS ……The Revenue…. It's a Changin'!
Should You Re-Examine How You Recognize The Revenue and Evaluate Costs?

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Well, isn't the recent CMS Notice of Proposed Rule Making, issued on April 27th, interesting? It changes a lot of things providers have relied on since the inception of PPS. Providers who most enjoyed the revenue value of the ten-visit therapy threshold may experience the biggest change…downward. CMS will adjust payments for therapy based upon the actual visits and episodes from the end-of episode billing. The base rate is being reduced by $52.77 for all providers, which is the amount that had represented the average payment for non-routine medical supplies. Providers that experience considerable use and the expense of non-routine medical supplies, will receive compensation (revenue), but **only** if they bill for them. Providers who do not provide non-routine medical supplies or do not bill for supplies even when they provide them, will only receive $12.96 to cover the loss of the base rate payment, unless that changes in the final rule.

PPS revenue is still prospective! CMS had considered a "per visit" payment component in declining dollar values for therapy visits after the new minimum thresholds of six, fourteen and twenty visits has been reached, but opted for incremental thresholds instead. Additionally, there will be a new separately determined revenue amount for non-routine medical supplies. With the exception of the $12.96 for a zero clinical domain score, supplies are no longer bundled in the base rate. Agencies that are recognizing revenue based on the amounts of the RAP and End of Episode as they are submitted for payment have monthly financial statements that are probably the least accurate and most misleading. Simply recognizing revenue using a daily rate based upon the episode's initial HHRG value, either for an average episode length of service or for the entire sixty-day period may not be the best answer to accurately determine your revenue, gross profit levels and actual profitability, especially in light of CMS' new "four-legged" model for case weights. Sound confusing? Well it is! And, you're not alone. So, what's an agency CFO to do?

To more accurately record and report PPS revenue, providers need to now consider implementing a method that **recognizes the revenue as expenses are actually incurred**…when the visits are made and the supplies are provided to the patients. To accomplish this approach, standard revenue values must established for each discipline and for each type of non-routine medical supply. The values must be based upon actual HHRG revenue factors. The recorded revenue for both visits and non-routine supplies for entire closed episodes should be reconciled with the dollar values of the final end-of-episode bills billable at the end of each month. This type of methodology follows the requirements of the AICPA matching revenue and expense. Use of this methodology assures that visit and supply revenues are recorded in the proper period for all open episodes as well, and gross profit levels for each service revenue category can be examined.

Visit costs must now be evaluated and measured differently. Simple average total cost per visit for each discipline can no longer be used to measure actual profitability or loss differences with visit variations, especially since there are varying therapy payment rates. The direct costs of a visit are the basic variables to be measured against incremental revenue, especially for therapies. The measure of differential direct costs depends upon the method of staff compensation. Differential direct cost for therapy staff paid on a per visit basis is the entire direct cost of salary, payroll taxes, fringe benefits, retirement contributions, workers compensation and auto allowance/reimbursement. When overtime is not an issue, the real differential cost is just the additional auto allowance/reimbursement for salaried staff or those compensated on an hourly

basis. If overtime is an issue, the overtime compensation, payroll taxes, workers compensation and retirement program (etc.) contributions are also included in the differential cost. The actual profitability or loss contribution of each additional therapy visit over the six-visit threshold is the incremental revenue of the visit less the differential cost. This concept is always used in the business world.

This is an example of the recognition differences for those providers that are recognizing Medicare PPS revenue using either 60 days or the days of an episode average LOS (estimated at 42 days) as a divisor for the amount indicated by the original HHRG. This actual case study is Mrs. Jones, an 80 year old woman whose 2nd episode of care began on March 12th. She is seen for dressing changes for a stage 2 sacral decubitus ulcer, medication monitoring and assessing, and for physical therapy due to debilitation from a CVA six month earlier. The 2008 HHRG score of C3F2S2 with a value of $2,846.32. The non-routine medical supply severity score is 1 with a value of $54.65. The total value of the episode was $2,900.97. The orders in the original plan of care was SN visits 2W3, 1W2 = 8 and PT visits 2W3 = 6. The orders were modified to SN visits 2W3, 1W2 = 8 and PT visits 2W4, 1W1 = 9. The HHRG score changed to C3F2S3 with a value of $3,281.38. She was discharged on April 15th. When recognizing revenue with an average daily rate, the HHRG score change would probably have to be captured at the recognition period, if it was actually identified when either billed to or paid by CMS.

The provider agency has established per visit rates of $185.00 for SN and $190.00 for PT, utilizing NAHC recommended methods #2 or #3. The individual non-routine medical supplies have been billed. To establish the charges rates, the vendor cost of the supplies was increased for overhead allocations and then marked up just 10%.

The "per day" rate for a 60-day episode is $48.35 ($2,846.32+54.65 = $2,900.97/60). The "per day" rate for a 42-day (episode average LOS) is $69.07 ($2,846.32+54.65 = $2,900.97/42). The following illustrates the differences in the realized revenue for each of the methods relative to the costs of the visits provided to the patient.

Revenue Recognition

	Rate	March (20 Days)	April (15 Days)	Amount Recognized	Amount Adjusted		Total Revenue
60 Day Period	$48.35	$967.00	$725.25	$1,692.25	$1,208.72		$2,900,97
42 Day Period	$69.07	$1,381.40	$1,036.05	$2,417.45	$483.52		$2,900.97
As Billed							
Initial Episode	60-40%	$1,740.58	$1,158.39	$2,900.97			$2,900.97
Subseq. Episode	50-50%	$1,150.49	$1,150.48	$2,900.97			$2,900.97
Per Visit							
SN	$185.00	$1,110.00	$370.00	$1,480.00	-		$1,480.00
PT	$190.00	$1,140.00	$570.00	$1,710.00	-		$1,710.00
Visit Revenue		$2,250.00	$940.00	$3,190.00	-		$3,190.00
Med. Supplies		$ 73.57	-	$ 73.57	-		$ 73.57
Adjustment		-	-	-	$ 17.81		$ 17.81
Total Per Visit		$2,323.57	$940.00	$3,263.57	$ 17.81		$3,281.38

The above table clearly demonstrates the distortions to revenue using a method of recognition that does not match revenue with the activities and related costs. The financial statement could very easily portray losses within ongoing episodes and for any particular month, when in fact they were probably profitable. Such inaccurate information could easily lead to unnecessary precipitous decisions by management that could negatively effect clinical and/or administrative

operations, or in other words, “knee jerk” reactions. Many hospital-based agencies have been sold or closed in the last several years because decisions were made based upon revenues and financial results that were incorrectly portrayed on financial statements.

Evaluating the differential costs for the additional PT visits that does not change the S score should be done prior to the visits being made so there are not any surprises. Decision should be based upon patient outcomes, not just on the finances, but there should be a firm understanding of the financial effects in advance.

Since Medicare PPS is becoming more sophisticated and complex, so must the providers become more sophisticated and knowledgeable about there own operations, revenues, costs and incremental profitability. ***Profitability cannot just be calculated by using averages…attention to detail is important and…as “they” say…the devil is in the detail!***