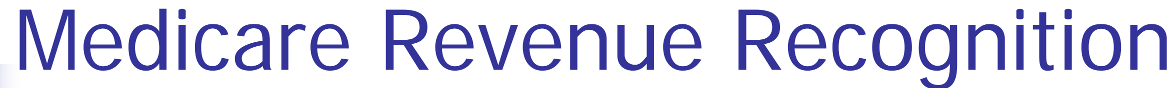
Presented By:

Pat Laff
Laff Associates,
and
H. Kenneth McNulty
Visiting Nurse Association of Boston

with materials prepared by
William J. Simione, Jr., CPA, FHHC
Simione Consultants, LLC



Medicare Revenue Recognition

Why is Accurate Revenue Recognition so Critical?

- Proper Matching of Revenue with Related Expenses Produces the Most Accurate Financial Picture of Operations
- Analysis of Past Periods and Planning for Future Periods
- Accuracy of Performance Accountability
  - To the Board of Directors and Parent Organizations
  - Of the Line Staff Directors, Managers and Supervisors
- Credit Line Relationships and Obligations
- Adherence to GAAP and Audit Requirements

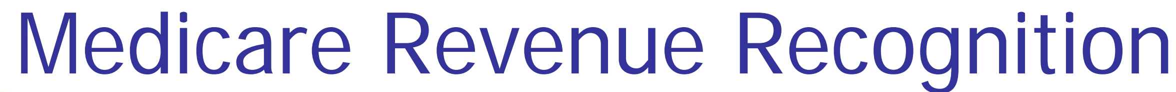
Recording Gross Medicare Revenue at Public/Visit Charges (Hospital Based/Affiliated Providers)

- CFOs of health care systems, based on recommendation of their auditors, are requiring their home health agencies (hospital based and/or affiliated) to record their gross Medicare revenue using gross charges per visit.
- Reason for this methodology:

  All hospital departments and/or subsidiaries "gross up" their revenue to their publish charges. Gross revenue needs to be consistent other departments and/or subsidiaries.

  Contractual allowance is used to adjust the gross revenue to the recognized HHRG amount.

  Recognized revenue should be further reduced for Medicare adjustments (i.e. LUPA, PEP, Therapy, etc.)



Medicare Revenue Recognition

Straight Line Day Method
Using Average Length of an Episode

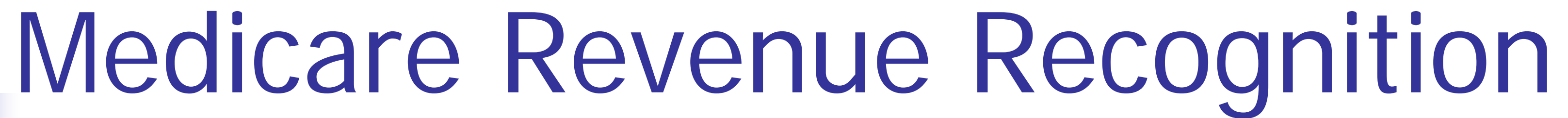
Prepared By

William J. Simione, Jr., CPA, FHHC

Simione Consultants, LLC

Medicare Revenue Recognition
Straight Line
Average Length of an Episode

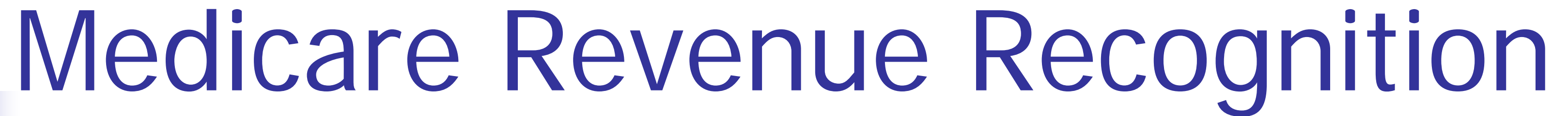
- Process
  - Agency computes the average length of an episode (ALOE) as either a rolling 12 month average or as the prior years ALOE
    - The ALOE differs from the average length of stay(ALOS) in that the ALOS is the time a patient is on service from admission date to discharge date, whereas the ALOE is the time from the episode start date to the end of the episode
  - Recommendation to change ALOE at a maximum every quarter if using 12 month rolling average. More frequent changes might not reflect current trend
  - Method can be used on either a patient-by-patient basis or in the aggregate



Medicare Revenue Recognition

- Aggregated Basis
  - The gross HHRGs for all episodes beginning in the month (whether initial or recert) are deferred and recognized over the ALOE
  - For the month the episodes begin, revenue is recognized assuming all patient episodes began on the middle day of the month. The following month, the balance of revenue is recognized, unless the ALOE minus the number of days recognized in the previous month is greater than the number of days in the current month.

