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# Health care entities

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# ***About the Health care entities guide***

PwC is pleased to offer the first edition of our *Health care entities* guide. This guide addresses the accounting for health care entities under US GAAP.

This guide summarizes the applicable accounting literature, including relevant references to and excerpts from the FASB's Accounting Standards Codification (the Codification). It also provides our insights and perspectives, interpretative and application guidance, illustrative examples, and discussion on emerging practice issues.

This guide should be used in combination with a thorough analysis of the relevant facts and circumstances, review of the authoritative accounting literature, and appropriate professional and technical advice.

## ***References to US GAAP***

Definitions, full paragraphs, and excerpts from the FASB's *Accounting Standards Codification* are clearly labelled. In some instances, guidance was cited with minor editorial modification to flow in the context of the PwC Guide. The remaining text is PwC's original content.

## ***References to other PwC guidance***

This guide provides general and specific references to chapters in other PwC guides to assist users in finding other relevant information. References to other guides are indicated by the applicable guide abbreviation followed by the specific section number. The other PwC guides referred to in this guide, including their abbreviations, are:

- *Consolidation (CG)*
- *Financial statement presentation (FSP)*
- *Financing transactions (FG)*
- *Insurance contracts (IG)*
- *Not-for-profit entities (NP)*
- *Property, plant, equipment and other assets (PPE)*
- *Revenue from contracts with customers (RR)*

## ***Guidance date***

This guide considers existing guidance as of March 31, 2023. Additional updates may be made to keep pace with significant developments. Users should ensure they are using the most recent edition available.

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***Chapter 1:***  
***Health care – accounting and  
financial reporting overview***

## 1.1 Overview and scope of health care entities

ASC 954, *Health Care Entities*, prescribes the accounting specifically for entities whose principal operations consist of providing or agreeing to provide health care services and derive all or almost all of their revenues from the sale of health care services and related goods. Also within the scope of ASC 954 are entities whose primary activities are the planning, organization, and oversight of such entities, such as parent or holding companies of health care providers.

### ASC 954-10-15-1B

The Health Care Entities Topic applies to the following types of health care entities:

- a. Clinics, medical group practices, individual practice associations, individual practitioners, emergency care facilities, laboratories, surgery centers, and other ambulatory care entities
- b. Continuing care retirement communities
- c. Health maintenance organizations and similar prepaid health care plans
- d. Home health agencies
- e. Hospitals
- f. Nursing homes that provide skilled, intermediate, and less intensive levels of health care
- g. Drug and alcohol rehabilitation centers and other rehabilitation facilities
- h. Integrated delivery systems that include one or more of the above types of entities.

Each of the entities within the scope of ASC 954 as described in ASC 954-10-15-1B provide health care services. Health care services are services provided to individuals by or under the direction of licensed medical professionals in connection with the diagnosis or treatment of an illness or injury. By extension, health care services also include the sale or rental of certain medical goods (such as medical devices, prosthetics, or durable medical equipment) that are prescribed and billed to patients or third-party payers in connection with medical treatment. Other types of entities that may be subject to ASC 954 also include laboratories that have no direct patient-facing activities or diversified companies where health care is one of several lines of business.

Health care entities in the private sector may be publicly held, privately held (e.g., by private equity investors), operated by religious organizations, or sponsored by local communities. In the public sector, they may operate under the auspices of federal, state, or local governmental authorities. Health care entities usually can be classified into one of the following categories based on their characteristics:

- **Investor-owned** – Health care entities owned by investors that provide goods or services with the objective of making a profit.
- **Not-for-profit, business oriented** – Health care entities which are characterized by no ownership interest and are essentially self-sustaining from fees charged for the sale and delivery of

goods and services. The fees charged by such entities are intended to help the entity maintain its self-sustaining status, rather than to maximize profits.

- **Not-for-profit, non-business oriented** – These are defined as voluntary health and welfare organizations; they derive the majority of their revenue from voluntary contributions from the general public to be used for general or specific purposes connected with health, welfare, or community services.
- **Governmental** – Public corporations, which are organizations founded and owned in the public interest, supported by public funds and governed by those deriving their authority from the federal, state, or local government.

Depending on their ownership and organizational structure, health care entities may be subject to different accounting and financial reporting standards. Figure HC 1-1 provides a description of the underlying accounting framework a health care entity should follow:

### Figure HC 1-1

#### Health care entities – accounting framework

Organization type	Accounting framework	Industry-specific GAAP
Investor-owned	FASB	ASC 954: Health-care entities
Not-for-profit, business oriented	FASB	ASC 954: Health-care entities
Not-for-profit, non-business oriented	FASB	ASC 958: Not-for-profit entities
Government	Governmental Accounting Standards Board (GASB) or Federal Accounting Standards Advisory Board (FASAB)	Various, including AICPA AAG-HCO Ch 15

## 1.2 FASB guidance for health care entities

ASC 954 contains industry-specific subtopics, incremental to the rest of the guidance in the codification, that are applicable to all health care entities unless they are explicitly scoped out (e.g., voluntary health and welfare providers) or because the subject matter clearly does not apply (e.g., for investor-owned healthcare organization, topics dealing with not-for-profit financial reporting). Otherwise, private sector health care entities are required to follow the guidance in ASC 954. If a health care entity conducts activities in an area covered by another industry-specific topic in the codification (e.g., ASC 944, *Financial Services -- Insurance*), it may be helpful to consider that incremental industry-specific guidance when evaluating the recognition and measurement of assets, liabilities, revenues, expenses, and gains and losses unique to those industries.

## **1.3 Nonauthoritative guidance for health care entities**

In addition to ASC 954, the AICPA and other professional organizations have issued a significant amount of nonauthoritative interpretive guidance that addresses issues specific to the health care industry.

### **1.3.1 AICPA Guidance – Audit and accounting guide**

The primary, non-authoritative source of industry-specific accounting principles, reporting practices, and auditing considerations for health care organizations is the Audit & Accounting Guide – Health care Entities (AAG-HCO).

### **1.3.2 Technical Practice Aids**

Section 6400 of the AICPA's Technical Practice Aids (TPAs) contains a number of nonauthoritative questions and answers specific to health care organizations. TPAs address the application of existing GAAP to specific issues. A listing of the TIS Section 6400 TPAs is provided in AAG-HCO Appendix B.

### **1.3.3 Other nonauthoritative guidance**

The Principles and Practices Board (P&PB) of the Healthcare Financial Management Association (HFMA) is a panel of twelve individuals who are nationally prominent in the area of health care accounting and financial reporting, and who set forth advisory recommendations on emerging accounting and reporting issues in the form of Statements and Issue Analyses. Although Statements by the P&PB are advisory in nature, they are of significant value to the industry in that they can be issued relatively quickly to disseminate consensus opinions, along with views on the issues and relevant background information, on topics for which guidance is needed. If authoritative GAAP is provided by the FASB or the AICPA that pertains to an issue addressed by a Statement of the P&PB, the statement usually is withdrawn. P&PB Issue Analyses provide short-term assistance on emerging issues.

Copies of P&PB Statements and Issue Analyses can be downloaded from HFMA's website ([www.hfma.org](http://www.hfma.org)).

## **1.4 Scope of this guide**

We have organized this guide to provide chapters that address topics that are unique to health care organizations and other relevant aspects of ASC 954, *Health care entities*.

The chapters address a variety of accounting issues relevant for health care organizations and should be used as a supplement to US GAAP and interpretive guidance applicable to reporting entities in general.

### **1.4.1 Not-for-profit financial reporting, Health care entities**

This guide does not address the financial reporting considerations for not-for-profit business oriented health care organizations included within the scope of ASC 954. Refer to our Not-for-profit entities guide for discussion of the financial reporting considerations for these entities.

#### **1.4.2 Government hospitals**

This guide does not address the accounting and reporting considerations for government health care organizations that follow accounting principles promulgated by the Governmental Accounting Standards Board. Refer to AAG-HCO 15 for discussion of the accounting and reporting considerations for governmental health care organizations.

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***Chapter 2:***  
***Fundamentals of health care  
revenue (providers)***

## 2.1 *Fundamentals of provider revenue cycle*

This chapter discusses fundamental characteristics of the revenue cycle in health care services transactions (i.e., the provision of medical services by health care providers to patients) and discusses the roles of the major participants in those transactions.

The fundamentals discussed in this chapter provide helpful background for HC 3, HC 4, and HC 5 regarding how ASC 606, *Revenue from contracts with customers*, applies to health care services transactions. In addition, this chapter highlights how different types of relationships among providers, health plans, managed care organizations (MCOs) and other intermediaries (see HC 4), and patients can affect the nature, amount, timing, and uncertainty of provider revenues and cash flows.

### 2.1.1 *Parties to revenue transactions*

A unique aspect of health care operations is that revenue transactions typically involve more parties than the traditional buyer (customer) and seller (vendor). Numerous parties may be involved in a transaction involving services to patients, including: (1) the individual who receives the care; (2) the physician who performs the services and/or orders the services on behalf of the patient; (3) the health care facility (e.g., hospital, home health company) that provides the setting (e.g., operating room) or administers the treatment (e.g., nursing or post-operative care); (4) if applicable, a third-party that pays the providers on behalf of the patient (e.g., a health insurance provider, Medicare, a health plan administrator on behalf of a private payer/employer); and (5) if applicable, various intermediaries, such as managed care organizations, physician practice management companies, or accountable care organizations. The patient may not interact or even be aware of these intermediaries, although they may influence both the type of care received and the amounts being paid.

In these transactions, the customer is the patient—the recipient of the health care services—even though services generally must be ordered on the patient’s behalf by a licensed medical professional (rather than by the “customer”) and the patient may have little ultimate responsibility for payment for the services. The party that pays for much of the cost of the services may be the government, through programs such as Medicare or Medicaid, a commercial health plan or a self-insured employer that has a contractual relationship with the patient, or an intermediary, such as a managed care organization that has contracted with a health plan or with the government. Separate contractual relationships may also exist between the payer and providers. The terms of those separate arrangements (individually or in concert) will impact the amount of revenue recognized for services provided to a patient by a provider.

For additional information regarding customers (patients) and payers in health care transactions, see HC 2.1.3 and HC 2.1.4, respectively. For additional information regarding intermediaries, see HC 4.

### 2.1.2 *Patient billing systems and “gross charges”*

When services are provided to a patient, the standard charges (often referred to as “gross charges” or “established charges”) associated with the encounter are entered into the provider’s patient billing system. In more complex settings, each input used in the process of providing care will be priced based on the established charges. For example, if a patient required stitches for an injury, charges could be generated for a suture kit, local anesthetic, syringe, bandages, and physician time. Thus, gross charges are internally recorded as the services are rendered. The data is used to create itemized bills showing all goods and services provided to a patient during an episode of treatment.

As discussed in HC 2.1.4, health plans and government programs often pay providers on a basis that differs from the provider's gross charges (e.g., based on episodes of care, diagnosis-related groupings, resource utilization groups, or number of inpatient days). Because the amounts providers are entitled to receive may bear little relationship to the gross charges, the gross charges (and related gross receivables) captured in the patient accounting system must be adjusted to reflect amounts providers are entitled to bill. Said differently, for financial statement purposes, the "gross charges" or "gross receivables" are irrelevant; revenue and accounts receivable are recognized in the financial statements based on amounts the providers are entitled to receive as consideration for the underlying services regardless of the "established charges."

Many patient billing systems use a contra-revenue account to reduce gross charges to amounts that can be recognized as revenue for financial reporting purposes. Under ASC 606 and for presentation on the statement of operations, patient service revenue is the net amount, after consideration of the contra-revenue adjustments. Predominant industry practice is to separately account for the gross components in the accounting system. The contra-revenue adjustments (and related adjustments to gross patient receivables) should be estimated and recorded in the period in which the services are provided. The contra-revenue accounts would include contractual allowances or adjustments, discounts, charity care, and allowances for implicit price concessions.

- **Contractual allowances or adjustments.** The difference between the provider's established rates for services provided and pricing under agreements with third-party payers. In traditional "fee-for-service" payment arrangements, the contractual allowance might be reflected in the individual patient ledger at the time of billing (if known) or it might be reflected later, based on notifications received from a health plan. In capitated payment arrangements (discussed in HC 4), the revenue reported in financial statements relates to the capitation fees for the stand-ready obligation to perform services, not the gross charges associated with the services actually performed.
- **Discounts.** As a matter of policy, some health care entities offer discounted rates in certain situations (e.g., to uninsured patients who do not qualify for charity care). Reductions to gross charges associated with discounts (that is, differences between the established rates and the reduced amount that, in effect, becomes an agreed-upon sales price) are, in practice, reflected as contra-revenue transactions in the underlying accounting records.
- **Charity care.** As discussed in HC 5.2.1, some patients may qualify for charity care and be granted a full or partial adjustment to their charges. No revenue should be recognized for the amount of the full or partial adjustment because no compensation is expected for these services. In practice, reductions of charges (estimated or actual) arising from charity care "write-offs" are often reflected as contra-revenue in the underlying accounting records.
- **Implicit price concessions.** If a provider does not perform credit assessments prior to providing services (and thus, provides the services without knowing whether the patient will be able to pay for the services), or if they provide services knowing that they will not be able to collect some or all of the consideration to which they would otherwise be entitled, expected uncollectable amounts are reflected as a reduction of revenues, rather than as credit losses (bad debt expense) (see HC 5.2.1). In practice, the underlying accounting records may reflect a "provision" or "allowance" for implicit price concessions for tracking purposes.

Revenue adjustments related to contractual allowances, discounts, and charity care are patient-specific; that is, they are reflected directly in individual patient accounts as reductions to the amount

billable to the patient (and if applicable, to a third-party payer). The provision for implicit price concessions, on the other hand, is not specific to individual patient accounts as an entity typically will not know how much will be collected (or remain uncollected) from specific patients. Thus, implicit price concessions are typically not “pushed down” to individual patient accounts and, thus, will not reduce the amount billed to an individual patient. A provider would continue to attempt to collect the amounts to which the provider is contractually entitled.

Notwithstanding the fact that gross charges are largely irrelevant for GAAP revenue recognition, they indicate the level of consumption of resources involved in treating a specific patient or class of patients. For example, while a government program such as Medicare might pay a hospital a flat diagnosis-related group (DRG) amount for inpatient care provided to an enrollee, the gross charges associated with that patient’s care will provide an indicator of the volume of resources actually consumed in treating that patient. For this reason, gross charge information is often used as an “input” measure of progress (that is, a methodology in which progress towards satisfying the performance obligation is evaluated based on the extent of resources consumed) when evaluating revenue that is recognized over time, as discussed in HC 3.2.5.1.

In addition, a ratio of costs to charges applied to the amount of gross charges can be used to estimate the costs of delivering a subset of the health care services. For example, as discussed in HC 5.2.2.1, a provider’s financial statements must disclose the estimated costs of charity care it provided during the reporting period. According to ASC 954-605-50-3, multiplying the gross charges written off for charity care by the ratio of costs to charges is a reasonable technique for estimating the costs of charity care.

### **2.1.3 Health care patients (customers)**

In health care services transactions, the fundamental contractual relationship is between the provider and the patient. The provider provides the services and the patient agrees to pay for those services. Unlike customers in other services transactions, however, patients may have little involvement in selecting and paying for the services they consume. This is because services generally are performed, or ordered on the patient’s behalf, by a licensed medical professional, and some or all of the payment often comes from a third-party payer, such as Medicare/Medicaid or private health insurance.

Thus, a critical element of a provider’s revenue recognition process is to classify patients based on the party or parties primarily responsible for payment of services (“payer class”). Payer or financial classes are key considerations utilized in revenue cycle monitoring, including billing and collections. In addition, these assignments typically also have a financial reporting impact as the accounting and reporting for health care revenue transactions under ASC 606 typically involve the use of portfolios disaggregated by payer classification.

Typically, a patient is assigned a payer classification when they first arrive at the provider’s office or facility. A patient with no health insurance coverage might be placed in a self-pay, charity care, or “Medicaid pending” payer class (see HC 2.1.3.2).

If the patient has health insurance or government program coverage, the patient will normally share financial responsibility with the health plan through features such as deductibles, coinsurance, or copayments (see HC 2.1.3.1). In those situations, there is no standardized or uniform approach for classifying the receivable. One entity might carry both the patient’s and payer’s portion of the receivable in the “third-party-payer class” while another might eventually shift the patient-responsible portion into a “self-pay” class (particularly after the primary payer has paid its portion). Still others

might classify accounts as either third-party or self-pay on the basis of which party has the greater share of the financial responsibility.

### **2.1.3.1 Customers (patients) with health insurance**

In addition to the contract for services between the health care provider and the patient, the patient may have a separate legal arrangement with a health plan, employer, or government program that specifies the terms under which the patient is entitled to assistance in paying for those services. That separate arrangement will address the types of services that will be covered and the extent to which the patient will share financial responsibility with the health plan through features such as deductibles, copayments, or coinsurance.

If the patient's health plan has a contractual arrangement with the provider, the provider's services will be considered "in-network" for that patient (see HC 2.1.4.2). Whether services are "in-network" or "out-of-network" will affect the amount the provider can bill for services, the portion of the bill for which the patient will be responsible (i.e., the cost-share with the health plan), and often, whether the insurance benefits will be paid directly to the provider or to the patient.

For purposes of measuring revenue, amounts due from health plans are generally regarded as fully collectible, while amounts due from patients are less likely to be collected in full. As discussed in HC 3, those collectability considerations enter into the determination of the amount of revenue that can be reported in a health care entity's financial statements under ASC 606 and what amounts, if any, are recognized as a credit loss (bad debt expense) under ASC 326 or ASC 310.

### **2.1.3.2 Customers (patients) without health insurance**

Providing care to patients who are not covered by insurance is inherent in the health care business model, particularly for hospitals that operate emergency departments. This is due largely to the federal Emergency Medical Treatment and Labor Act, which requires Medicare-participating hospitals with emergency departments to screen and treat emergency medical conditions regardless of a patient's ability to pay. Essentially, the law establishes a "treat first, ask questions later" policy. As a result, hospital emergency departments often function as a "safety net" provider for patients who lack insurance coverage but require medical attention (including care for routine illnesses).

An uninsured patient that goes to an emergency room for treatment might initially be classified into one of three payer classes: "pending Medicaid," charity care, or self-pay. If the patient will require costly inpatient care, the hospital may attempt to retroactively enroll them in Medicaid, a state-administered program that provides medical benefits to certain low-income individuals. While the hospital awaits the state's determination, the patient will be classified as "pending Medicaid." If the patient is deemed to be eligible, their patient account will be reclassified to an insured payer category (i.e., Medicaid). If a Medicaid application is not made or is not successful, a hospital may evaluate whether the patient will qualify for care at reduced or no charge under its financial assistance (i.e., charity care) policy, if it has one. Although a charity care patient's gross charges will be accumulated in a patient record just like any other type of patient, in the end, the services will not be countable as revenue for financial reporting purposes. HC 5.2.1 provides additional information on reporting charity care services.

If the patient does not qualify for charity care (for example, because the hospital cannot obtain the necessary financial documentation, or because the patient's income exceeds the policy's thresholds), the patient will be assigned to a self-pay payer class. As a matter of policy, hospitals often provide an

across-the-board discount to patients in the self-pay class and usually will work with the patient to arrange a plan for payment of their account over time. In general, such services are intrinsically at higher risk for nonpayment than are services where a significant portion of the charges will be paid by a third-party payer. Under ASC 606, this has implications for the amount of revenue that is recognizable for financial reporting purposes related to these services, as discussed in HC 3.3.1.

The above discussion is specific to hospitals with emergency departments. Although not required by law to do so, other providers may voluntarily decide to provide care at little or no cost to indigent patients or assist them with locating alternative sources of care. If the provider has a charity care policy and the patient qualifies, those services are classified as charity care and accounted for as discussed in HC 5.2.1. Otherwise, the patients are classified as self-pay, and revenue will be recognized for financial reporting purposes as discussed in HC 3.3.1.

#### **2.1.4 Payers of health care revenue**

Relationships with third-party payers (or when patients are uninsured, the lack of a relationship) play a significant role in how health care is purchased. Consequently, those relationships have a significant impact on how much revenue a provider will earn.

The extent of services covered by third-party payer contracts typically varies by the type of health care provider.

- For hospitals, rehabilitation facilities, home health companies, hospices, physicians, clinical laboratories, and other ambulatory care providers, third-party payers pay for the majority of services provided.
- For skilled nursing facility (SNF) services, health insurance often provides coverage for short stays in SNFs immediately following a hospitalization. Payment for long-term residential care services is usually funded through specialized long-term care insurance policies or Medicaid (which pays for long-term residential care and support services for Medicaid beneficiaries). When no third-party benefits are available, nursing home services are "private pay" or "self-pay" (that is, the individual or their family pays for the care).
- In continuing-care retirement communities, residential SNF care is financed primarily through up-front and/or monthly fees paid by residents.

The largest of all third-party payers is the federal government, which pays for health care services for enrollees in Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Federal Employee Health Benefits (FEHBP) programs. For additional information on the significant role played by federal and state governments in paying for health care services, see HC 2.2.

Third-party payers typically do not pay the health care entity's established rates. The amount paid may be based on government regulations (for Medicare, Medicaid, and other government programs), negotiated in-network prices (for services for a particular health plan), or the specific commercial health insurance policy or employer's plan design.

When a third-party payer is involved, the responsibility of paying for health care services typically is shared between the payer and the patient. The payer's portion will typically carry a presumption of high collectability; the portion that is the patient's responsibility, on the other hand, may have

significant risk for non-collectability. As discussed in HC 3, under the ASC 606 reporting model, these different collectability profiles will affect the measurement of transaction price (i.e., the amount of revenue that is recognizable) related to these services.

#### **2.1.4.1 Provider payment methods – fee-for-service arrangements**

Fee-for-service is the predominant method of payment. Under this model, a provider submits a bill to the patient’s third-party payer to request payment for the services performed (referred to as “filing a claim”). The provider uses standardized medical codes to detail the services provided and lists the provider’s charges for the services. If the payer approves the claim, it pays its share (either to the patient or to the provider) based on the terms of the arrangement and whether it has a relationship with the provider.

If no contractual agreement exists between the provider and the insurer regarding the amounts that will be charged to that insurer’s subscribers, members, or enrollees, the payment will normally be based on “reasonable and customary” charges determined by the health plan for the provider’s geographic service area (or sometimes by reference to the provider’s charges for the services).

If the health plan has negotiated an agreement with the provider (through separate contractual arrangements) to pay discounted rates for care provided to the plan’s subscribers, members, or enrollees, the amount of payment for a particular service might be established on a retrospective or a prospective basis. Retrospective payment typically means that either the payment amount is based in some fashion on the amount the provider normally charges for the specific services billed, or that payment is based on the estimated costs of the services provided (“cost reimbursement”). More often, payers use prospectively-determined payments to incent providers to provide more cost-effective care. Under a prospective payment methodology, the payer’s rates are set in advance for specific treatments or services and are known (or knowable) by the provider in advance of providing the care. The amount of the payment received for that treatment or service will not vary, regardless of the level of resources (for example, labor and supplies) the provider had to employ in treating the specific patient. If the payment does not cover the costs of providing the service, the provider must absorb any excess. Commonly used prospective payment methodologies include:

- **Fee schedules.** Fee schedules stipulate flat amounts that will be paid for services performed by a physician or allied health professional (e.g., Medicare’s physician fee schedules).
- **Per diem.** Under a per diem arrangement, the provider is paid a flat rate per day of inpatient care provided, regardless of the level of intensity of the care provided (e.g., Medicare’s per-diem methodology for skilled nursing facility services).
- **Per case (per discharge, per encounter, per visit).** When payment is made on a per-case basis, the provider is paid a predetermined amount based on the patient’s “discharge category” (e.g., Medicare diagnosis-related groups for hospital inpatient services).

In some cases, fee-for-service payment structures might include penalties or bonuses based on “target” levels of service or payments, or adjustments based on quality scores. HC 2.2.1.2 discusses certain such alternative payment models; similar type of adjustments to fee-for-service payments can also be part of a provider’s contract with private sector payers. Additional commentary and examples related to estimating adjustments to amounts payable by providers as a result of bonuses or penalties (i.e., “variable consideration” under ASC 606) under programs that require providers to share risk with

Medicare can be found in the AICPA Revenue Recognition Audit and Accounting Guide (AAG-REV 7.6.73 through AAG-REV 7.6.108).

Note that the term “fee-for-service” has two distinct meanings in the health care sector. As used in this discussion of provider revenue, fee-for-service describes a third-party payer’s contractual arrangement to pay a provider for services rendered. That is, third-party payers compensate providers based on the specific underlying services provided, not based on, for example, total population health metrics or per member per month arrangements. “Fee-for-service” may also be used to describe a type of program under Medicare or Medicaid (for example, “fee-for-service Medicaid” as contrasted to Medicaid managed care – see HC 2.2.1). Providers can (and typically do) receive “fee-for-service” payments from Medicare and Medicaid under either the FFS or managed care structures.

#### **2.1.4.2 *Provider payment methods - capitation arrangements***

Under a capitation arrangement, a health care entity (normally a physician practice or integrated health system) is paid a predetermined amount to “stand ready” to provide covered services that may be needed by enrollees during a specified time period, rather than being paid on a case-by-case basis as individual elements of care are provided. In those arrangements, the provider earns revenue regardless of whether any services are actually provided during the period covered by the capitation payment.

The predetermined amount is typically a fixed amount per enrollee (usually defined as a “per patient, per month” or “PMPM” fee) to provide covered services to a specified group of individuals enrolled in a health plan during an established period. The fixed amount is determined in advance of the contract year.

Accounting for capitation arrangements by health care providers is discussed in HC 4.

#### **2.1.4.3 *“In-network” versus “out-of-network” services***

Most health plans will establish a network of providers that have contractually committed (through separate arrangements with the health plan) to provide care at discounted rates to the plan’s subscribers, members, or enrollees. The provider’s services are considered “in network” for patients that are covered by the health plan. Network providers are often referred to as “participating providers.”

When a provider is part of an insured patient’s network, the amount the provider can charge and the prospects for collectability of those amounts can be significantly different than for similar services provided to a patient “out-of-network.” The discussion that follows is specific to private sector plans. The guidance for care provided to Medicare enrollees differs slightly and is discussed in HC 2.2.1.1.

Whether services are “in-network” or “out-of-network” will affect the amount the provider can bill for services, the portion of the bill for which the patient will be responsible (i.e., the cost-share with the health plan), and often, whether the insurance benefits will be paid directly to the provider or to the patient. Amounts due from health plans are generally regarded as fully collectible, while amounts due from patients are less likely to be collected in full. As discussed in HC 3, those collectability considerations will enter into the measurement of revenue in a health care entity’s financial statements under ASC 606.

When a provider's services are in-network, its established charges will be irrelevant for revenue recognition purposes, because the rate negotiated with the health plan will establish the agreed-upon contractual prices for the services. The provider will "write off" the difference between its established charges and the negotiated rate to "contractual allowances" (a contra-revenue account, discussed in HC 2.1.3). Typically, the patient and health plan will share responsibility for payment of the negotiated rate, with the health plan paying a significant portion (e.g., 80%) and the patient paying a much smaller portion (e.g., 20%), referred to as "coinsurance." The provider's risk of non-collection of the negotiated rate will usually be limited to the portion due from the patient.

If the provider's services are considered "out-of-network," the dynamics surrounding payment (and revenue recognition) differ in several ways.

- Some health plans (for example, HMOs) will only provide coverage for out-of-network services in emergency situations. In those situations, if the provider's services are not of an emergency nature, the patient is uninsured for those services and will be responsible for 100% of the charges.
- If the health plan provides coverage for non-emergency services, the insurance benefits typically are less than for in-network services. The insurance benefits will be a percentage of a "reasonable and customary" charge determined by the health plan for the provider's geographic service area. For example, a plan that pays 80% of the negotiated rate for in-network services might pay only 70% of the reasonable and customary charge for out-of-network services.
- The provider normally is permitted to bill the patient for the difference between its established charges and the "reasonable and customary amount." Thus, the patient will be responsible for paying this amount in addition to their coinsurance (the percentage of the reasonable and customary amount that is the patient's responsibility).
- Out-of-network benefits often are paid directly to the patient, rather than to the provider. In some cases, the provider may be able to obtain an assignment of benefits from the patient, which is a legal agreement that authorizes the plan to pay the benefits directly to the provider. If the benefits are paid directly to the patient, health care entities should consider any additional collection risk associated with collecting payment directly from the patient instead of the health plan.

Example HC 2-1 illustrates the differences in the recognition of in-network and out-of-network revenue.

### **EXAMPLE HC 2-1**

#### **Comparison of in-network versus out-of-network revenue**

Hospital admits Patient A whose health insurance is provided by Insurer X. Under the Patient A's terms of coverage, once the patient has met their annual deductible, Insurer X will pay 80% of the negotiated network rate for in-network services, and Patient A's coinsurance will be 20% of the network rate. Hospital also admits Patient B, whose health insurance is provided by Insurer Y. Hospital is not a member of Insurer Y's provider network. If Patient B receives out-of-network care, Insurer Y will pay 60% of the "reasonable and customary rates" for the services, and Patient B's coinsurance will be 40%.

Hospital's gross charges for both patients' stays are \$40,000. Insurer's X's negotiated network rate with Hospital for the services provided to Patient A is \$18,300, and the reasonable and customary charges are \$19,000. Patient A has met their deductible for the year. Hospital requires patients that are out-of-network to assign their insurance benefits to Hospital (thus allowing Insurer Y to pay its portion directly to Hospital).

What entries would Hospital record related to each patient's stay?

*Analysis*

For Patient A, since Hospital belongs to Insurer X's provider network, Hospital is contractually obligated to accept \$18,300 as payment-in-full for Patient A's stay. The \$21,700 difference between Hospital's established charges and the network negotiated rate (\$40,000 less \$18,300) represents a contractual allowance (a contra-revenue account). Insurer X is responsible for \$14,640, which is 80% of the network negotiated rate (\$18,300 x 80%) and Patient A's coinsurance is \$3,660 (\$18,300 x 20%).

For Patient B, because Hospital is not part of Insurer Y's provider network, Insurer Y will pay \$11,400, which is 60% of the reasonable and customary fee (\$19,000 x 60%) and Patient B's coinsurance is \$7,600 (\$19,000 x 40%). However, because there is no contractually-negotiated fee between Hospital and Insurer Y, Hospital may bill Patient B for the difference between its gross charges and the reasonable and customary fee (\$40,000 - \$19,000 = \$21,000). Thus, Patient B's responsibility will be \$28,600 (\$40,000 - \$11,400). Because Patient B has assigned its benefits under its policy with Insurer Y to Hospital, Hospital will receive Insurer Y's payment directly.

The following table compares the respective journal entries for related to the fees related to Patient A and Patient B's care.

Entry	Patient A (In-network)	Patient B (Out-of-network)
Dr. Accounts receivable—Due from health plan	\$14,640	\$11,400
Dr. Accounts receivable—Due from patient	\$ 3,660	\$28,600
Dr. Contra-revenue—Contractual adjustments	\$21,700	\$ 0
Dr. Contra-revenue—implicit price concessions	[see below]	[see below]
Cr. Revenue—Gross charges	\$40,000	\$40,000

While it may initially appear that the out-of-network services are more lucrative for Hospital, that is likely not the case once the likelihood of collection of the patient portion is considered. Typically, amounts due from health plans are fully collectible, while amounts due from patients carry a higher risk of uncollectibility. For example, if Hospital successfully collects all of the amount due from Insurer X, but only collects \$2,000 of the amount due from Patient A, Hospital's total revenue is \$16,640 as a result of providing the in-network services. On the other hand, if Hospital only collects \$2,000 from Patient B, Hospital's total revenue is only \$13,400.

Because the amount due from an individual patient is likely to have higher collection risk, Hospital will need to estimate the amount it expects to collect from patient. The difference is not recorded as a bad debt expense, but instead is recorded as a contra-revenue, representing an implicit price concession.

## 2.2 *Overview of Medicare and Medicaid*

Virtually all institutional health care providers (e.g., hospitals, nursing homes, home health agencies, hospices) and most physicians serve Medicare or Medicaid beneficiaries to some extent. Some providers' revenues are significantly dependent on compensation from these and other government programs. Due to those programs' size and nationwide scope, decisions made by the federal government's Centers for Medicare & Medicaid Services (CMS) significantly impact and influence the entire US health care delivery system. Private health plans often follow their lead.

While federal government and state governments are not "customers" in health care providers' revenue transactions for accounting purposes (i.e., the government is not receiving the goods or services), their "purchasing" power enables them to exert influence that is similar to rights found in contracting relationships when the government is the customer. For example:

- As sovereign powers, governments possess unilateral rights not normally present in commercial relationships. Because of their size and power, amounts paid to providers are neither negotiated nor established by the marketplace but instead can be unilaterally imposed by CMS and state agencies.
- The regulations governing provider relationships with CMS and the laws on which Medicare and Medicaid are based are inherently political and subject to frequent change. Changes in program interpretations, requirements, or "conditions of participation" after the fact can have implications for revenues previously recognized (refer to HC 3.3.2).
- Revenues earned in providing services to government program beneficiaries may be subject to adjustment as a result of examinations by government agencies or their contractors. The audit process and the resolution of significant related matters (including disputes based on differing interpretations of regulations) might not be finalized until several years after the services were rendered.
- Additional risks may result from the applicability of certain laws that provide for potentially significant penalties if violated. For example, a provider that is found to have submitted false claims for payment may be subject to punitive measures ranging from civil monetary penalties to suspension or debarment from participation in Medicare or Medicaid.

HC 2.2.1 and HC 2.2.2 provide more details on the Medicare and Medicaid programs, respectively. These sections compare and contrast the two programs and also highlight ways in which they are similar to or different from private sector health plans.

### 2.2.1 *Medicare*

Medicare is a federal government insurance program administered by the Centers for Medicare & Medicaid Services (CMS). The largest health insurance program in the United States, it serves Americans age 65 and older as well as younger individuals with certain disabilities and diseases.

Medicare has four components:

- Part A, primarily for inpatient hospital services;
- Part B, for outpatient services such as physician visits;
- Part C, for Medicare managed care (“Medicare Advantage”); and
- Part D, for prescription drugs.

Benefits are available to enrollees through two structures: Medicare Advantage (Medicare managed care) and traditional Medicare. In Medicare Advantage, benefits are offered through private sector commercial health plans under contract with CMS; in traditional Medicare, benefits are offered through a health insurance program operated by CMS.

Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are bundled plans that combine the benefits from Part A and Part B, and usually Medicare drug coverage (Part D) as well. In Medicare Advantage, CMS pays premiums to the health plans that, in turn, are responsible for paying for all covered services provided to enrollees. Because the plan operators are private sector health plans, the relationships with providers (for example, network contracting) are those described in HC 2.1.4.1 (instead of CMS’ rules described at HC 2.2.1.1).

In traditional Medicare (sometimes referred to as “fee-for-service” or FFS Medicare), CMS acts as an insurer, contracting with providers and paying claims for health services provided to Medicare enrollees. CMS administers traditional Medicare through a network of fiscal intermediaries (Medicare Administrative Contractors, or MACs), which are private sector organizations that serve as the primary operational contact between CMS and the health care providers. In addition to handling enrollment and claims payment functions, MACs review and audit institutional providers’ cost reports (see below) and make settlement determinations on behalf of CMS.

Patients enrolled in traditional Medicare can see any provider they choose, but the extent to which they will share financial responsibility with CMS for payment of the bill will vary based on whether the provider is part of Medicare’s network (see HC 2.2.1.1). Unlike private sector health plans, CMS unilaterally establishes rates paid to providers; it does not negotiate. Providers file claims for services provided to beneficiaries and generally are paid prospectively determined rates as discussed in HC 2.1.4.1. Reimbursement for claims based on reasonable costs (i.e., cost reimbursement) is used in only a few situations. Regardless of whether claims payments are prospectively determined or cost reimbursed (retrospectively), the total compensation to which institutional providers will be entitled for services provided during a fiscal year will be determined by filing a cost report (a regulatory report described in HC 2.2.1.3).

### **2.2.1.1 *Participating, non-participating, and opt-out providers in traditional Medicare***

As discussed in HC 2.1.4.2, most health plans will establish a network of providers that have committed (through contractual arrangements with the health plan) to provide care at discounted rates to the plan’s subscribers, members, or enrollees. In traditional Medicare, networking relationships with CMS take one of three forms: “opt out,” “participating,” or “non-participating.” The relationship selected will have implications for the amounts providers can bill for their services and how much of that amount will be paid by Medicare or the patient (i.e., cost sharing). Amounts due from CMS are regarded as fully collectible while amounts due from patients are less likely to be fully

collectible. As discussed in HC 3, collectibility considerations impact the amount of revenue recognized in a provider's financial statements under ASC 606.

### ***Opt-out providers***

A provider that opts out of Medicare signs an agreement to be excluded from the program. Services provided to Medicare patients will not be covered. The provider can charge whatever it wishes, but the patient is fully responsible.

### ***Participating providers***

Participating providers have a relationship with CMS closely resembling that of in-network providers in private-sector health plans (see HC 2.1.4.2). The contractual agreement with CMS (referred to as a provider agreement) generally has a one-year term and automatically renews unless the provider withdraws or is debarred from the program. The provider agreement incorporates by reference the complex laws and regulations for Medicare payment, and providers agree to accept Medicare's approved amounts as the contractual prices for all services provided to Medicare patients. Because Medicare's approved amount will establish the agreed-upon contractual prices for services, a provider that treats a Medicare patient will "write off" (i.e., never recognize as revenue) the difference between its established charges and the Medicare rate to the contra-revenue account "contractual allowances," as discussed in HC 2.1.3. Once the patient's deductible has been met, CMS typically will pay 80% of the approved amount directly to the participating provider, and the patient is responsible for the 20% coinsurance.

### ***Non-participating providers***

Under federal law, almost all institutional health care entities must be participating providers; physicians, allied health professionals (i.e., practitioners other than physicians or nurses, such as physical therapists), and certain other providers and suppliers are permitted a choice. A non-participating provider can elect on a claim-by-claim basis to accept Medicare's approved amount or not. If they choose to accept the approved rate (referred to as "accepting assignment"), they are paid like a participating provider. Otherwise, Medicare sets a slightly lower rate for the services, and pays its share (usually 80%) directly to the patient, not the provider. The provider is permitted to "balance bill" the patient for a portion of the difference between its established charges and the Medicare rate; that amount (referred to as the "limiting charge") is capped at 15% over the Medicare non-participating provider rate. Thus, the non-participating provider must collect from the patient the balance-billing amount, the patient's coinsurance amount, and CMS's payment. Example HC 2-2 illustrates the accounting entries for a non-participating provider.