Medicare Revenue Recognition



- Pros
  - Matches revenue and expenses
  - Allocation basis is consistent with agency's current trends
  - Methodology is simple as the average length of an episode should be easily obtained
  - Does not depend on the agency's information system for the calculation of revenue
  - Allows the agency to recognize revenue either on a patient-by-patient basis or in the aggregate

Medicare Revenue Recognition Straight Line Average Length of an Episode

- Cons
  - Agency must enter discharge dates into their information system **timely**
  - The average length of an episode must be accessible from the agency's information system
  - A periodic review of the current average length of an episode needs to be completed

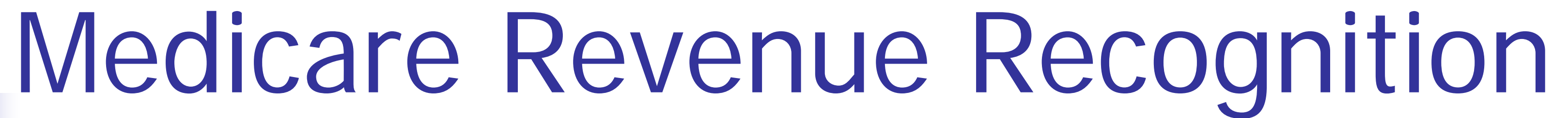
Medicare Revenue Recognition

Percentage of Completion Model Using Current Twelve Month Rolling Average of Total Visit Cost

Presented by

H. Kenneth McNulty

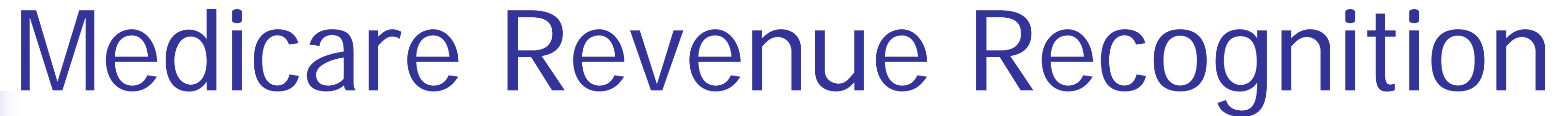
Visiting Nurse Association of Boston



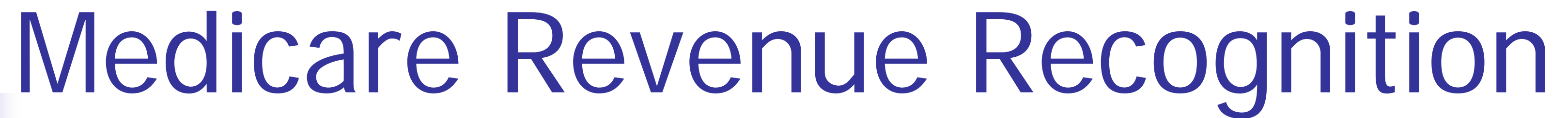
Medicare Revenue Recognition

- Purpose
  - Match revenue with expense
  - Allow flexibility to adjust for changing patterns of care
  - Simplify the recording of monthly income
  - Report monthly income that reflects the cost of individual visits and hours
  - Recognize actual HHRGs to report income

Medicare Revenue Recognition

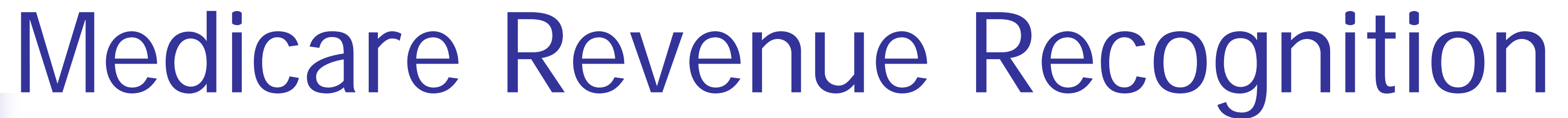


- Purpose
  - Establish actual gross profit margins
  - Uses current year activity to spread expenses
  - Assumes no markup on supplies and that supply costs are included in the visit cost



Medicare Revenue Recognition

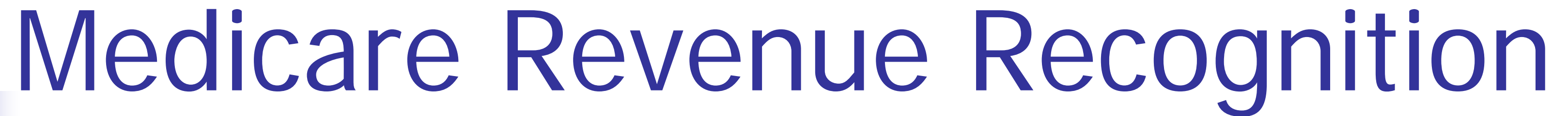
- Process
  - The provider prepares a twelve month rolling cost report quarterly
  - Cost report can be the Medicare Cost Report or any other cost method the provider wishes
  - Cost report includes all direct and indirect costs per visit or hour



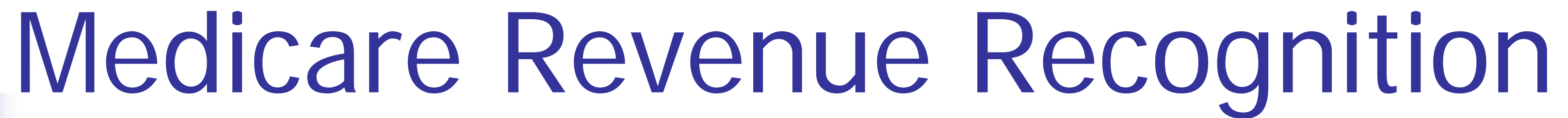
Medicare Revenue Recognition

- Process
  - Determine the number of visits and hours by discipline within the episodes
  - Split them into 15 day increments
    - Day 1 - 15
    - Day 16 - 30
    - Day 31 - 45
    - Day 46 - 60

Medicare Revenue Recognition



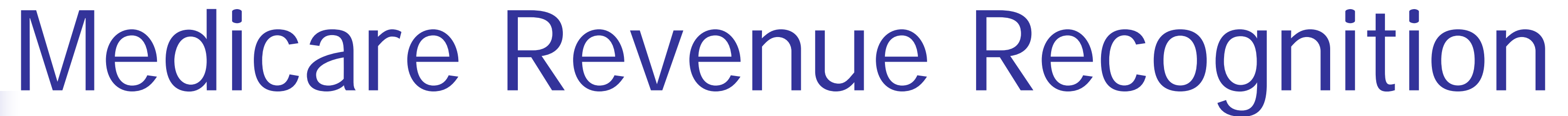
- Process
  - Price out with the cost per episode segment
    - Use the cost per visit or hour
    - Use the visit and hours
    - Calculate the total cost for each of the 4 segments of an episode
  - Determine the ratio of expenses in each 15 day period
  - Use these ratios to recognize revenue



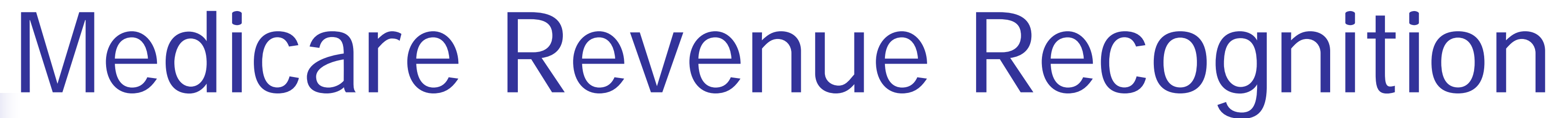
Medicare Revenue Recognition

- Process
  - Apply the ratio to the aggregate HHRG generated revenue for the month to determine the amount allocated over the 60 day episode
  - Apply the ratio to the calendar month
    - 1st month Day 1 - 15
    - 2nd month Day 16 - 30
    - 2nd month Day 31 - 45
    - 3rd month Day 46 - 60

Medicare Revenue Recognition



- Process
  - Adjust deferred revenue each month using the deferral calculated above
  - Allows for additional reserves for PEP or M0825 reserves



Medicare Revenue Recognition

- Process
  - Redo cost report and ratios quarterly to test for changes in visit or cost patterns
  - Adjust ratios as necessary