## **EXAMPLE HC 2-2**

### ***Accounting by a Medicare non-participating provider***

Physician Associates (PA) is a non-participating provider under Medicare. PA performs an in-office procedure for a Medicare patient. PA's gross charges for the services are \$800.

PA decides not to accept assignment for the patient's claim. Medicare's non-participating provider rate for the services is \$450. Medicare will pay 80% of that amount, and the patient is responsible for the other 20%. As a non-participating provider, the limiting charge for the services is capped at \$518 (15% above the non-participating provider rate). Patient has met their deductible for the year.

What entries should PA record related to patient’s office visit?

*Analysis*

Medicare will pay \$360 on the claim, which is 80% of the non-participating provider rate (\$450 x 80%) and patient’s coinsurance amount will be \$90 (\$450 x 20%). PA can also balance-bill the patient for the \$68 difference between the limiting charge (\$518) and the non-participating provider rate (\$450). The \$282 difference between PA’s established gross charges and the capped limiting charge amount (\$800 – \$518) represents a contractual allowance.

Because Medicare pays its portion to the patient when the provider is non-participating, PA must collect the entire \$518 from the patient (\$360 Medicare-reimbursed portion + \$90 coinsurance + \$68 balance billing amount). Thus, PA would record the following entries:

Dr. Accounts receivable—Due from patient	\$ 518	
Dr. Revenue—Contractual adjustments	\$ 282	
Dr. Accounts receivable—Due from Medicare	\$ 0	
Dr. Revenue—Implicit price concessions	[see below]	
Cr. Revenue—Gross charges		\$ 800

Because the amount due from an individual patient is likely subject to much higher collection risk, PA will need to estimate the amount it expects to collect from patient and the amount it is likely to forgo in the form of an implicit price concession. It would not be appropriate for PA to recognize the full \$800 in revenue if its collection history from patients in this financial class have not historically paid 100% of amounts due.

**2.2.1.2 Alternative fee-for-service Medicare payment models**

Fee-for-service is the most common payment mechanism used in traditional Medicare. As such, each health care entity involved in care during an individual’s illness or course of treatment will bill and be paid separately for each service they provide, with little or no coordination among providers across the spectrum of services. Concerns about this inefficiency within traditional Medicare has led CMS to evaluate alternative approaches to fee-for-service payment that would incent more cost-efficient care without sacrificing quality.

The Medicare Shared Savings Program (MSSP) is an alternative payment model that offers physicians, hospitals, and other providers an opportunity to better coordinate care by creating accountable care organizations (ACOs). An ACO agrees to be held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service beneficiary population. ACOs are discussed in HC 4.

Bundled payment care initiatives also incent providers to work together to coordinate care provided. Some models might provide a single comprehensive payment that covers all services provided within a specific time frame for a patient with a certain medical condition across a continuum of care that includes hospitals, physician groups, post-acute care facilities and services, and others. Other models

involve establishing cost and quality targets across the continuum of care that provide bonuses or penalties to an “anchor” provider that spearheads the process (for example, a hospital that performs joint-replacement surgery on a patient who will also require home health care and outpatient physical therapy, in addition to ongoing monitoring by the surgeon). For commentary and examples related to estimating performance-based bonuses or penalties under such a program, see the discussion of “risk sharing arrangements” in the AICPA Revenue Recognition Audit and Accounting Guide (AAG-REV 7.6.73 through AAG-REV 7.6.108).

### **2.2.1.3 Potential retrospective adjustments of Medicare compensation**

Providers must consider the possibility of adjustments CMS may make in future years to retroactively adjust the amount of compensation to which they are entitled for the current year’s services. For example, institutional providers, such as hospitals, nursing homes, home health companies, and hospices, are exposed to recoupment risk arising from future adjustments that may be made in connection with audits or desk reviews of cost reports (see HC 2.2.1.3). All providers have recoupment risk associated with post-payment review and denials of claims (see HC 2.2.1.3) and from potential government allegations of billing fraud (see HC 6.2.1).

The potential for such adjustments represents an uncertainty that must be considered when estimating revenue for the period in which the services were provided. Such uncertainties cause compensation from government programs to be considered variable for purposes of applying ASC 606, as discussed in HC 3.3.2.

#### **Compensation obtained through cost reports**

The cost report is an annual report to CMS that details the revenues, costs, and expenses associated with the services provided by the provider/facility to Medicare patients. The data included within these reports is utilized by CMS to compute final reimbursement for Medicare claims.

For providers whose rates are prospectively determined, the cost report is used to provide additional details about specific costs or programs that may have been incurred, such as for treating high volumes of high-acuity patients or low-income patients, or for providing a clinical setting for the education of interns and residents and other allied health professionals. In essence, these amounts (referred to as pass-through costs) are lump-sum adjustments to the standard prospective rates.

For the relatively few providers whose compensation is determined with hindsight (that is, they are paid on a reasonable-cost basis), the cost report is the vehicle used to determine the actual reimbursable costs incurred in providing services to Medicare patients. Such providers receive interim payments as claims are filed throughout the contract year. After year end, the fiscal intermediary (Medicare Administrative Contractor) settles with the provider for the difference between interim payments and actual reasonable costs calculated in the cost report.

Cost reports often are not filed with fiscal intermediaries until after a provider’s financial statements have been issued. In those situations, the Medicare revenue estimates included in the financial statements will include an estimate of the provider’s calculation of additional compensation due from or payable to CMS that is expected to arise from the cost report.

Subsequent to filing, the cost reports are subject to routine reviews or audits by the fiscal intermediaries, which may result in adjustments to the provider’s calculation of amounts due from or payable to CMS. Often, final settlement does not occur until several years after the cost report has

been filed. The potential for retroactive adjustments resulting from final settlement of cost reports represents an uncertainty that must be considered in estimating revenue for the period in which the services are provided. Example HC 3-5 in HC 3 illustrates the estimation of revenue when these uncertainties exist.

### ***Retrospective adjustments for denial of claims***

All providers that file claims under either the traditional Medicare or Medicare Advantage programs are exposed to risk for retrospective adjustment of compensation based on post-payment review and denials of claims that were processed and paid by the MAC or fiscal intermediary. CMS engages recovery audit contractors (“RAC auditors”) for this purpose.

RAC auditors perform reviews or audits to ensure that claims payments made at the time services were provided were appropriate. Claims for items or services that are subsequently deemed to be “not medically necessary,” not covered by the program, or improperly documented or coded can be flagged for recoupment by RAC auditors up to three years after the payments were received. Although issued prior to ASC 606 (and thus refers to ASC 605 and ASC 954-605 revenue recognition language), the nonauthoritative Healthcare Financial Management Association Principles & Practices Board Issue analysis, *Accounting For RAC Audit Adjustments and Exposures*<sup>1</sup> provides helpful context and commentary on accounting issues associated with RAC audits.

The potential for retroactive adjustments resulting from RAC audits represent an uncertainty that must be considered in estimating revenue for the period in which the services were provided. HC 3.3.2 discusses application of the ASC 606 model when estimating revenue provided to enrollees in government programs, and AAG-REV 7.6.71 illustrates how to estimate the impact on revenue of amounts repayable due to RAC audits.

#### **2.2.2 Medicaid**

Medicaid is a government insurance program that helps low-income individuals and families obtain and pay for health care services. It also provides benefits not normally covered by Medicare, including residential nursing home care services. While Medicaid is jointly funded by federal and state governments, its programs are established and administered on a state-by-state basis. Individual state programs operate under general guidelines established by the federal government and overseen by CMS.

In order to be entitled to the federal funding, each state has a formal agreement with CMS (the Medicaid “state plan”) detailing how that state’s program is administered. In effect, the state plan represents a contract between that state and the federal government indicating the services that will be covered, how providers will be paid for services, and committing to the joint funding. To make changes in benefits or how they pay providers, state agencies must submit and receive CMS approval of a “state plan amendment” (SPA). For example, enactment by a state of a Medicaid provider tax program (discussed in HC 5.3) typically requires a SPA.

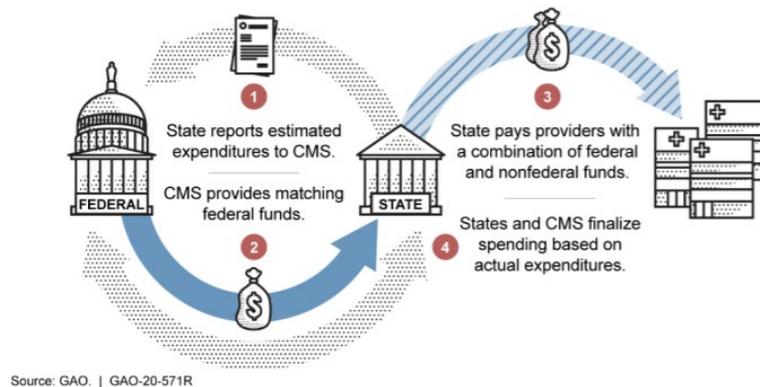
Under the joint funding arrangement, the federal government matches a percentage of the total expenditures that will be made by a state to pay health care providers, shown in Figure HC 2-1. This matching is referred to as federal financial participation (FFP), which means the federal government’s

<sup>1</sup> [www.hfma.org/content/dam/hfma/Documents/policies-and-practices/issue-analysis-accounting-rac-audit-adjustments-exposures.pdf](http://www.hfma.org/content/dam/hfma/Documents/policies-and-practices/issue-analysis-accounting-rac-audit-adjustments-exposures.pdf)

share of a state's expenditures under the Medicaid program. Under this arrangement, the federal government determines their share of a state's expenditures using the state's financial medical assistance percentage (FMAP). For example, if a state's FMAP percentage is 70%, then each state dollar expended for Medicaid services will be matched by 70 cents from the federal government.

### Figure HC 2-1

#### Federal government matching of state Medicaid expenditures



Benefits are made available to enrollees through two structures: Medicaid managed care and traditional Medicaid.

Under Medicaid managed care, state agencies outsource program benefits to a private sector health plan (referred to as a Medicaid managed care organization, or MMCO) through which enrollees will receive most or all of their services. MMCOs accept a set premium payment per enrollee (usually per-member-per-month, or “PMPM”) and in turn, pay providers for the covered services that are specified in the MMCO’s contract with the state. In such arrangements, the third-party payer is the MMCO, not the Medicaid program itself. Because the plan operators are private sector health plans, the relationships with providers (for example, network contracting) are those described in HC 2.1.4.2. Most often, the plans pay providers on a fee-for-service basis (that is, based on filing claims for services provided to enrollees).

In traditional Medicaid (sometimes referred to as “fee-for-service” or FFS Medicaid), the state acts as an insurer operating a health insurance plan. Due to the low-income status of the beneficiaries, cost-sharing between the program and the patients is less significant than in either private health insurance or traditional Medicare.

States will enroll providers who agree to treat Medicaid patients and accept the program’s rates as the contractual prices for those services. Claims submitted by enrolled providers are processed by the state agency’s Medicaid Management Information System (MMIS) for review, verification, and payment. Subsequent to payment, various audit and review processes may be conducted by state and federal administrators, such as the MMIS or in some cases, a RAC auditor (see HC 2.2.1.3) to verify that the payments made were appropriate.

Payment rates are determined by the state for each service in accordance with its approved Medicaid state plan, and the “units” for payment vary by provider type. For example, the approved rates for acute-care hospitals might be structured as per-case amounts that depend upon individuals’ diagnoses (i.e., DRGs), as a per-diem amount paid for each day of inpatient care, or as a percentage of the provider’s established charges. Skilled or intermediate-care nursing facilities are commonly paid a per diem for each day of residential care.

State Medicaid programs often have other characteristics similar to traditional Medicare, including use of cost reports, fiscal intermediaries, post-payment reviews of claims, and potential for government investigations (see HC 2.2.1.3). As a result, providers serving Medicaid patients are at risk for retrospective adjustment of their compensation. The potential impact of such adjustments must be estimated and provided for in the period the services were rendered to the covered patients.

#### **2.2.2.1 Medicaid supplemental payments**

In addition to the base payments received for specific services provided to individual Medicaid patients (under either traditional Medicaid or through MMCOs), providers will receive supplemental payments. Most supplemental payments function as adjustments to base rates. For example, upper payment limit (UPL) payments are intended to increase base rates to the levels that Medicare would have paid for the same services. Disproportionate share hospital (DSH) and uncompensated care pool payments are made to providers that have higher costs associated with serving large numbers of low-income patients. In addition, graduate medical education (GME) payments adjust the rates paid to teaching hospitals for higher patient care costs associated with clinical education of medical students. The supplemental payments described in this paragraph enter into the determination of patient service revenue under ASC 606.

Delivery system reform incentive payments (DSRIP) are supplemental payment streams from Medicaid. DSRIP are calculated independent from the uncompensated care pool and, in substance, help providers pay for fundamental changes in how care is delivered in order to improve health care quality and access. DSRIP are considered grants and are recognized using an appropriate model for nonexchange revenue transactions—likely an analogy to ASC 958-605 or IAS 20 for business entities, ASC 958-605 for not-for-profit entities, and GASB 33 for governmental entities.

In traditional Medicaid, providers typically receive supplemental payments in quarterly or annual lump sum amounts. For providers paid under Medicaid managed care, pass-through supplemental payments are included in the capitation rates paid to the MMCOs, and the MMCOs in turn make the supplemental payments to hospitals, physicians, or nursing facilities, as directed by the state.

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***Chapter 3:  
Revenue from fee-for-service  
patient care***

### 3.1 Revenue from fee-for-service patient care overview

Broadly speaking, a provider’s compensation for patient care activities can be earned through two different channels. In one channel, services are provided to patients in exchange for a fee that is specific to the service provided (fee-for-service or FFS). In the other, the provider is compensated for “standing ready” to provide services that may be needed during a specified time period, regardless of the nature or volume of services that will ultimately be provided (capitation contracts).

This chapter provides an overview of the revenue recognition model in ASC 606, *Revenue from contracts with customers*, and describes how it would be applied to transactions in the fee-for-service channel. Fee-for-service transactions are the predominant way in which health care providers in the US are compensated.

### 3.2 ASC 606 five-step model

ASC 606-10-05-3 describes the core principle regarding the recognition of revenue.

#### ASC 606-10-05-3

The core principle of this Topic is that an entity recognizes revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

In order to implement that principle, the standard lays out five broad steps:

- Step 1—identify the contract with the customer (see HC 3.2.1)
- Step 2—identify performance obligations (see HC 3.2.2)
- Step 3—determine transaction price (see HC 3.2.3)
- Step 4—allocate transaction price to performance obligations (see HC 3.2.4)
- Step 5—recognize revenue (see HC 3.2.5)

This chapter references excerpts from the AICPA Audit and Accounting Guide, *Revenue Recognition* (AAG-REV), chapter 7, *Health Care Entities*. That nonauthoritative interpretive guidance was developed by an AICPA Health Care Revenue Recognition Task Force under the supervision and ultimately approval of the AICPA’s Financial Reporting Executives Committee (FinREC) to assist providers and auditors with understanding the application of ASC 606’s broad principles in the context of health care services transactions.

#### 3.2.1 Step 1 – Identify the contract

The first step is to evaluate a contract’s characteristics to determine whether it should be accounted for using the ASC 606 model. This section discusses Step 1 in the context of health care services transactions. For a comprehensive discussion of the general requirements of Step 1, see RR 2.

For providers, the threshold issue in Step 1 is to identify the party that is the customer in the revenue transaction. As discussed in HC 2.1.3.1, health care service transactions often involve more parties than the traditional buyer and seller. Thus, the key question is whether the customer is the patient that receives the health care services or a third party that negotiates with the provider and establishes the amount that will be paid to the provider for the provision of services.

According to AAG-REV 7.6.46, from the perspective of the provider, the “contract with the customer” relates to the arrangement with the patient. Under that arrangement, the health care entity agrees to provide the services requested by the patient, and the patient agrees to pay for those services. As discussed in HC 2, separate contracts between health care providers and third-party payers that establish negotiated prices for the services (discussed in HC 2.1.4.1) are not “contracts with customers” under ASC 606. Instead, those arrangements are considered in determining the transaction price for the contract between the provider and patient (see HC 3.2.3).

### Question HC 3-1

A patient makes an appointment with Physician Associates (PA). The patient has commercial health insurance coverage through Health Plan. During the intake process, patient signs a patient responsibility form in which they acknowledge their responsibility to pay and authorizes Health Plan to make payments directly to PA. PA is a “participating provider” in Health Plan’s provider network.

For purposes of ASC 606, who are the “parties to the contract?”

#### ***PwC response***

The fact pattern describes three separate contractual arrangements – an arrangement between patient and PA (the provider), an arrangement between patient and Health Plan, and an arrangement between PA and Health Plan. The arrangement between the patient and PA is the “contract with the customer” for purposes of applying ASC 606.

The separate agreement between PA and Health Plan establishes agreed-upon contractual prices for services that PA may provide to Health Plan’s subscribers. These prices will be a focus of Step 3 (transaction price).

The separate agreement between patient and Health Plan provides that Health Plan will reimburse the patient for an agreed-upon portion of costs it incurs in connection with obtaining medical services specified in the insurance contract. Patient’s assignment of its rights to the payment gives Health Plan the ability to make the payment directly to PA, rather than to patient. The party that is financially responsible—patient or Health Plan—will also be a relevant consideration in Step 3 (transaction price) in determining the consideration to which the entity expects to be entitled in exchange for those services.

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The ASC 606 model uses a definition of a “contract” for accounting purposes that is based on common legal definitions of a contract in the United States. Its key elements are described in ASC 606-10-25-2.

**ASC 606-10-25-2**

A contract is an agreement between two or more parties that creates enforceable rights and obligations. Enforceability of the rights and obligations in a contract is a matter of law. Contracts can be written, oral, or implied by an entity's customary business practices

Accordingly, a contract with a customer must be enforceable by law in order for the rights and obligations to be considered under the ASC 606 model. In determining whether a contract with a patient exists for accounting purposes, providers must consider the five criteria specified in ASC 606-10-25-1.

**ASC 606-10-25-1**

An entity shall account for a contract with a customer ... only when all of the following criteria are met:

- a. The parties to the contract have approved the contract (in writing, orally, or in accordance with other customary business practices) and are committed to perform their respective obligations.
- b. The entity can identify each party's rights regarding the goods or services to be transferred.
- c. The entity can identify the payment terms for the goods or services to be transferred.
- d. The contract has commercial substance (that is, the risk, timing, or amount of the entity's future cash flows is expected to change as a result of the contract).
- e. It is probable that the entity will collect substantially all of the consideration to which it will be entitled in exchange for the goods or services that will be transferred to the customer.

Criteria (a) through (c) relate to the parties' rights and obligations under the arrangement. The rights of the parties must be identifiable from the contract; otherwise, the entity will not be able to identify its performance obligations in Step 2 of the process (HC 3.2.2).

The arrangement between the provider and patient does not have to be written; it can be oral or evidenced through established business practices. In accepting the patient's request to be seen, contacting a patient to establish an appointment, or admitting a patient to an inpatient setting, the provider indicates its willingness to provide services requested by the patient. On the patient's end, requesting an appointment or presenting themselves for assessment or treatment inherently constitutes a request for services. In addition, patients (or their legal representatives) typically will sign a "patient responsibility form," which acknowledges the patient's responsibility to pay for the services, or in some cases may sign a consent form for certain procedures. In situations involving emergency treatment of a patient who is unconscious or otherwise unable to sign a legally enforceable agreement (e.g., a minor), an oral or implied contract may exist based on legal standards and customary health care practices.

See AAG-REV 7.6.05 for additional commentary about the existence of a contract.

## Question HC 3-2

Hospital's practice is to obtain a signed patient consent form prior to performing certain procedures. Patient does not sign a consent form prior to receiving services due to administrative oversight or the procedure did not require a signed consent. Can an enforceable contract exist if the patient has not signed written consent for services?

### ***PwC response***

Typically, yes. The lack of a written agreement and the fact that the hospital's policy is to obtain a patient acknowledgement does not necessarily mean that a contract does not exist. However, the hospital will need to consider the individual facts and circumstances to determine if there is an oral or implied contract, including customary business practices. For example, if the patient scheduled the procedure in advance or presented themselves for treatment, the hospital may conclude that there is a legally enforceable oral or implied contract with the patient.

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Regarding criterion (c), as long as there is an enforceable right to receive payment in exchange for the goods or services, the transaction price does not need to be expressly stated within the agreement. In fact, in contracts for health care services, the transaction price often differs from the amount that will be billed to the patient, as discussed in HC 3.2.3.

Criterion (d) requires that the contract have commercial substance (that is, the entity must expect its cash flows to change as a result of the services provided). It is closely related to criterion (e), which requires that the provider be able to conclude that it is probable that it will collect the consideration to which it will ultimately be entitled, based on an assessment of the customer's ability and intent to pay as amounts become due. Often, providers will perform services without knowing whether the patient will be able to pay the bill (or the portion of the bill for which the patient is responsible). When a provider is aware of significant credit risk on the part of a customer at the inception of an arrangement (for example, the individual requesting services is uninsured or underinsured), the health care entity must consider that risk in its evaluation of whether the customer is committed to perform its obligations under the contract (i.e., to pay for services rendered).

As discussed in AAG-REV 7.6.19 and AAG-REV 7.6.43, for purposes of assessing criterion (e), the collectability assessment for patient contracts that are inherently at high risk for non-payment would be made using an estimated transaction price that is reduced by the expected uncollectible amounts. Two important concepts discussed in Step 3 – *implicit price concessions* (see HC 3.2.3) and the use of a *portfolio approach* (see HC 3.4.1) – underpin that conclusion. Because the estimated transaction price in these situations typically is based on the lower amounts expected to be collected, such contracts would be deemed to pass criterion (e).

### Question HC 3-3

Normally, Hospital's ability to collect accounts receivable from patients in the uninsured self-pay payer class has been poor (historically, an average of 20% of the total gross charges is collected from this class of patients). Thus, it appears unlikely that Hospital would be able to conclude that it is probable that it will collect all of the consideration to which it is entitled for services to those patients. How is the collectability threshold in ASC 606-10-25-1(e) evaluated in such situations?

#### *PwC response*

If Hospital provides services to patients that are inherently at high risk for non-payment, the collectability analysis typically would be based on an expectation of performance for a portfolio of high-credit-risk contracts as a whole, rather than on the basis of expectations of collectability from each individual high-credit-risk patient. (If Hospital did not utilize the portfolio approach and instead performed the evaluation for each individual patient, it would be unlikely that the arrangement would qualify as a contract with a customer.)

The collectability assessment for the portfolio would use an estimated transaction price that is based on the expected performance of the portfolio of contracts in the aggregate. Thus, if the entity historically collects 20 cents on the dollar on average for contracts in this portfolio, the transaction price for a portfolio of contracts representing \$1 million of charges would be estimated at \$200,000. Because the amount expected to be collected will be the same as the expected transaction price, Hospital would conclude that it is probable that the entity will collect the \$200,000, and the contracts within the portfolio will pass criterion (e). The logic is that, absent evidence to the contrary, Hospital is just as likely to collect the average amount (in this case, 20 cents on the dollar) from any one patient in the portfolio as another. Example HC 3-3 in HC 3.4.2 illustrates the calculation of the transaction price in such a situation.

#### **3.2.1.1 Identifying the contract's term**

Another important aspect of the contract with the customer is properly identifying its term (duration). For many FFS health care arrangements, the service—a procedure, an office visit, a hospital stay—may be delivered in a finite period of time and identifying the contract term will be straight forward. However, in some long-term care arrangements, such as in-home nursing or skilled nursing services in a facility, identifying the contract term may be more challenging.

For accounting purposes, the contract's term may differ from the stated term as a result of features such as termination rights and renewal options. Providers will need to carefully evaluate such features to determine how they affect contract duration (that is, the period in which there are enforceable rights and obligations between the parties), as the duration directly impacts the identification of performance obligations and how and when revenue can be recognized under the contract.

#### **Excerpt from ASC 606-10-25-3**

An entity shall apply the guidance in this Topic to the duration of the contract (that is, the contractual period) in which the parties to the contract have present enforceable rights and obligations.

For example, if an arrangement is cancellable at the discretion of the patient and without penalty (as is often the case with health services arrangements covering extended periods), the stated contract term

is disregarded. For ASC 606 purposes, the contract term extends from inception to the earliest date on which the customer can terminate. Essentially, this becomes a contract for the shorter term, with options to renew.

### **FASB Staff Q&A Revenue**

Excerpt from Question 8: How do customer termination rights and penalties affect the identification of a contract duration?

The staff thinks that paragraph BC391 of Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), clarifies that customer cancellation rights can be similar to a renewal option. The staff thinks that this would typically be the case when there are no contractual penalties that compensate the other party upon cancellation and when the customer has the unilateral right to terminate the contract for other than cause or contingent events outside the customer's control.

Similar issues arise for “evergreen” contracts, such as open-ended contracts for residential care. Often, the stated term of the contract between the resident and the skilled nursing facility (SNF) is one month, with automatic renewal unless one of the parties provides notice of termination. However, if the resident has the unilateral right to terminate at any time during the month with no penalty (so the provider's compensation would be limited to payment for days of service actually provided), the contract actually has a day-to-day term with options to renew. In other words, each day is a separate contract that will automatically renew for another day unless terminated.

Example 7-5-2 and Example 7-5-3 in AAG-REV 7.5.08 illustrate these concepts. See HC 3.2.2.1 for discussion of how termination features and renewal options affect the determination of performance obligations.

### **3.2.2 Step 2 – Identify the performance obligations in the contract**

Under ASC 606, the actions or deliverables for which the customer has contracted are referred to as “performance obligations.” Step 2 in the five-step process is to identify the performance obligation in a contract with the customer.

According to ASC 606-10-25-14, a performance obligation is a promise in a contract to provide the customer with a distinct *good or service*, a distinct *bundle of goods or services*, or a *series* of distinct goods or services that are substantially the same. Some contracts may involve a single performance obligation, while others may include multiple performance obligations. Appropriately identifying the performance obligations directly impacts how and when revenue can be recognized under a contract.

HC 3.2.2.1 (which focuses on identifying distinct bundles of services) and HC 3.2.2.2 (which focuses on a series of repetitive services) consider the aspects of identifying performance obligations that are most relevant to fee-for-service health care services contracts. For a comprehensive discussion of Step 2 considerations, see RR 3.

#### **3.2.2.1 Identifying distinct bundles of services**

Health care services contracts typically involve delivery of more than a single good or service to the patient. Delivering health care services normally involves diagnosis, evaluation, and carrying out a

plan of care prescribed by a medical professional. Thus, identifying the performance obligation(s) within a health care services contract involves determining (from the perspective of the patient) whether the patient is contracting to purchase an array of individual goods and services in the course of the office visit or inpatient stay (in which case each good or service might represent an individual performance obligation), or instead whether the patient is contracting for the “output” of a process that incorporates those goods and services (for example, diagnosis and treatment for a sore throat; a routine physical examination; a knee replacement).

ASC 606-10-25-19 outlines two criteria that are used to determine whether an individual good or service promised in a contract should be accounted for as a separate performance obligation (i.e., it is “distinct”).

#### **ASC 606-10-25-19**

A good or service that is promised to a customer is distinct if both of the following criteria are met:

- a. The customer can benefit from the good or service either on its own or together with other resources that are readily available to the customer (that is, the good or service is capable of being distinct).
- b. The entity’s promise to transfer the good or service to the customer is separately identifiable from other promises in the contract (that is, the promise to transfer the good or service is distinct within the context of the contract).

In health care services transactions, criterion (b) typically acts as an initial screen in this evaluation. Its objective is to determine whether the nature of the provider’s promise is to transfer individual goods or services to the patient, or instead to transfer a “combined item” to which those individual goods and services are an input.

ASC 606-10-25-21 provides the overarching principle that is relevant to evaluating criterion (b).

#### **ASC 606-10-25-21**

In assessing whether an entity’s promises to transfer goods or services to the customer are separately identifiable in accordance with paragraph 606-10-25-19(b), the objective is to determine whether the nature of the promise, within the context of the contract, is to transfer each of those goods or services individually or, instead, to transfer a combined item or items to which the promised goods or services are inputs. Factors that indicate that two or more promises to transfer goods or services to a customer are not separately identifiable include, but are not limited to, the following:

- a. The entity provides a significant service of integrating goods or services with other goods or services promised in the contract into a bundle of goods or services that represent the combined output or outputs for which the customer has contracted. In other words, the entity is using the goods or services as inputs to produce or deliver the combined output or outputs specified by the customer.
- b. One or more of the goods or services significantly modifies or customizes, or are significantly modified or customized by, one or more of the other goods or services promised in the contract.

- c. The goods or services are highly interdependent or highly interrelated. In other words, each of the goods or services is significantly affected by one or more of the other goods or services in the contract. For example, in some cases, two or more goods or services are significantly affected by each other because the entity would not be able to fulfill its promise by transferring each of the goods or services independently.

Factor (a) in ASC 606-10-25-21 describes an interrelationship between promised goods and services that are present in most health care services contracts. Viewed from the patient's perspective (as required by ASC 606), the individual goods and services are "inputs" that will be used in a process to produce an outcome (i.e., output) for which the patient is contracting. If the patient is contracting for a combined output, the array of goods and services that will be utilized in the process *must* be combined into a single performance obligation, and consideration of ASC 606-10-25-19(a) becomes irrelevant.

Example HC 3-1 illustrates the application of this guidance to a contract between a hospital and a surgical patient. AAG-REV 7.5.08 provides additional illustrations of this determination for inpatient hospital services (Example 7-5-1) and physician office services (Example 7-5-2).

### **EXAMPLE HC 3-1**

#### **Single performance obligations – combined bundle of goods or services**

Surgeon admits a patient to Hospital for knee replacement surgery. Hospital is responsible for the overall management of the process that accompanies Surgeon's services, which includes providing (among other things) professional services of employees (e.g., nursing and technicians), a prosthetic joint, surgical instruments, drugs, surgical supplies, anesthesia, a sterile environment, and pre- and post-operative care. The patient remains in the hospital for four days, and the resources required to care for the patient will differ significantly for each day of care (with the most intensive resources required on the day of surgery and the day following surgery).

How many performance obligations are embodied in Hospital's contract with the patient?

#### *Analysis*

In this fact pattern, the bundle of goods and services provided by the hospital represent a single performance obligation. While certain of the promised goods and services might, in theory, be capable of being distinct performance obligations (because the patient could benefit from the goods and services either on their own or together with other readily available resources), Hospital does not make these services available for purchase "a la carte." Hospital only provides these services as part of a treatment plan prescribed by a medical professional; with the exception of cafeteria meals or hospital-based pharmacy sales, they cannot be individually purchased by an individual. Further, the individual goods and services are not separately identifiable from the overall promise in the contract, which is to provide the setting and care required for replacing the knee; the individual goods or services are simply inputs into that process.

Ultimately, Hospital provides a significant service of integrating the various goods and services into the treatment plan which has been ordered on the patient's behalf by the physician; therefore, Hospital would conclude there is one performance obligation.

For additional commentary on this determination, see the interpretive guidance beginning at AAG-REV 7.2.01, which discusses general considerations related to identifying the performance obligations in health care contracts, including the notion of “significant integration” of services.

### 3.2.2.2 Applying the “series guidance”

According to ASC 606-10-25-14, a performance obligation is a promise in a contract to provide the customer with a distinct *good or service*, a distinct *bundle of goods or services*, or a *series* of distinct goods or services that are substantially the same.

#### ASC 606-10-25-14

At contract inception, an entity shall assess the goods or services promised in a contract with a customer and shall identify as a performance obligation each promise to transfer to the customer either:

- a. A good or service (or a bundle of goods or services) that is distinct
- b. A series of distinct goods or services that are substantially the same and that have the same pattern of transfer to the customer (see paragraph 606-10-25-15).

ASC 606-10-25-14(a) -- identifying distinct bundles of goods or services within a contract—is discussed in HC 3.2.2.1. Sometimes the process associated with a prescribed course of treatment will involve delivering a series of substantially similar treatments – for example, a series of recurring outpatient physical therapy or rehabilitation services. This section discusses accounting considerations related to those situations, which are the topic of ASC 606-10-25-14(b).

Consider a situation when a patient is prescribed a series of six physical therapy visits, and the arrangement between the patient and the physical therapy provider cannot be cancelled by either party. If the guidance in ASC 606-10-25-14(a) were to be applied, the noncancelable arrangement would represent a single contract with six separate performance obligations, which introduces complexities into the accounting.

ASC 606-10-25-14(b) – referred to as the “series guidance” – addresses these situations and, if the characteristics of the individual treatments qualify, significantly simplifies the accounting. It states that a series of distinct goods or services provided over a period of time is viewed as a single performance obligation if the distinct goods or services are substantially the same and have the same pattern of transfer to the customer. When both characteristics are present, application of the “series guidance” is mandatory (not optional). The guidance provides criteria for determining whether a series of distinct goods or services has the “same pattern of transfer.”

#### Excerpt from ASC 606-10-25-15

A series of distinct goods or services has the same pattern of transfer to the customer if both of the following criteria are met:

- a. Each distinct good or service in the series that the entity promises to transfer to the customer would meet the criteria...to be a performance obligation satisfied over time.

- b. ...the same method would be used to measure the entity’s progress toward complete satisfaction of the performance obligation to transfer each distinct good or service in the series to the customer.

For additional information on the “pattern of transfer” and application of the “series guidance” in general, see RR 3.2.2.

The situations discussed above pertain to arrangements that are noncancelable. However, a patient who is prescribed a series of physical therapy visits might decide not to finish the series, and normally there is no penalty should they choose to end treatment early. If an arrangement for a series of services is cancellable at the discretion of the patient and without penalty, the “series guidance” cannot be applied. Consequently, the identification of performance obligations differs in these circumstances. In these situations, the stated contract term is disregarded. Instead, the duration of the arrangement is viewed as a relatively short initial contract term accompanied by a series of renewal options. The initial contract term ends on the earliest date on which the customer can terminate without significant penalty.

### **Excerpt from ASC 606-10-25-3**

An entity shall apply the guidance in this Topic to the duration of the contract (that is, the contractual period) in which the parties to the contract have present enforceable rights and obligations.

In the physical therapy example, the right to terminate the arrangement shortens the term of the contract between the patient and the provider to a single treatment. The additional treatments are viewed as “renewal options” that can be exercised at the patient’s discretion. Therefore, if the patient completes the entire course of treatment, the arrangement would comprise six separate contracts, the initial contract and five renewal contracts.

### **FASB Staff Q&A Revenue**

Excerpt from Question 8: How do customer termination rights and penalties affect the identification of a contract duration?

The staff thinks that paragraph BC391 of Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers* (Topic 606), clarifies that customer cancellation rights can be similar to a renewal option. The staff thinks that this would typically be the case when there are no contractual penalties that compensate the other party upon cancellation and when the customer has the unilateral right to terminate the contract for other than cause or contingent events outside the customer’s control.

For health care providers, the concept of a short-term, cancellable contract with “renewal options” is a new accounting concept for healthcare arrangements introduced by ASC 606. Like any option that is a right to buy something in the future for a specified price, renewal options in this context give a customer the right to extend a contract in order to acquire additional goods or services of the same type as those supplied under the original contract (in our example, five options to acquire additional physical therapy visits of the same type as the initial visit). Depending on the specified price of the optional services, the renewal option could provide the patient with a “material right,” which is an

additional promise embedded in the contract that would need to be accounted for as a separate performance obligation.

#### **Excerpt from ASU 2014-09 Basis for Conclusions**

BC391. A renewal option gives a customer the right to acquire additional goods or services of the same type as those supplied under an existing contract.... A renewal option could be viewed similarly to other options to provide additional goods or services. In other words, the renewal option could be a performance obligation in the contract if it provides the customer with a material right that it otherwise could not obtain without entering into that contract.

According to ASC 606, if the additional services are offered at the “standalone selling price” (that is, the price at which the services would be sold separately to any other customer), then no material right exists. The arrangement has a single performance obligation, which is to provide the services associated with the initial visit.

#### **Excerpt from ASC 606-10-55-43**

If a customer has the option to acquire an additional good or service at a price that would reflect the standalone selling price for that good or service, that option does not provide the customer with a material right.

However, if the option gives the patient the right to acquire the services for free or at a discount, a material right may be embedded in the contract. A material right is an option to purchase additional goods or services at a price that is less than what the customer would have paid if they had not entered into the original contract. RR 7.2 provides further information on analyzing whether a price concession provided on future services is a material right that represents a separate performance obligation under the contract.

#### **Excerpt from ASC 606-10-55-42**

If, in a contract, an entity grants a customer the option to acquire additional goods or services, that option gives rise to a performance obligation in the contract only if the option provides a material right to the customer that it would not receive without entering into that contract.... If the option provides a material right to the customer, the customer in effect pays the entity in advance for future goods or services, and the entity recognizes revenue when those future goods or services are transferred or when the option expires.

RR 7 provides additional discussion over accounting for material rights included within a contract.

Example HC 3-2 illustrates the accounting for a physical therapy program consisting of several distinct but similar services that contains a termination option. Example 7-5-2 and Example 7-5-3 in AAG-REV 7.5.08 provide additional examples for physical therapy and residential skilled nursing facility (SNF) care, respectively. For additional information on customer options (including renewal options), refer to RR 3.5 and RR 7.

## EXAMPLE HC 3-2

### Outpatient physical therapy services – program of multiple treatments with option for cancellation by patient

Patient A sees a physician for diagnosis and treatment of an injury. The physician orders six physical therapy sessions for Patient A. Patient A's insurance company will pay a fixed amount for the therapy services on a per-visit basis, up to the total number of visits ordered by the physician.

Patient A makes an appointment with PT Clinic. PT Clinic provides the initial therapy session and indicates its willingness to provide the entire series of treatments. At any point in the series, Patient A is free to discontinue PT Clinic's services without penalty (for example, to change to a different physical therapy clinic, or to simply discontinue receiving therapy).