Presented By: Pat Laff

117 Club Course Drive
Hilton Head Island, SC 29928
(843) 671 - 4170

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

PURPOSE

- Recognize Revenue in Direct Relationship to Operational Activity.
  - Unit of Service and Product Expense.
- Utilize Consistent Revenue Rates for Each Unit of Service and Product.
- Accurately Recognize Adjusted HHRG Revenue as Episodes are Closed.
- Update Rates as Necessary to Assure Highest Degree of Monthly Accuracy of Visit and Product Activity for Open Episodes.
- Establish Actual Gross Profit Margins.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Process - Initial Rate Calculations

- Visit Rates and Medical Supply Revenue are Based upon Actual HHRG Data From the Previous Year's (PS&R Data) Closed Episodes.
  - Actual Visits by Discipline.
  - Vendor Cost of Billable Medical Supplies.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Process - Initial Rate Calculations

- The Ratio of Vendor Cost of Medical Supplies to Total Cost is Determined

  (from Medicare Cost Report or Cost Accounting Methodology).
- The Desired Markup From Total Cost is Established.
- The Ratio of Vendor Cost To Revenue is Applied to the Vendor Cost of Medical Supplies in the Closed Episodes to Determine Medical Supply Revenue.

Process - Initial Rate Calculations

- The Direct Costs for Each Discipline for the Previous Fiscal Year is Divided by the Respective Number of Visits to Determine the Direct Costs per Visit.
- A Variance from the Direct Cost of Skilled Nursing is Determined for Each of the Other Disciplines.
- The Non-Nursing Visits are Converted to Nursing Visit Equivalents Using the Variances and Totaled.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Process - Initial Rate Calculations

- The Determined PPS Medical Supply Revenue is Subtracted from the Total HHRG Revenue to Establish the Revenue Allocated to the Closed Episode Visits.
- The Revenue Allocated to the Closed Episode Visits is divided by the Total Nursing Visit Equivalents to Determine the Revenue per Nursing Visit Equivalent.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Process - Initial Rate Calculations

- The Revenue for Each of the Other Disciplines is Determined by Multiplying the Revenue per Nursing Visit Equivalent by Each Respective Discipline Variance.
- Each of the Respective Revenue Rates are Rounded Up or Down to the Agency's specifications (Even Dollar or Five Dollar Value, etc.).
- These Rates and the Medical Supply Charge Ratio may be Used for all Payors, if appropriate.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Revenue Recognition - Initial & Each Year

- Monthly Activity
  - Recognize Medicare PPS Revenue Based upon the Medicare Visits at the Specific New Revenue Rates and the Medical Supply Cost at the Vendor Cost to Charge Ratio.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Revenue Recognition - Initial & Each Year

- Monthly Closed Episode Reconciliation
  - From the Closed Episodes, Determine the Total Number of Visits by Discipline and the Vendor Cost of Medical Supplies.
  - Using the Established Revenue Rates and Vendor Cost to Supply Ratio, Determine the Amount of Recognized Revenue.
  - Subtract the Recognized Revenue from the Actual HHRG Revenue and Recognize the Difference in a Revenue Variance Account.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Revenue Recognition - Initial & Each Year

- Rate Revision Calculations are Completed at the End of Each Fiscal Year or as Often as Deemed Appropriate.
  - Appropriateness Includes Regulatory Changes Effecting the Base Rate.
    - Market Basket
    - Labor Market Basket
    - Rural Add-on
  - Changes of Service Areas That Adds or Deletes MSAs or Non-MSAs.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Pros

- Directly Matches Revenue with Expenses for all Direct Cost Centers.
- Standardizes Revenue Rates.
- Properly Recognizes Medical Supply Revenue.
- Consistency and Accuracy of Monthly and Year to Date Income Statements.
- Can be Based on Gross or Net HHRG Revenue.
- Establishes Gross Margins and Profits.

HHRG - Per Visit and Medical Supply Medicare Revenue Recognition

Cons

- Requires Timely Visit and Supply Data for Closed Episodes and Prior to Receipt of the PS&R.
- Requires the Ability to Make the Initial and Subsequent Rate Calculations, the Monthly Reconciliations and the Related Journal Entries.

WE HAVE NOT SUCCEEDED IN ANSWERING ALL OF OUR PROBLEMS.
INDEED, WE OFTEN FEEL WE HAVE NOT COMPLETELY ANSWERED ANY OF THEM.
THE ANSWERS WE HAVE FOUND ONLY SERVE TO RAISE A WHOLE SET OF NEW QUESTIONS. IN SOME WAYS WE FEEL WE ARE AS CONFUSED AS EVER, BUT WE BELIEVE WE ARE CONFUSED ON A MUCH HIGHER LEVEL, AND ABOUT MORE IMPORTANT THINGS.