At inception, how many performance obligations are included in the arrangement between PT Clinic and Patient, and what is their nature?

#### *Analysis*

This arrangement has a single performance obligation, which is for PT Clinic to provide the services associated with the initial visit.

The key point to consider is that Patient A has discretion as to whether to continue receiving the services from PT Clinic. At any point in the treatment series, Patient A might opt to change to a different physical therapy provider or to discontinue treatment altogether. For purposes of ASC 606, this means that the arrangement between PT Clinic and Patient A contains a termination provision. If Patient A terminates the arrangement, Patient A would have no obligation to pay PT Clinic for any services beyond those actually provided (i.e., there is no penalty for terminating).

Under ASC 606, the enforceable rights and obligations under this arrangement—PT Clinic's obligation to provide services, and Patient A's obligation to pay for those services—are limited to the first visit in the series, due to Patient A's ability to cease further treatment from PT Clinic without penalty. In effect, the arrangement is a contract for a single treatment with renewal options (that is, an option to return five more times) that can be exercised at Patient A's request. If and when Patient A exercises an option (that is, returns for another treatment), that visit (and any subsequent visits) will each represent a separate, renewable contract. Said differently, if Patient A completes the entire series of treatments, it will involve six separate contracts, each with its own performance obligation.

At the inception of the arrangement, PT Clinic must also evaluate whether Patient A's option to renew the contract provides Patient A with a material right; if so, the contract would contain an additional performance obligation to stand ready to provide the additional services at a discount if the customer requests them. Under ASC 606, a material right is the right to acquire the additional goods and services at a discounted price. In this fact pattern, because the prices for each succeeding treatment remain the same, the renewal option is not a material right.

Note that if the arrangement had been non-cancellable (e.g., if Patient A were obligated to pay for all six treatments in the series, regardless of whether they actually receive all the services) and each treatment was substantively the same, PT Clinic would have likely concluded that its performance obligation was a series under ASC 606-10-25-14(b). In that case, the entire series of treatments would have been viewed as a single performance obligation recognized over the period that the treatments

are performed. PT Clinic would need to determine an appropriate measure of progress for recognizing revenue.

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### **3.2.3 Step 3 – determine the transaction price**

Step 3 of the five-step model is to determine the transaction price, which is the amount of consideration to which an entity expects to be entitled in exchange for transferring the promised goods and services under the contract (or portfolio of similar contracts). This represents the amount that will ultimately be recognized as contract revenue.

The determination of the transaction price is often the most complex aspect of a health care provider's revenue recognition process. This section covers the basics of Step 3. Variable consideration (e.g., implicit price concessions, retroactive price adjustments by government payers) is discussed in depth in HC 3.3, HC 3.4, and HC 3.5. For health care providers, most health care service revenue will have some element of variable consideration.

ASC 606-10-32-2 identifies fundamental principles for establishing the transaction price.

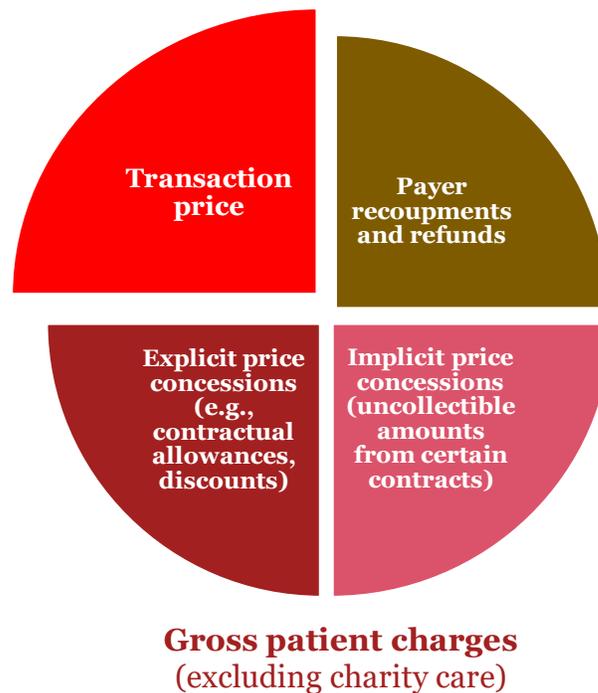
#### **ASC 606-10-32-2**

An entity shall consider the terms of the contract and its customary business practices to determine the transaction price. The transaction price is the amount of consideration to which an entity expects to be entitled in exchange for transferring promised goods or services to a customer, excluding amounts collected on behalf of third parties (for example, some sales taxes). The consideration promised in a contract with a customer may include fixed amounts, variable amounts, or both.

The notion of “transaction price” is focused on the amount of consideration that the provider *expects to be entitled to* rather than the amount billed to the patient (or other payers). In many arrangements to provide health care services, the transaction price is often a relatively small fraction of the provider's overall “gross charges,” as illustrated in Figure HC 3-1.

**Figure HC 3-1**

Derivation of transaction price -- fee-for-service arrangements

**3.2.3.1 Fixed consideration**

In many cases, gross patient charges will be reduced by explicit price concessions, which are explicit reductions in the price for the services. An example is a contractual allowance or contractual adjustment. As discussed in HC 2.1.4.1, health plans will often negotiate discounted rates on behalf of their subscribers, members, or enrollees. The difference between the provider's established rates for its services and the discounted rate it agrees to accept is often tracked as a contractual allowance (a contra-revenue account) in the underlying accounting records (see HC 2.1.2). Amounts billed to both patients and payers will reflect these explicit, or contractual, price concessions.

Another example of an explicit price concession is a policy discount. This might be an across-the-board discount offered to uninsured patients who do not qualify for charity care; a discount negotiated individually with an uninsured patient; or a courtesy discount provided to a health care entity's employees. As with contractual discounts and allowances, the difference between gross charges and the amount billable after application of the discount is considered a reduction of the transaction price (reduction of revenue) for the specific contract.

**3.2.3.2 Variable consideration**

Variable consideration also has to be evaluated when determining the transaction price. In healthcare, variable consideration can be significant and can include reductions to gross charges (such as those due to implicit price concessions or payer recoupments), or increases in the transaction price (such as those due to payer refunds). Variable consideration is discussed more extensively in HC 3.3, with an overview of the concepts provided below.

Implicit price concessions differ from explicit price concessions in that they typically are not specific to individual patients and also because they are not contractually specified or determinable at the inception of the contract. They arise because the portion of bills for which patients are responsible (either through deductibles and coinsurance, or because patients are uninsured) often carries a high risk of uncollectibility, and providers often perform services without knowing whether patients will be able to pay. Thus, in order to determine transaction price pursuant to the principle in ASC 606 of “the amount that the provider expects to be entitled to,” amounts that are not expected to be collectible from patients will reduce the transaction price “up front” rather than being treated as bad debt expense.

This upfront reduction of revenue differs from the handling of uncollectible customer amounts in most other industries. In healthcare, the provider is not extending credit to the patients in the traditional sense; instead, they are providing services despite knowing that the patient may not be able (or willing) to pay. Because the entity does not know at inception how much will be collected (or will remain uncollected) from specific patients, implicit price concessions are not “pushed down” to individual patient accounts (that is, they are not reflected in patient bills) but instead, are estimated on a portfolio basis by class of patient (see HC 2.1.4) and reduce aggregate patient care revenues. For internal record-keeping purposes, these estimated implicit price concessions can be thought of similar to an allowance for doubtful accounts (bad debt reserve) and will periodically be updated based on actual collections experience. Implicit price concessions are discussed further in HC 3.3.1.

Payer recoupments and refunds are another form of variable consideration that will affect transaction price. Any compensation that a provider expects to have to return to a government payer, such as Medicare and Medicaid, must be estimated at the time services are provided and excluded from the transaction price. Under the existing regulatory framework, those payers retain rights to perform post-payment reviews that may result in denials of claims previously paid or retroactively adjust compensation through other means (e.g., settlement or reduction of future claim payments). The potential for such adjustments must be estimated and excluded from revenue in the periods that the related services were provided as discussed in HC 3.3.2.

### **3.2.3.3 *Non-revenue transactions***

Gross patient charges utilized in determining the transaction price exclude charges related to charity care services provided. As discussed in HC 5.2.1, charges associated with charity care services do not qualify for recognition as revenue. Thus, arrangements involving charity care services do not represent a contract with a customer because a provider does not expect to be entitled to any compensation for these services (see AAG-REV 7.6.15).

### **3.2.3.4 *Significant financing components included in contracts***

In some contracts within the scope of ASC 606, payments by or on behalf of customers are received either significantly before or significantly after the seller provides the goods or services. Sometimes contracts are structured in this manner in order to provide financing to one of the parties (either explicitly or implicitly). For example, a customer might make a large upfront payment that provides financing to the seller (in lieu of the seller obtaining financing from an outside lender). Alternatively, a seller that allows the customer to pay significantly in arrears might be financing the customer’s purchase. In either of these situations, the contract would contain a financing component that might need to be identified and separated from the revenue transaction as either interest income (if the seller allows the customer to pay in arrears) or interest expense (if the customer pays in advance). The assessment of whether a financing component exists and if so, whether it is “significant” under the

guidance in ASC 606-10-32-15 through ASC 606-10-32-19 is a matter of judgment and is based on the facts and circumstances of each contract (see RR 4.4).

Providers often receive compensation either before or significantly after the services were provided. For example, as discussed at HC 3.5, they might receive notices of third-party settlement adjustments or risk-sharing bonuses or penalties months (or years) after the services were provided to the patients. In addition, they might offer extended payment plans to uninsured self-pay patients that span months or years. In evaluating these situations in light of the guidance for identifying a significant financing component, providers should consider the following unique aspects of health care service transactions.

□ *Amounts due to/due from government payers*

At any given time, providers may have substantial amounts that are due to or due from Medicare or Medicaid (for example, in connection with estimated cost report adjustments/settlements or in connection with government risk-sharing programs that can provide incentive payments or claw back funds under penalties). Sometimes, these amounts may not be settled until several years after the periods in which the related health care services were provided to patients. However, as neither the health care entity nor the payer in these situations intend to provide the other party with financing and, pursuant to ASC 606-10-32-17(b), a substantial amount of the consideration promised is variable and the timing of payment varies on the basis of the occurrence or nonoccurrence of a future event that is not substantially within the control of the provider or the patient, such lags between the time the services are provided to patients and the time payment is received (or made) by the government do not give rise to a significant financing component.

The payment terms for services provided to Medicare and Medicaid patients are established under separate contractual arrangements entered into between the government program and the provider, under which the government program controls the timing and amount of payments. The payment terms are not negotiated as part of the contract between the provider and the patient, which is the focus of the significant financing component analysis for ASC 606 purposes.

□ *Receivables from patient contracts with implicit price concessions*

Typically, a financing component in receivables arises from a seller's offer (implicit or explicit) to finance a customer's purchase of goods or services. Prior to extending the offer to finance, the seller will have evaluated the customer's credit standing, and the seller will expect compensation (interest income) for providing the service.

In the health care industry, however, providers often perform services without knowing whether the patient will be able (or willing) to pay the portion of the bill for which they are responsible. Such services give rise to *implicit price concessions*, as discussed in HC 3.3. Providers would be unlikely to offer a patient financing (and expect interest income) in situations where they do not expect to be able to collect the full amount of the receivables; thus, financing would not have been contemplated when the terms of the arrangement were established with the patient.

Even when providers enter into arrangements with uninsured self-pay patients that provide extended payment terms over periods greater than one year, the purpose of those arrangements is to enhance the provider's chances of collecting consideration from the patient (and minimizing the amount to be written off), not to provide the patient with financing. Consequently, the arrangement to provide health care services to the patient is not considered to contain a significant financing component in these situations.

However, if the provider assesses credit prior to providing services and extends credit to the patient (for example, for some self-pay elective procedures), then it would be appropriate for the provider to evaluate whether the arrangement contains a significant financing component. If the provider concludes the arrangement contains a significant financing component, it would need to separate it from the health care services revenue (refer to RR 4.4).

For additional information on healthcare-specific considerations related to evaluating financing components, see AAG-REV 7.6.63 through AAG-REV 7.6.67 and AAG-REV 7.6.105. The “Financing Component” subsection of AAG-REV 7.7.59 provides illustrative disclosures.

### **3.2.4 Step 4 – allocate the transaction price**

As discussed at HC 3.2.2, most health care services contracts promise to provide a bundle of goods and services that represent a single distinct performance obligation. When a contract contains a single performance obligation, Step 4 is irrelevant (i.e., no allocation of the transaction price is required), and the health care entity proceeds directly to Step 5 – recognize revenue (HC 3.2.5).

However, if the contract contains more than one distinct performance obligation, the transaction price determined in Step 3 must be allocated to each of the distinct performance obligations in the contract based on the relative standalone selling price of the goods and services being provided to the patient. The best evidence of a standalone selling price is the price an entity charges for that good or service when sold in similar circumstances to similar customers. For components that aren’t normally sold separately (as is often the case in health care fee-for-service arrangements), guidance on estimating standalone selling prices is provided in ASC 606-10-32-32 to ASC 606-10-32-35.

For a comprehensive discussion of Step 4 considerations, see RR 5.

### **3.2.5 Step 5 – recognize revenue**

The final step of the ASC 606 model is to recognize revenue when (or as) the entity satisfies a performance obligation by transferring the goods or services promised in the contract.

#### **ASC 606-10-25-23**

An entity shall recognize revenue when (or as) the entity satisfies a performance obligation by transferring a promised good or service (that is, an asset) to a customer. An asset is transferred when (or as) the customer obtains control of that asset.

From a health care service provider’s point of view, the concepts of “transferring control” and “obtaining control” may seem counterintuitive, as the service provider is not delivering a tangible product. However, conceptually, a service also transfers an asset (i.e., a benefit) to the customer, even if that benefit is consumed immediately.

A customer might “obtain control” of the benefits over time (as/while the entity is performing), or at a point in time (when the entity’s performance is complete). This determination must be made at the inception of the contract and is made from the perspective of the customer. According to ASC 606-10-25-24, in order to conclude that a performance obligation is satisfied over time, it must meet one or more specified criteria. If the performance obligation does not meet any of those criteria, it is satisfied at a point in time.

**ASC 606-10-25-24**

For each performance obligation identified..., an entity shall determine at contract inception whether it satisfies the performance obligation over time (in accordance with paragraphs 606-10-25-27 through 25-29) or satisfies the performance obligation at a point in time (in accordance with paragraph 606-10-25-30). If an entity does not satisfy a performance obligation over time, the performance obligation is satisfied at a point in time.

As noted in HC 3.2.3, healthcare arrangements may involve multiple payment streams (for example, from the patient, from the third-party payer at the time of service, from the third-party payer in the course of settling the cost report, incentive payments). Regardless of the amount, timing, and variety of payers, all payment streams included in the transaction price pursuant to Step 3, including estimates for variable consideration, are recognized according to the timing of satisfaction of the performance obligation based on the identified measure of progress. Refer to HC 3.3.1.2 and HC 3.3.2 for discussion over subsequent adjustments to the transaction price.

A performance obligation is satisfied over time if it meets one or more criteria specified in ASC 606-10-25-27.

**Excerpt from ASC 606-10-25-27**

An entity transfers control of a good or service over time and, therefore, satisfies a performance obligation and recognizes revenue over time, if one of the following criteria is met:

- a. The customer simultaneously receives and consumes the benefits provided by the entity's performance as the entity performs...
- b. The entity's performance creates or enhances an asset (for example, work in process) that the customer controls as the asset is created or enhanced...
- c. The entity's performance does not create an asset with an alternative use to the entity..., and the entity has an enforceable right to payment for performance completed to date...

AAG-REV 7.5.08 provides several illustrative examples of applying the notion of “transfer of control” in the context of health care services. In cases when the patient is receiving clinical care (e.g., inpatient hospital, outpatient physician, physical therapy, skilled nursing), because the patient simultaneously receives and consumes the benefits provided by the health care provider (criterion (a)), the performance obligations are typically satisfied over time, even when the time from start to finish is very short. In many cases, the time frame for recognition over time may be so short that there will be no substantive difference between point-in-time versus over-time recognition. In situations when the patient is not present when the services are provided (for example, clinical lab tests performed on samples provided by the patient), the determination of the pattern of control transfer may be less straightforward. These situations may involve consideration of criterion (b) or criterion (c) considering, for example, the hypothetical implications of another entity having to step in partway through the contract to fulfill the remaining performance obligation to the customer (see RR 6.3.1), or whether the customer would be obligated to pay for the work performed to date if it cancelled the contract for a reason other than nonperformance (see RR 6.3.3).

Example HC 3-3 illustrates application of the “transfer of control” guidance for clinical lab tests.

### **EXAMPLE HC 3-3**

#### **Laboratory revenue recognized at a point in time or over time**

A patient visits an outpatient clinical lab (Lab A) for a blood test ordered by her physician. A lab technician draws a blood sample and provides patient with the expected time frame for the test results to be provided to the ordering physician. Lab A is entitled to payment upon completion of the test. If Lab A is unable to complete the test (if, for example, the sample drawn is found to be inadequate), it is not entitled to payment for its performance up to that point.

Is Lab A’s performance obligation satisfied at a point in time or over time?

#### *Analysis*

Lab A’s performance obligation would be satisfied (and revenue recognized) at a point in time. Lab A’s performance obligation is to provide the results to the ordering physician. In determining its conclusion, Lab A would evaluate its performance obligation against the criteria in ASC 606-10-25-27;

- Because the patient is not present while the test is being performed, the patient is not able to consume the benefits as the lab is performing the test. Further, if Lab A is unable to complete the test, a replacement lab would likely need to reperform the work, rather than using the work already performed by Lab A. These factors indicate that control of the benefit does not transfer to the patient as the work is performed and thus, criterion (a) is not met.
- Criterion (b) is not met because no tangible or intangible asset is created by Lab A’s work that is controlled by the patient.
- If the contact is terminated prior to completion (for example, the sample drawn from the patient is inadequate and testing cannot be performed), Lab A would not have an enforceable right to payment for the work completed to date. Thus, criterion (c) would not be met.

Because none of the criteria for recognition over time are met, Lab A’s performance obligation would be satisfied (and revenue recognized) at a point in time, which is when the testing process is complete and the results are delivered to the patient’s physician for communication to the patient.

For more information on the general rules for determining whether a performance obligation is satisfied over time or at a point in time, see RR 6.3.

#### **3.2.5.1 Performance obligations— measuring progress toward completion**

When a performance obligation meets one or more of the criteria in ASC 606-10-25-27 (and thus, will be satisfied over time), a health care entity will need to determine a measure of progress toward completion of that performance obligation to determine how much revenue should be recognized at a reporting date that occurs between the inception of the arrangement and the complete satisfaction of the performance obligation.

**ASC 606-10-25-31**

For each performance obligation satisfied over time... an entity shall recognize revenue over time by measuring the progress toward complete satisfaction of that performance obligation. The objective when measuring progress is to depict an entity's performance in transferring control of goods or services promised to a customer (that is, satisfaction of an entity's performance obligation).

Progress is evaluated using either an output method or an input method, whichever best depicts the pattern of transfer of control of the goods or services. For a general discussion of the considerations in selecting an appropriate measure of progress, see RR 6.4. Health care providers will often use input methods, which evaluate progress (and thus the measure of revenue) based on the amount of resources consumed towards satisfying the performance obligation. One common input method – often referred to as the “cost-to-cost” method – uses the ratio of costs incurred at any point to total estimated costs of completing the performance obligation to measure the extent of progress toward completion (sometimes referred to as “percentage-of-completion”). Health care entities often use a variation of this method, which uses gross patient charges (rather than actual costs of delivery) as a proxy for measuring the consumption of resources (i.e., costs) used in treating patients. In an inpatient hospital stay, for example, progress towards completion of the performance obligation might reasonably be measured by comparing cumulative gross charges incurred as of an interim measurement date to the total expected gross charges for the entire inpatient stay. For additional information on the rationale for using gross charges as a measure of resource consumption, see HC 2.1.2. For additional commentary and examples on measuring progress, see Example 7-5-1 in AAG-REV 7.5.08.

In practice, many providers do not estimate total expected gross charges for the entire stay and instead use a “shortcut” to estimate revenue at any point in time over the period of performance. This process is often applied when the overall transaction price is not easily determinable before the patient is discharged. Many providers have determined that gross charges are an appropriate measure of progress, have assigned patients into financial classes, and use portfolio data by financial class to estimate the transaction price for patients; these determinations allow for the use of a streamlined formula to estimate revenue. The streamlined formula is to multiply gross charges to date by the discount factor for the financial class to which the patient has been assigned.

Example HC 3-4 illustrates application of the “transfer of control” guidance in a hospital’s contract for health care services.

**EXAMPLE HC 3-4****Revenue recognized over time – inpatient hospital stay**

Surgeon admits a patient to Hospital for knee replacement surgery on June 29, 20X1 (Day 1). Hospital is responsible for the overall management of the process that accompanies Surgeon’s services, which includes providing (among other things) professional services of employees (e.g., nursing and technicians), a prosthetic joint, surgical instruments, drugs, supplies, anesthesia, a sterile environment, and pre- and post-operative care.

Hospital has determined that all of the goods and services provided to the patient associated with the knee replacement surgery represent a single performance obligation (see Example HC 3-1).

The patient's total gross charges during the four-day stay were \$10,000, incurred as follows: Day 1, \$2,000; Day 2, \$4,000; Day 3, \$3,000; Day 4, \$1,000. Patient has commercial insurance coverage, and Hospital has determined that 55% of the transaction price (\$5,500) will be collectible based on the negotiated rates with the insurer and the financial classification of the patient.

Hospital has a June 30 fiscal year-end. How should revenue be recognized for this contract in Hospital's 20X1 financial statements?

### *Analysis*

Based on the guidance in ASC 606-10-25-27(a), the performance obligation should be accounted for over time because the patient simultaneously receives and consumes the benefits from the transfer of goods or services as the care is provided. Assume that Hospital considers various input and output methods and determines that it will measure progress toward complete satisfaction of the performance obligation.

The amount of revenue recognizable as of June 30, 20X1 is determined by multiplying the transaction price by the measure of the progress at the end of day on June 30, 20X1 (i.e., Day 2): \$6,000 cumulative gross charges through end of Day 2 divided by \$10,000 total expected gross charges for the stay is 60%, multiplied by the transaction price of \$5,500 yields revenue of \$3,300.

Using the streamlined formula, Hospital could also estimate its revenue at the end of Day 2 by multiplying the cumulative gross charges to date (\$6,000) by the percentage of total expected consideration from this payer class (55%), which would also be \$3,300.

## **3.3 Variable consideration**

Under the ASC 606 framework, *variable consideration* refers to consideration that is contingent on the occurrence (or nonoccurrence) of future events. For providers, most patient care contracts will involve variable consideration, for reasons such as:

- implicit price concessions provided to patients (see HC 3.3.1),
- the potential for refunds to or recoupment of payments received from third-party payers—for example, compensation under Medicare/Medicaid provider agreements subject to potential retrospective adjustments (see HC 3.3.2), or
- performance bonuses or penalties included in risk-sharing arrangements (see HC 3.3.2).

When a contract contains variable consideration, Step 3 of the ASC 606 model requires the entity to estimate the amount of consideration to be included in the transaction price.

### **ASC 606-10-32-5**

If the consideration promised in a contract includes a variable amount, an entity shall estimate the amount of consideration to which the entity will be entitled in exchange for transferring the promised goods or services to a customer.

The estimate must be made at the inception of the contract using all relevant data (historical data, current data, reasonable projections). ASC 606 provides two approaches—the expected value method (e.g., probability-weighted estimates) or the most likely amount method—whichever is the best predictor of future results.

#### **ASC 606-10-32-8**

An entity shall estimate an amount of variable consideration by using either of the following methods, depending on which method the entity expects to better predict the amount of consideration to which it will be entitled:

- a. The expected value—the expected value is the sum of probability-weighted amounts in a range of possible consideration amounts. An expected value may be an appropriate estimate of the amount of variable consideration if an entity has a large number of contracts with similar characteristics.
- b. The most likely amount—the most likely amount is the single most likely amount in a range of possible consideration amounts (that is, the single most likely outcome of the contract). The most likely amount may be an appropriate estimate of the amount of variable consideration if the contract has only two possible outcomes (for example, an entity either achieves a performance bonus or does not).

See RR 4.3.1 for a comprehensive discussion of estimating variable consideration. In some health care services arrangements, the expected value method will be the appropriate method because it takes into account the probability of various amounts of payments. The most likely amount method, which uses the single most likely amount in a range of possible consideration amounts, may be appropriate in other health care services arrangements that are limited to one or two outcomes. Importantly, the method selected is not a policy choice; an entity should use the method that it expects will best predict the amount of consideration to which it will be entitled.

Once the estimate is made, it remains possible that the actual consideration may prove to be lower than the amount estimated. To mitigate the risk that revenue is recognized in excess of the amount ultimately realized, which would require negative adjustments to revenue in future periods, variable consideration is subject to a “constraint” imposed by ASC 606-10-32-11. The constraint stipulates that the estimated transaction price must be constrained (capped) to exclude any amount for which it is probable that a significant reversal of revenue would be required in the future if the uncertainty resolves unfavorably.

#### **ASC 606-10-32-11**

An entity shall include in the transaction price some or all of an amount of variable consideration estimated in accordance with paragraph 606-10-32-8 only to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved.

When assessing the constraint, entities should consider both the likelihood *and* magnitude of a revenue reversal. ASC 606-10-32-12 identifies factors that could increase these risks. For example, an entity with limited experience in making estimates involving these contracts may have a higher likelihood of a revenue reversal than would an entity with significant experience. See RR 4.3.2 for a

comprehensive discussion of these factors. Importantly, the estimate of variable consideration is not constrained if the potential reversal of cumulative revenue recognized is not significant, or if a potential reversal that would be significant is not probable of occurring. Said differently, there is no basis to defer revenue simply because the amount collectible is uncertain.

When assessing the need to constrain an estimate of variable consideration, a health care entity should also consider whether the estimate inherently incorporates the principles on which the guidance for constraining estimates is based (see HC 3.5.2). In such cases, there is no further needed to separately apply a constraint.

In addition to guidance on the “day one” accounting issues described above—how variable consideration should be estimated and whether it should be constrained—ASC 606 also provides “day two” guidance addressing subsequent changes in the estimate or the constraint. ASC 606-10-32-14 requires an entity to update its estimate of variable consideration at each reporting date.

#### **ASC 606-10-32-14**

At the end of each reporting period, an entity shall update the estimated transaction price (including updating its assessment of whether an estimate of variable consideration is constrained) to represent faithfully the circumstances present at the end of the reporting period and the changes in circumstances during the reporting period.

Revisions in estimates are reflected as increases or decreases in the transaction price in the period the change occurs. If the performance obligation to which the change in transaction price relates has already been satisfied—i.e., revenue has already been recognized—then any change in the transaction price, up or down, will result in an immediate increase or decrease in revenue. If an entity experiences frequent subsequent adjustments that result in revenue decreases, it may need to re-assess whether its estimation process, including its application of the constraint, is appropriate.

### **3.3.1 *Implicit price concessions***

Health care services provided under fee-for-service arrangements are typically billed to the patient (and if applicable, to the patient’s third-party payer) after the services are provided—that is, they are billed “in arrears.” In most other industries outside the health care sector, businesses that bill in arrears will have screened their customers’ financial condition prior to agreeing to provide the goods or services. In those situations, the entities have chosen to extend credit to their customers based on the customers’ ability to pay and, implicitly, accepted of the risk of nonpayment. In health care, however, providers often will, or are required to, provide services without knowing whether the patient will be able (or willing) to pay for the services or the portion of the bill for which they are responsible. In those situations, providers have not evaluated the patient’s wherewithal to pay and are not extending credit; rather, they are providing services with the understanding that they are not likely to receive all of the compensation to which they are entitled.

This unique aspect of healthcare revenue transactions has two important implications. Ordinarily, if an entity had no basis to assume the collection of the transaction price is probable, a contract would not exist. However, if an entity expects that some amount of consideration will be collected and the entity is likely to accept an amount less than the stated transaction price, an entity can conclude that a contract exists and revenue may be recognized at the lesser amount, which reflects an implicit price concession. The second implication is the distinction between an implicit price concession—which

results in a reduction in transaction price (revenue)—and a valid receivable that subsequently becomes uncollectible due to the customer’s (patient’s) credit risk—which results in a credit loss (bad debt expense).

According to ASC 606-10-32-7(b), if facts and circumstances indicate that the entity’s intention when entering into the contract was to offer a price concession to the customer, the consideration is variable. When consideration is variable, the estimate of the transaction price will incorporate the entity’s expectation of collections and thus, amounts not expected to be collectible are excluded from the transaction price. If on the other hand, the entity has chosen to accept the customer’s credit risk, amounts that are not expected to be collected are considered credit losses on recognized receivables (bad debt expense). See HC 5.2.3 for additional discussion of how to distinguish implicit price concessions from bad debts.

AAG-REV 7.6.24 through AAG-REV 7.6.25 provide interpretive guidance for the health care sector that addresses implicit price concessions. That guidance concludes that if either of the following factors is present, an entity has implicitly provided a price concession to a patient (or to patients in a particular patient class):

- a) The provider has a customary business practice of not performing credit assessments prior to providing services (for example, because it is required by law or regulation, or has a mission to provide medically necessary or emergency services prior to assessing a patient’s ability or intent to pay).
- b) The provider continues to provide services to a patient (or patient class) even when historical experience indicates that it is not probable that the entity will collect substantially all of the billed amount.

Implicit price concessions arise from services provided to insured as well as uninsured patients. With insured patients, the implicit price concession relates to the ‘self-pay’ portion of the charges because the health plan or government program typically does not pay the patient’s entire bill. Providers must collect from patients any deductible and coinsurance amounts, differences between the provider’s charges and amounts allowed by the payer (e.g., insurance company or government program), and insurance payments sent directly to the patient (instead of to the provider).

### **3.3.1.1 *Estimating implicit price concessions***

If the provider concludes that it is offering implicit price concessions, it would estimate the transaction price (or the variable portion of the transaction price) using the methodology described in HC 3.3. For services provided to uninsured patients, the entire transaction price would be variable and subject to estimation. For services provided to insured patients, only the portion of the transaction price associated with amounts for which the patient is responsible would be subject to estimation of implicit price concessions.

Under ASC 606, the portfolio approach (see ASC 606-10-10-4 and AAG-REV 7.7.1 through AAG-REV 7.7.15) is typically employed when estimating the transaction price that includes implicit price concessions. The provider’s expectations of cash collections in the aggregate from contracts within a particular payer class or classes, based on historical experience, will inform the estimate of transaction price. For example, a health care entity might establish separate “portfolios” for uninsured self-pay patients, various classes of insured patients with co-payments and deductibles, or subgroups within

those classifications based on the level at which they believe there is a meaningful distinction in collectibility expectations.

In order to use that approach, the provider would need to conclude that the expected outcome from using a portfolio approach is not expected to differ materially from an individual contract approach. That is, the provider would need to conclude that its expectations with respect to a specific contract within the portfolio are no different than its expectations with respect to any other contract within the portfolio (said differently, it is as likely to collect the average amount from that patient contract as it is from any other patient contract in a given portfolio, or patient class).

The portfolio concept is based on combining a large volume of contracts with homogeneous characteristics in order to derive an average outcome that is representative of the population. Practically speaking, it would be difficult for changes in an individual contract to make a difference in the performance of the portfolio. AAG-REV 7.7.10 indicates that a contract should be removed from a portfolio if the entity subsequently determines that the contract does not have similar characteristics with the remainder of the portfolio.

As discussed in HC 3.3.2, estimates of the transaction price for health care services revenue should incorporate the entity's expectations of cash collections at a level at which it is probable that the cumulative amount of revenue recognized would not result in a significant revenue reversal. When estimating variable consideration associated with implicit price concessions, it may not be necessary to separately assess the need for a constraint, as the estimated transaction price (or component of the transaction price) for a portfolio of contracts is based on the amount expected to be collected. Said differently, in those situations, the calculation of the variable consideration inherently incorporates the principles on which the guidance for constraining estimates of variable consideration is based.

Example HC 3-5 illustrates the estimation of implicit price concessions for the uninsured self-pay patient class.

### **EXAMPLE HC 3-5**

#### **Estimating implicit price concessions for uninsured self-pay patients**

Hospital treats uninsured patients. Hospital offers a 60% across-the-board discount to uninsured patients, and it has a history of collecting 10% (on average) of these discounted charges from patients in this class. Hospital continues to provide services to uninsured patients even when historical experience indicates that it is not probable that Hospital will collect substantially all of the discounted charges.

Hospital has determined it has sufficient historical experience about the uninsured self-pay patient class to apply a portfolio approach in estimating the transaction price. Hospital identifies the "uninsured self-pay" patient class as a portfolio based on qualitative and quantitative factors, including an analysis that shows that the uninsured self-pay patient class shares similar collection patterns based on historical information (that is, variances from reporting period to reporting period in the percentage of collections have been insignificant in the aggregate).

During the most recent reporting period, gross charges for patients in the uninsured self-pay patient class were \$2 million. Hospital estimates that 10% of amounts billed to patients in this category are collectible.

Considering implicit price concessions, what is the estimated transaction price for these services?

### *Analysis*

In the period the services are initially provided, Hospital would recognize the following transactions for this patient class (in aggregate):

Dr. Accounts receivable	\$2,000,000	
Cr. Gross revenue		2,000,000

### *Gross charges associated with portfolio of self-pay patients*

Hospital would first reduce the transaction price for the contracts in the portfolio by the 60% across-the-board discount applied as a matter of policy to uninsured patients (an explicit price concession of \$1.2 million (\$2 million x 60%).

Dr. Discounts (contra-revenue)	\$1,200,000	
Cr. Accounts receivable		1,200,000

### *To reflect explicit price concession applicable to portfolio of self-pay patients*

The remaining charges of \$800,000 (\$2,000,000 - \$1,200,000) would be billed to the patients. Based on Hospital's estimate of collectibility, it would calculate that \$80,000 (\$800,000 x 10% historical collection rate) is the amount of compensation to which it will be entitled for providing these services (that is, the transaction price for the services). Because the facts and circumstances indicate that Hospital's intention when entering into the contracts with these patients was to provide an implicit price concession, the uncollectible \$720,000 (\$800,000 billed charges less \$80,000 expected collections) would be accounted for as an additional reduction of the transaction price. This is the implicit price concession.

Dr. Implicit price concessions (contra revenue)	\$720,000	
Cr. Allowance for uncollectible A/R (contra asset)		720,000

### *To reflect implicit price concession applicable to portfolio of self-pay patients*

Hospital would likely not need to separately assess the need for a constraint as the estimate of the variable consideration inherently incorporates the principles on which the guidance for constraining estimates of variable consideration is based.

Example HC 3-6 illustrates the estimation of implicit price concessions for a patient class that has private insurance with typical deductibles and coinsurance provisions.

## **EXAMPLE HC 3-6**

### **Estimating implicit price concessions for insured patients with traditional deductibles and coinsurance**

Hospital is a participating provider with Health Plan A. Under the terms of the participation agreement, services provided to Health Plan A's subscribers will be discounted by 40% from Hospital's established charges. Health Plan A's traditional health insurance policies state that after deductibles have been met, Health Plan A will pay a portion of a subscriber's bill for covered health care services,

and the subscriber will be responsible for the remaining balance. Based on Hospital A's historical experience, patients are responsible for 20% of the contracted price.

Based on its historical experience, Hospital expects to collect all of the amount due from Health Plan A, but only a portion of the amount due from the patients. Hospital does not have a policy of assessing patients' intent and ability to pay the portion of the bill for which they are responsible prior to providing service.

Hospital utilizes the portfolio approach in estimating the transaction price. Hospital identifies the "Health Plan A co-pays" customer class as a portfolio based on qualitative and quantitative factors. This portfolio includes an estimate of deductible and co-pay balances for each patient based on their health plan's general policies and information obtained during the admissions process. Hospital will not know with certainty how much it will actually collect from these patients until collection efforts have been exhausted. Based on Hospital's historical experience with patients covered by insurance similar to that provided by Health Plan A (i.e., that patient class), it estimates that it will collect approximately 30% of the remaining amount due from patients after insurance (blend of deductibles and coinsurance).

The established charges for services provided by Hospital to Health Plan A's subscribers during the reporting period total \$1,000,000.

Considering both explicit price concessions (contractual discounts) and implicit price concessions, what is the transaction price associated with these services?

### *Analysis*

The explicit price concession is \$400,000 (40% x \$1,000,000). Based on the remaining \$600,000 (\$1,000,000 - \$400,000), the implicit price concession is estimated at \$84,000 (\$600,000 times the estimated patient deductible and coinsurance of 20% times the estimated amounts *not* expected to be collected of 70%). This yields a transaction price of \$516,000 (\$600,000 - \$84,000).

In the period the services are initially provided, Hospital would recognize the following transactions for this patient class (in aggregate):

Dr. Accounts receivable	\$1,000,000	
Cr. Gross revenue		1,000,000

### *Gross charges associated with portfolio of Health Plan A patients*

Hospital would first reduce the transaction price for the contracts in the portfolio by the 40% contractual discount negotiated with Health Plan A (an explicit price concession of \$400,000 (\$1,000,000 x 40%)).

Dr. Contractual allowances (contra-revenue)	\$400,000	
Cr. Accounts receivable		400,000

### *To reflect explicit price concession applicable to portfolio of Health Plan A patient services*

The remaining discounted charges of \$600,000 (\$1 million less \$400,000 of contractual adjustment) will be billed to the patients and Health Plan A. Of that amount, \$480,000 (\$600,000 x 80%) is estimated to be payable by Health Plan A, and \$120,000 (\$600,000 x 20%) is estimated to be paid by

the patients. Based on its historical experience, Hospital expects to collect all of the amount due from Health Plan A, but only \$36,000 of the remaining amount due from the patients (30% x \$120,000). The \$84,000 of patient co-payments that Hospital does not expect to collect (\$120,000 - \$36,000) represents an implicit price concession because Hospital does not have a policy of assessing patients' intent and ability to pay their coinsurance amounts prior to providing service. The implicit price concession is accounted for as an additional reduction of the transaction price.

Dr. Implicit price concession (contra revenue)	\$ 84,000	
Cr. Allowance for uncollectible A/R (contra asset)		84,000

*To reflect implicit price concession applicable to portfolio of Health plan A patients*

Subsequent to initial recognition, if Hospital determines it will only collect \$500,000 (instead of the \$516,000 it initially estimated), it would account for the difference as an increase to the implicit price concession (a reduction to the estimate of the transaction price) in the period that the estimate changes.

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Example HC 3-7 illustrates the estimation of implicit price concessions for patients insured by high deductible plans.

### **EXAMPLE HC 3-7**

#### **Estimating implicit price concessions for insured patients in high-deductible plans**

Medical Group Practice (MGP) is a participating provider with Health Plan B. Under the terms of the participation agreement, services provided to Health Plan B's subscribers will be discounted by 40% from MGP's established charges. Health Plan B's high-deductible health insurance policies state that subscribers are responsible for paying the first \$7,500 of charges during the year, after which Health Plan B will pay 80% of a subscriber's bills for covered services with 20% coinsurance from the subscriber.

Based on its historical experience, MGP expects to collect all amounts that are the responsibility of Health Plan B but only a portion of the amounts due from individual patients. However, at the time services are rendered, MGP will not know whether a patient has met its deductible and, therefore, how much they can expect to receive specifically from Health Plan B versus the patient.

During the reporting period, gross charges for services provided to subscribers in Health Plan B's high deductible plan total \$750,000. MGP considers all Health Plan B's patients in the high deductible plan as a portfolio. Using historical data for services provided to patients covered under similar arrangements as Health Plan B's high deductible plan, MGP determines that it expects to collect a combined total of \$250,000 from Health Plan B and its subscribers.

Considering both explicit price concessions (contractual discounts) and implicit price concessions, what is the transaction price associated with these services?

#### *Analysis*

The explicit price concession is \$300,000 (40% x \$750,000) and the implicit price concession is estimated at \$200,000 (\$750,000 less \$300,000 less estimated collections of \$250,000). Thus, the

transaction price is \$250,000 (\$750,000 less \$300,000 explicit price concession less \$200,000 implicit price concession).

In the period the services are initially provided, Hospital would recognize the following transactions for this patient class (in aggregate):

Dr. Accounts receivable	\$750,000	
Cr. Gross revenue		750,000

*Gross charges associated with portfolio of Health Plan B patients*

MGP would first reduce the transaction price for the contracts in the portfolio by the 40% contractual discount negotiated in the contract with Health Plan B (an explicit price concession of \$300,000 (\$750,000 x 40%).

Dr. Contractual allowances (contra-revenue)	\$ 300,000	
Cr. Accounts receivable		300,000

*To reflect explicit price concession applicable to portfolio of Health plan B patients*

The remaining discounted charges of \$450,000 (\$750,000 less \$300,000 of contractual adjustment) will be billed to the patients and Health Plan B, who share responsibility for payment as described in the fact pattern. At the time services are provided, MGP will not know whether the Health Plan B subscribers will have met their deductibles; consequently, MGP does not know with certainty the portion of these contracts that will be paid by Health Plan B and the portion for which subscribers are responsible.

The \$200,000 that MGP does not expect to collect (\$450,000 discounted charges less expected collections of \$250,000) would be attributed entirely to the subscriber portions, as (based on experience) MGP expects to collect all amounts that are Health Plan B's responsibility whereas MGP does not have a policy of assessing patients' intent and ability to pay their coinsurance amounts prior to providing service. These implicit price concessions would be accounted for as an additional reduction of the transaction price.

Dr. Implicit price concession (contra revenue)	\$ 200,000	
Cr. Allowance for uncollectible A/R (contra asset)		200,000

*To reflect implicit price concession applicable to portfolio of Health Plan B patients*

Therefore, MGP would determine the transaction price to be \$250,000 (gross charges of \$750,000, less contractual adjustments of \$300,000, less the estimated implicit price concessions of \$200,000).

Subsequent to initial recognition, any changes in the estimate to reflect amounts actually collected would generally be accounted for as increases or decreases in the implicit price concession (that is, a change in the estimate of the transaction price) in the period that the estimate changes.

### **3.3.1.2 Subsequent changes in the estimate of price concessions**

Subsequent to initially estimating implicit price concessions related to a portfolio of contracts, the provider will continue to attempt to collect the balances on the patient accounts within that portfolio.

If the actual collection experience for the portfolio differs from the initial estimates, those subsequent changes are accounted for as increases or decreases in the transaction price. Assuming that the underlying performance obligation to which the change in price relates has already been satisfied, as would be expected in most health care services arrangements, those changes in transaction price are immediately recognized as increases or decreases in revenue (not credit losses (bad debt expense)) in the period in which the estimate changes, consistent with the guidance in ASC 606-10-32-42 through ASC 606-10-32-45g.

In practice, most health care providers employ a portfolio approach to estimating implicit price concessions. If, however, a provider is not using a portfolio approach, judgment will be required to determine whether at inception, a contract exists (i.e., whether the provider believes it is probable that they will collect all of the consideration to which they are entitled) and, if so, whether subsequent changes in the amounts expected to be collected are indicative of implicit price concessions or a credit loss (bad debt). An adverse change in a patient's creditworthiness (for example, the patient filed for bankruptcy or lost their job) might indicate that the reduction in collections is more appropriately considered a credit loss (bad debt) rather than a reduction in the transaction price (see AAG-REV 7.6.34). These matters are further discussed in illustrative Example 7-6-1 and Example 7-6-3 in AAG-REV 7.6.43. Absent specific information regarding a deterioration in the patient's financial condition, subsequent reductions in collections will generally be considered an implicit price concession.

### **3.3.2 Government payer programs**

In addition to variable consideration from implicit price concessions associated with individual patients' amounts, variable consideration also arises from features of government programs that create variability in the amount the programs themselves will pay. Examples of those features include the following:

- For an institutional provider, government payers may also compensate the provider through cost report filings for a portion of the overall reimbursement (i.e., transaction price). Complex laws and regulations on which those payments are based include an ability for the government to retroactively adjust the rates it pays for care-specific charges based upon the filing of the cost report by the provider and subsequent audits by the government payer or its designated auditor. The audit process and the resolution of significant related matters (including disputes on differing interpretations of regulations) might not be finalized until several years after the services are rendered.
- State Medicaid programs must obtain CMS approval for changes to state plans. If a state makes payments to a provider during a given year under a program (or an amendment to a program) that has not yet been approved by CMS, those payments may be subject to clawback or recoupment if CMS does not ultimately approve the program. See discussion of provider tax programs at HC 5.3.
- Claims paid during a contract year that appeared at the time to be valid may be subject to adjustment in future years as a result of examinations by government agencies or contractors, or regulatory investigations. See discussion of recovery audit contractor (RAC) audits at HC 2.2.1.3 and discussion of government investigations at HC 2.2.1.3. These uncertainties might not be resolved until several years after the services are rendered.
- Alternative payment programs that require providers to share risk with Medicare often utilize a retrospective settlement feature linked to a performance-based bonus or penalty. Consequently,

the potential for the payment of bonuses or incurrence of penalties pertaining to current year services may not become known until a future period.

### **3.3.2.1 *Estimating variable consideration related to government programs***

When a contract contains variable consideration, the amount of variable consideration would be estimated using either the “expected value method” or the “most likely amount method” described in ASC 606-10-32-8 and HC 3.3. With respect to government program payments, the types of variability described in HC 3.4 often will require estimation of amounts that a provider may have to return to a government program, rather than amounts of additional consideration to be received.

The need for providers to exclude amounts that may have to be returned to a government program is similar to a retailer’s estimates for products sold subject to a right of return. If the expected value method is used, it will take into account the probability of various repayment scenarios, while the most likely amount method will consider the single most likely amount in a range of possible repayment scenarios.

A provider can use different estimation methods for different types of uncertainties; for example, it might use one method for estimating amounts to be refunded related to expected cost report adjustments and another for estimating amounts to be refunded under disproportionate share hospital (DSH) payments, whichever better reflects the expected outcome. Importantly, however, the method selected is not a policy choice; an entity should use the method that it expects will best predict the amount of refund for that uncertainty.

Most institutional providers have many years of experience estimating potential adjustments arising from future audits or desk reviews of cost reports. Although the most likely amount method is typically more appropriate in situations when an outcome will be one of two (or very few) possibilities, AAG-REV 7.6.52 indicates that providers may apply this method in other scenarios if they believe it will better predict the amount that the entity will ultimately be required to repay to the program.

All relevant information (historical data, current data, or reasonable projections) is used in making these estimates. Factors to consider include the extent of a provider’s experience with estimates of that type, the historical accuracy of its estimates, its experience with the fiscal intermediary or RAC auditors, and its current charges, allowable costs, and relevant patient statistics.

Approaches vary from entity to entity, depending on individual facts and circumstances, particularly with respect to estimating future cost report settlement adjustments. For example, some health care systems may evaluate settlements on an individual facility and/or individual cost report year basis (that is, evaluating each cost report by facility and by year, individually), while others may use aggregated historical information. As noted in AAG-REV 7.6.61, some third-party settlement issues may apply to multiple cost reports, and health care entities should use all available information regarding the cost report settlement process to evaluate similar third-party settlement issues.

AAG-REV illustrates the estimation of several other situations involving government program retroactive adjustments, as follows.

- AAG-REV 7.6.70 illustrates the expected value method in estimating future cost report adjustments.
- AAG-REV 7.6.71 illustrates estimating amounts repayable in connection with RAC audits.

- AAG-REV 7.6.72 illustrates estimation of an accrual for DSH payments when the current year cost report has not yet been completed.
- Commentary and examples related to estimating adjustments related to performance-based bonuses or penalties under programs that require providers to share risk with CMS can be found in AAG-REV 7.6.73 through AAG-REV 7.6.108.

AAG-REV 7.6.62 states that differences between original estimates and subsequent revisions, including final settlements, represent changes in the estimate of variable consideration and should be included in transaction price (i.e., revenue) in the period in which the revisions are made in accordance with ASC 606-10-32-14.

### **3.3.2.2 *Constraining estimates of variable consideration***

The amount of estimated variable consideration to be included in the transaction price is recognized subject to a “constraint,” which requires that the estimated amount be adjusted downward to exclude any amount for which it is probable that a significant reversal of cumulative revenue will occur in the future if the uncertainty resolves unfavorably. Thus, with respect to the potential for government program retroactive adjustments, health care entities will need to ensure that their estimate of variable consideration is constrained to a low enough amount such that it is not probable there will be a significant revenue reversal at the time final settlement is made with the government payer. An estimate of variable consideration does not need to be constrained if the potential reversal of cumulative revenue recognized is not significant, or if a potential reversal is significant but not probable of occurring.

If an entity’s estimation methodology for a particular type or component of government program settlements inherently incorporates the principles on which the guidance for constraining estimates is based, it would not need to separately constrain that estimate. For example, given that many institutional providers have extensive historical experience with estimating cost report settlement adjustments, the constraint parameters may already be inherent in their estimation process.

When assessing the need for a constraint, entities should consider both the likelihood and magnitude of a revenue reversal. ASC 606-10-32-12 identifies factors that could increase these risks. For example, an entity with limited experience in making estimates involving these contracts may have a higher likelihood of a revenue reversal than would an entity with significant experience. See RR 4.3.2 for a general discussion of these factors. AAG-REV 7.6.56 through AAG-REV 7.6.61 and AAG-REV 7.6.93 through AAG-REV 7.6.97 provide relevant commentary that is specific to assessing settlement constraints.

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***Chapter 4:***  
***Risk contracting by health  
care organizations***

## 4.1 Risk contracting overview

Most of the revenue for patient care services received by providers is based on the quantity of services provided, which is the traditional “fee-for-service” model (see HC 3.1). However, payers (including individuals, the government, and traditional health insurance entities), in an effort to control healthcare costs, are increasingly moving away from the traditional fee-for-service model. In many cases, contracts with providers have incentives aimed at improving patient care quality while also reducing costs. Those types of arrangements, sometimes called value-based care arrangements or alternative payment models, can result in providers assuming additional economic risk as the transaction price for their services is not based solely on the volume of services provided. In those cases, the provider is compensated for “standing ready” to provide services that may be needed during a specified time period, regardless of the nature or volume of services that will ultimately be provided. Broadly, any arrangement under which the transaction price is not solely based on fixed fees for services would be considered a risk arrangement. Risk contracting can encompass many different types of arrangements, from an arrangement in which the compensation is primarily based on fee-for-service but with additional compensation or bonuses based on the achievement of certain quality benchmarks, to an arrangement in which the provider assumes full responsibility for and 100% of the risk of managing the health care services for a defined population of patients. The latter contract, for which a provider is paid a fixed fee for standing ready to provide defined services to a population of patients, is known as a capitated contract.

In addition to changes in the fee structures, the systemic focus on controlling health care costs and population health management has led to an increase in strategic alliances between providers, payers, and other parties. These alliances can take the form of traditional managed care organizations, accountable care organizations, joint ventures, or other contractual risk-sharing arrangements. In many cases, these strategic alliances or value-based care arrangements can blur the lines between traditional providers of health care services and payer organizations.

This chapter outlines some of the accounting considerations that are unique to these risk-sharing contracts and integrated delivery models. This chapter focuses on the accounting under ASC 606, *Revenue from Contracts with Customers*, although as outlined in ASC 606-10-15-2, entities must first evaluate whether other guidance would apply. Because some of the arrangements covered in this chapter involve multiple parties working together to provide health care to patients, it is imperative for entities to carefully determine the nature of the services they are providing and to whom (i.e., their customer under the risk contract). See HC 4.3 for further discussion of these considerations. Those determinations will drive the accounting model to be applied. Some risk arrangements may be, in whole or in part, within the scope of ASC 815, *Derivatives and Hedging*, or ASC 460, *Guarantees*. When considering the applicability of ASC 815, entities should consider whether the contract meets any of the scope exceptions in ASC 815. For example, ASC 815-10-15-52 scopes out certain insurance contracts that compensate the holder only as a result of an identifiable insurable event. See DH 2 for information regarding the accounting definition of a derivative and DH 3 for information on scope exceptions to derivative accounting. Certain risk contracts may also meet the definition of a guarantee (see ASC 460-10-15-4). However, ASC 460-10-15-7(i) excludes transactions that constitute a guarantee of an entity’s own future performance. See FG 2 for further information on accounting for guarantees.

This chapter focuses on the application of the ASC 606 revenue model to risk contracts as well as the timing of recognition of expenses and losses arising from the risk-sharing mechanisms.

## 4.2 *Risk contracting by institutional providers*

The discussion in this section pertains to risk contracting issues from the perspective of an institutional provider of health care services (e.g., a hospital); risk contracting issues for non-institutional providers (e.g., managed care organizations (MCOs), accountable care organizations (ACOs), and other types of organizations) are discussed at HC 4.3. This section presumes that the contract has been determined, at least in part, to be in the scope of ASC 606. See HC 4.1 for considerations as to other guidance that could apply. See Healthcare Financial Management Association's (HFMA) Principles & Practices Board Statement 11, *Accounting and Reporting by Institutional Health Care Providers for Risk Contracts*, and *Issue Analysis: Revenue Recognition Implications Under Topic 606 for Capitation and Risk Sharing Arrangements*, for additional nonauthoritative guidance on this topic.

### 4.2.1 *Revenue recognition—institutional risk contracts*

Risk contracts are arrangements in which providers and payers agree to share in the financial risk associated with providing health care services to patients. The compensation to institutional providers in some risk contracts is based on services provided to patients under fee-for-service, per diem, per case, or per episode arrangements and include an adjustment to the volume-based transaction price based on pre-defined risk metrics. Revenue recognition considerations for volume-based pricing arrangements are discussed at HC 3. The predominant payment arrangement under most risk contracts, however, is a per-patient (member) capitation payment, which entitles the provider to a fixed amount for each member of a defined member (patient) population.

In capitation arrangements, institutional providers such as hospitals generally agree to provide (or arrange to provide) all of the inpatient services a patient will require. Therefore, the hospital may have to subcontract with other providers to perform any services that it is unable to provide. Examples of common subcontracted services include ancillary diagnostic services (e.g., imaging services such as MRIs and CT scans) or specialized inpatient services (such as burn intensive care, heart surgery, or skilled nursing).

This section discusses some of the unique considerations of applying ASC 606 to capitation arrangements within each of the steps in the five-step revenue accounting model detailed in ASC 606.

#### 4.2.1.1 *Step 1 – identify the contract*

As discussed in HC 3, health care revenue transactions often involve multiple parties: the patient, the provider, and a third-party payer who pays the provider on behalf of the patient (e.g., insurance companies, health plans, governmental programs such as Medicaid or Medicare). Thus, the key question in any health care arrangement is whether, from the perspective of the institutional provider, the customer is the patient that receives the health care services or the third party that pays the provider for those services.

According to section 7.6.46 in the AICPA's Audit and Accounting Guide (AAG) for revenue recognition (AAG-REV), from the perspective of the health care provider and for purposes of applying ASC 606, the contract with the customer is the arrangement between the health care provider and the patient. Separate contracts between health care providers and third-party payers, which establish negotiated prices for services, are not "contracts with customers" under ASC 606 but are instead considered in

determining the transaction price for the goods or services provided under the contract between the patient and the health care provider.

The conclusion reached in AAG-REV 7.6.46 extends to capitation arrangements; the “contract with the customer” under the ASC 606 criteria is between the provider and the patient receiving the services. Capitation contracts, similar to fee-for-service contracts, establish the negotiated price for the health care services and thus impact the determination of the transaction price (step 3, see HC 4.2.1.3) for the services provided to the patient.

#### **4.2.1.2 Step 2 – identify the performance obligations**

Under a capitation arrangement, the health care provider promises to provide care to a group of patients over a stated term. At the beginning of the capitation period, the provider does not know the volume or type of services each patient will require over the contract term, but if a covered patient seeks care, the provider must treat the patient. Therefore, the provider has a stand-ready obligation throughout the contract term.

Stand-ready obligations are considered promises within a contract under ASC 606-10-25-18(e). These obligations will typically meet the criteria to be accounted for as a series of distinct goods or services and therefore, a single performance obligation. Refer to RR 3.3.2 and RR 6.4.3 for additional discussion of the series guidance and stand-ready obligations.

#### **4.2.1.3 Step 3 – determine the transaction price**

The determination of the transaction price can be one of the more challenging steps in the accounting for risk contracts because of the impact of variable consideration. Capitation arrangements typically include two transaction price components. The first is a fixed, periodic fee that is paid on a per member, per month (PMPM) basis. In a risk arrangement that contains only a PMPM fee, the entity assumes all of the financial risk. In order to calibrate the level of financial risk each party is willing to bear and the compensation for that risk, many risk arrangements include a second, variable component that may either result in a surrender of a portion of the PMPM fee, or additional consideration based on various contractually specified performance metrics. Providers should consider both components in determining the overall transaction price of the contract.

In addition, while a provider (or a group of providers) may enter into a primary risk contract with a payer, individual health care providers are likely not providing the totality of health care services to the population of patients covered under the primary risk contract. Therefore, an individual provider will need to separately evaluate and calculate how the total contract consideration from the payer will be split between the individual providers in the group.

#### ***Fixed component – capitation or PMPM fee***

Payers typically make PMPM payments to providers in exchange for the provider agreeing to stand ready to provide services to the covered patients over the contract period. These fees are fixed and are made to the health care providers regardless of the volume of services provided.

### ***Variable component – risk adjustments***

Risk-based arrangements can contain a variety of mechanisms for adjusting the transaction price. The list below includes some common types, but these mechanisms may be referred to by various terms and may be combined in contracts.

- Risk corridors allow the parties to share in cost or savings beyond a certain threshold. For example, if claim costs exceed 105% of a target amount, the payer could be required to make additional payments to the provider. Conversely, if claim costs are less than a target amount (e.g., 95% or less than the target), the provider could be required to repay a portion of the PMPM amount.
- Withholds are a mechanism for the payer to withhold a portion of the PMPM amount until certain benchmarks or quality metrics are achieved.
- Shared savings/shared losses contracts are similar to risk corridors but the shared savings or losses may be based on non-financial metrics, such as improved quality. Shared savings/shared loss arrangements may also be used as an add-on to a traditional fee-for-service arrangement.
- Risk pools are a common term for the group of providers in a risk contract to share favorable and unfavorable financial results.

Payments for risk adjustments (often called settlements) may be calculated at various interim settlement dates throughout the contract term or at the end of a contract period. In either case, these settlement amounts would be applied to all of the services rendered under the contract (i.e., both retroactively to services previously provided and prospectively to services not yet rendered) to determine the ultimate transaction price for a given risk contract. This is similar to cost-based Medicare revenue, which is discussed in HC 2.2.1.2. Because the ultimate transaction price will depend on the final settlement for a particular contract period, estimates of the settlement need to be made, and the transaction price and revenue adjusted each period for this variable consideration using either the expected value or most likely amount method (see HC 3.3). The provider will also need to consider the constraint on the recognition of variable consideration in ASC 606 (see RR 4.3.2).

Two of the more significant challenges in estimating the ultimate transaction price from a risk contract are (1) significant timing mismatches between cash flows and revenue to be recognized and (2) the inability to timely access the data needed to make the estimate.

With respect to the mismatch between cash flow and revenues, consider, for example, a risk adjustment for high utilization or catastrophic cases. In this type of arrangement, the payer often withholds a portion of the agreed-upon capitation fees each month, effectively creating a “reserve” account. When the provider submits claims for payment for services that exceed a specified ceiling, the provider receives an additional payment (for the amount of the excess) from the reserve account. If the reserve account is exhausted, the payer must continue to pay the difference on such claims from its own funds. If funds remain in the reserve account at the end of the contract term, they are remitted to the provider. In this example, since the provider is entitled to the amounts remaining in the reserve account, the distribution is not additional revenue; rather, it represents payment of the originally agreed-upon transaction price (i.e., PMPM amount).

With respect to the inability to timely access data needed to estimate variable consideration, providers may not have timely access to all relevant claims data to definitively calculate the provider’s risk share.

Settlements are typically calculated by comparing actual cost incurred throughout the duration of the contract to a pre-established benchmark; actual costs incurred are usually based on member claims data from multiple providers. In some instances, the payer is the only party with full access to the underlying claims data for the member population and only shares the information with individual providers on a periodic basis. Nevertheless, providers are required to estimate variable consideration and cannot simply default to fully constraining the estimate due to that lack of information. Providers should consider all available information, likely including historical performance for similar contracts or patient populations, to estimate risk settlements.

#### **4.2.1.4 Step 4 – allocate the transaction price**

As discussed in HC 4.2.1.2, obligations under a capitation arrangement will likely meet the criteria to be accounted for as a series, and therefore, a single performance obligation. When a contract contains a single performance obligation, no allocation of the transaction price is required. However, if the contract contains more than one distinct performance obligation, the transaction price determined in Step 3 must be allocated to each of the distinct performance obligations in the contract based on the relative standalone selling price of the goods and services being provided to the patient. The best evidence of a standalone selling price is the price an entity charges for that good or service when sold in similar circumstances to similar customers. For components that are not normally sold separately, guidance on estimating standalone selling prices is provided in ASC 606-10-32-32 to ASC 606-10-32-35.

For a comprehensive discussion of Step 4 considerations, see RR 5.

#### **4.2.1.5 Step 5 – recognize revenue**

As discussed above, under a capitation arrangement, the provider's obligation to provide health care services to patients over the contract term represents a stand-ready obligation that is treated as a series under ASC 606-10-25-15 (see RR 3.3.2). Revenue under capitation arrangements should be recognized based on an appropriate measure of progress toward completing the performance obligation. In a capitation arrangement, it is typically appropriate to utilize a time-based measure of progress and recognize the transaction price (any fixed capitation fees plus an estimate of the variable consideration from any risk-sharing pools) using a straight-line method over the contract period.

If a provider presents a line item captioned "Patient Service Revenue," revenue recorded under capitation arrangements may be presented within the same financial statement line item as patient service revenue recorded under other payment arrangements (e.g., fee-for-service). If capitation payments are received in excess of the amount of revenue recognizable under the estimate of variable consideration and the applicable measure of progress, those amounts should be reported as a contract liability (traditionally referred to as deferred revenue).

Example HC 4-1 illustrates application of ASC 606 to a capitation arrangement.

## EXAMPLE HC 4-1

### Recognition of revenue under a capitation arrangement

Hospital enters into an arrangement with Insurance Company to provide inpatient services for 1,000 members of Insurance Company's health plan. Insurance Company agrees to pay Hospital \$500 per member per month for all services provided during the month. The payments are fixed regardless of the nature or cost of the actual services provided to Insurance Company's health plan members by Hospital. The contract does not contain any risk pools or risk-sharing provisions.

How should Hospital recognize revenue for the capitation arrangement?

#### *Analysis*

Hospital's promise to Insurance Company's health plan members is a stand-ready obligation to provide inpatient services over the contract term. Hospital would determine a measure of progress that best reflects its performance in satisfying this obligation. Assuming Hospital concludes that a time-based measure of progress is appropriate, Hospital would recognize \$500,000 in revenue (\$500 per member per month x 1,000 members) each month.

## 4.3 Risk contracting by non-institutional providers

As health care providers and payers, including both federal (Centers for Medicare & Medicaid Services) and state government payers, continue to focus on delivering cost-efficient, quality care to patients, the line between health care providers and health insurers (payers) has become substantially less defined. Health care providers continue to assume additional risk (and opportunity) through alternative payment models (see HC 4.2) or through creation of their own health insurance plans. Payers, for their part, have begun to acquire or otherwise form strategic alliances with providers. This confluence of providers and payers can take many forms, ranging from vertical integration through acquisitions to the formation of joint ventures or other contract or multi-party cooperation arrangements.

Additionally, the shift toward value-based care and the increased focus on managing the overall cost of delivery has precipitated the emergence of additional participants, and an expansion of their role, in the overall health care delivery ecosystem. These participants may include specialists in alternative health care delivery models (e.g., telemedicine), management service organizations that allow for clinicians to focus exclusively on serving their patients (e.g., physician practice management companies), or organizations that assume the responsibility for managing the overall health and wellness of entire patient populations (e.g., managed care organizations). These entities are difficult to categorize as either, or exclusively a traditional payer or provider. While some entities may take on the obligations of a provider or payer, others may serve merely as an intermediary or advisor to one of those traditional stakeholders within the patient revenue cycle.

As a result, there is not a "one-size-fits-all" model for revenue recognition. Common value-based care models are discussed below; however, these models will likely evolve in the future so a thorough understanding of the entity's role, the contractual arrangement, and the relevant accounting guidance is necessary.

- Payers  
Payers may provide, or arrange for, health care services. They may elect to shift away from the traditional insurance model of accepting full financial risk for the cost of medical care in return for member premiums and toward becoming fully integrated health networks that provide, or arrange to provide, health care for their members. These strategic shifts are achieved through multiple avenues, including acquisitions of existing providers.
- Health care providers  
Providers may create their own insurance plans. They may create a vertically integrated network through the formation or acquisition of an insurance plan. Control over both the health plan and the delivery of care allows traditional providers to holistically manage their patient populations.
- New entrants  
Providers, payers, and other entities that contribute to the collective management and delivery of health care services (e.g., care coordination, administrative services) for a defined population or group of members.

#### **4.3.1 Types of non-institutional providers**

Organizations that might be characterized as non-institutional providers can be created through the formation of partnerships or joint ventures between traditional health care providers and health payers. However, these organizations can also be independent entities that contract with payers or providers to assist in the management of patient populations and the delivery of care. Common types are discussed below.

##### **4.3.1.1 Managed care organizations**

Managed care organizations (MCOs) ensure that services provided to patients are necessary, efficiently delivered, and appropriately priced by directly contracting with providers. As part of this process, MCOs perform care coordination and utilization review services, which may include determining the tests, medications, and length of stay in the hospital that will be covered by the MCO based on the MCO's determination of what is medically necessary.

MCOs may be formed and controlled by institutional providers, physician networks, and/or health plans. However, MCOs may also be independent management services organizations that neither own or employ providers nor are they be a registered health plan. In these instances, MCOs will typically contract with both payers and providers to perform various management and care coordination services and may assume some or all of the financial risk related to the provision of health care services.

Regardless of their form and ownership, MCOs typically fall into one of three categories:

- Health maintenance organizations (HMO)  
HMOs provide, or arrange for the provision of, medical and preventative care to plan members in exchange for fixed, prepaid amounts. Members are assigned a primary care physician, who is generally required to provide a referral before the members can see other health care professionals within the HMO network.

- Preferred provider organizations (PPO)  
PPOs contract with independent health care providers, including physicians, hospitals, home health agencies, and rehabilitation facilities. Under a PPO arrangement, members are given the freedom to choose any provider; however, they are financially incentivized through reduced copayments or lower deductibles to visit in-network, contracted care providers.
- Point of service plans (POS)  
POS plans combine the characteristics of HMOs and PPOs. These plans require patients to have a primary care doctor to oversee care and provide referrals; out-of-network care is available at a slightly increased cost.

Some elements of the accounting by an MCO may require a significant level of judgment, and those judgments can have a material impact on the amount of revenues and expenses reported in the MCO's financial statements. Entities should first determine if they are within the scope of ASC 944, *Financial Services – Insurance*, in which case, insurance accounting would be applied and not the ensuing discussion in this guide. For MCOs that are not in the scope of ASC 944, the key judgments typically include (1) the assessment of whether the entity is the principal or an agent in the delivery of health care services and (2) determining whether the MCO has provided a guarantee to a third-party payer subject to the guidance in ASC 460 – *Guarantees*. For further information on the principal versus agent assessment, see HC 4.3.2 and RR 10. For further information on the accounting for guarantees, see the PwC *Financing transactions* guide.

#### **4.3.1.2 Physician practice management companies**

Physician practice management companies (PPMs), which may also be referred to as administrative services organizations (ASOs) or management services organizations (MSOs), provide non-clinical practice management services to a medical practice (e.g., physician practice). The services provided by PPMs depend on the specific contractual arrangements with the medical practice but will often include revenue cycle management, managed care contracting, human resource management, marketing and public relations, and the provision of administrative personnel. Additionally, PPMs often aggregate individual physician or dental practices into larger groups that can negotiate better rates with insurance companies or other payers.

Most states regulate, to some degree, the legal form of organization under which a physician or dentist, or groups thereof, may practice. Typically, state laws only permit a medical professional to practice as an individual, a member of a partnership, or as an employee of a professional corporation (that is, a corporation in which all the shareholders are medical professionals). Further, state laws generally prohibit, either by specific provisions or as a matter of general policy, a medical professional from conducting a practice as an employee of a general business corporation. These limitations are frequently referred to as "corporate practice of medicine" (CPOM) prohibitions.

In states with strict CPOM prohibitions, PPMs may provide administrative and other non-clinical support to physician practices, but they are prohibited from impacting or controlling a physician's clinical judgment and independent, medical decision-making, which is reserved solely for the physician and the physician practice.

If the physician practice is not consolidated (see HC 4.5), PPMs should evaluate arrangements (i.e., individual contracts) with physician practices using the principal versus agent considerations under ASC 606 (see HC 4.3.2 and RR 10).

#### **4.3.1.3 Accountable care organizations**

Accountable care organizations (ACOs) are specifically defined by the Centers for Medicare & Medicaid Services (CMS) as groups of doctors, hospitals, and other health care providers who come together to provide coordinated, high-quality care to patients in exchange for a portion of the savings that are achieved. ACOs strive for improved patient outcomes at a lower cost through care coordination and information sharing across the delivery network.

Similar to MCOs, ACOs often enter arrangements with payers and providers to perform care coordination services. These services typically include utilization management, care management for chronically ill members, and other services targeted toward reducing the overall cost of care. Given that ACOs typically do not assume primary responsibility for the provision of patient care (i.e., they do not control the delivery of health care services), they are not the principal in the arrangement with the patient. As a result, they typically present their net share of the overall member premiums that they manage as administrative revenue. Notwithstanding that “typical” conclusion, ACOs should consider their specific arrangements to determine if they are the principal or the agent in the provision of health care service, and, in turn, whether they should report revenue on a gross or net basis. In the event that an ACO concludes that it is an agent for the provision of some or all of the health care services provided to its patient population, it should also assess whether its arrangement includes a guarantee to a third-party payer that would be subject to the guidance in ASC 460, *Guarantees*. See FG 2 for more information about accounting for guarantees.

#### **4.3.1.4 Virtual health platforms**

Through virtual health platforms, patients can interact with physicians live, in real-time, through virtual collaboration platforms. Through these platforms, providers and patients communicate directly, often resulting in a diagnosis, treatment plan, or prescription. In addition, technology companies have collaborated with providers to design patient and population health management platforms, which help increase patient engagement across all stages of a physician visit, including patient access, pre-visit, at the point of care, and post-visit. Companies that provide such technology platforms will need to evaluate the principal versus agent considerations under ASC 606 (see RR 10) to determine if they are the party controlling the provision of health care services to patients (i.e., the principal) or facilitating the connection between the patients and the providers using their platform (i.e., the agent). The considerations utilized in this assessment are similar to the considerations utilized for MCOs, PPMs, and ACOs and are discussed in HC 4.3.2.

#### **4.3.1.5 Other non-institutional providers**

MCOs, ACOs, PPMs, and virtual health platforms do not constitute an exhaustive list of all of the types of organizations involved in the health care delivery ecosystem. New business models continue to evolve in the quest to improve the quality of patient care at a lower cost. These models may incorporate characteristics of some, or all, of the organization types discussed above. For example, a physician practice management company may also participate in or own an ACO that provides care coordination services for patients, as well as a technology platform to coordinate care. While each business model is different, the underlying premise is the same whether an entity is considered a traditional provider, a payer, or takes some other form. All entities must carefully consider their contractual arrangements and underlying business activities to determine the appropriate accounting model. The concepts in HC 4.3.2 should be considered when an organization is either directly or indirectly involved in the provision of or payment for health services.

### 4.3.2 *Revenue recognition for risk contracts*

The discussion in this section pertains to risk contracting issues from the perspective of a non-institutional provider of health care services. Institutional providers are discussed at HC 4.2. This section presumes that the entity is not subject to ASC 944, *Financial Services - Insurance*, and that the contract, or a portion thereof, has been determined to be in the scope of ASC 606. See HC 4.1 for a discussion of other guidance that may be applicable.

Non-institutional providers may have a direct or indirect impact on the delivery of health care services to patients. Often the question arises as to which entity, or entities, should recognize patient service revenue in arrangements involving multiple parties. There are two interrelated judgments that often arise in risk contracts:

- Determination of the nature of the services provided. Because the services within the scope of risk contracts often support, in some way, the provision of health care to patients (e.g., via care coordination or utilization review) a determination must be made as to whether those services represent the provision of health care services to patients or administrative services to payers or providers.
- Determination of the customer. As discussed in HC 3, the customer for the delivery of health care services is the patient regardless of which party actually bears the financial cost of (pays for) the service. In addition to shifting some of the financial risk, risk contracts also may assign functions that are part of the overall delivery of health care to multiple parties. Entities entering into risk contracts may be considered to be providing health care services to patients or, on the other hand, may provide management, administrative, and cost-containment services to payers and/or providers.

These interrelated judgments factor into the assessment of whether the entity that enters into a risk contract is the principal in the provision of health care services to patients and, thus, should record health care revenue on a gross basis. When the entity's customer is clearly the payer or provider, an assessment of whether the entity is the principal or agent assessment may not be necessary.

Example HC 4-2 outlines a scenario in which the customer is clearly the payer.

#### **EXAMPLE HC 4-2**

##### **Determination of the customer – services arrangement**

Entity A enters into an arrangement with Health Plan to provide claims processing and utilization review services for Health Plan. In consideration for services provided under the contract, Health Plan agrees to pay Entity A a \$25 PMPM fee based on the total number of Health Plan members each month.

Should Entity A consider Health Plan or Health Plan's members to be their customer?

##### *Analysis*

Under this arrangement, Entity A's customer would be Health Plan. While Health Plan members may be impacted by actions taken by Entity A, the nature of services provided by Entity A represent administrative services provided to Health Plan in the context of managing its financial risk for health

care delivered by providers to patients. The services are not health care services provided to Health Plan's members.

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Example HC 4-3 outlines a more complex scenario.

### **EXAMPLE HC 4-3**

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#### **Determination of the customer – risk arrangement**

Entity B enters into an arrangement with Health Plan to provide claims processing and utilization review services for Health Plan. In addition, Entity B also agrees to provide care coordination and primary care services through its contracted network of primary care physicians for Health Plan's members and assumes full responsibility for the cost of all member medical care, whether provided by its provider network or others. In consideration for services provided, Health Plan agrees to pay Entity B a \$500 PMPM capitated fee based on the total number of Health Plan members each month.

Should Entity B consider Health Plan or Health Plan's members to be their customer?

#### *Analysis*

It depends. In this arrangement, Entity B is providing both administrative services to Health Plan as well medical services to Health Plan's members. Under this arrangement, it is not immediately clear which party is Entity B's customer. It may be that each is a customer for different elements of the arrangement. Entity B should carefully consider the principal versus agent guidance described in RR 10 in making this determination.

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## **4.4 Risk contracts – other accounting considerations**

In instances when an institutional provider enters into a capitated risk contract or a non-institutional provider determines it is providing or arranging for the provision of medical services, the organization's associated revenues are based on the ultimate transaction price for the health care services delivered to patients. In these instances, organizations would also recognize expenses for the payment to third-party providers or sub-contractors for patient care. The guidance discussed in this section is based on expense and loss recognition codified in ASC 954-405, *Health care entities—Liabilities*. While in certain circumstances the entity may not be within the scope of ASC 954, we believe it would be appropriate to consider this guidance by analogy.

### **4.4.1 Timing of expense recognition**

One key consideration under a value-based care arrangement is the timing of expense recognition related to patient care. For example, if a patient member is diagnosed as having an illness that will require long-term treatment, should all costs of future treatment be recognized at the date of initial service (that is, the date on which it is identified that the member has an illness or shows symptoms requiring the member to obtain future health care services), or should these be recognized as costs of the periods in which treatment is actually provided to the patient?

The answer depends on the accounting guidance that is relevant to the entity and the contractual arrangement. Entities within the scope of ASC 944 would follow that framework for recognition of expense. Contractual arrangements which are, in full or in part, subject to the guidance in ASC 460

regarding guarantees would have to consider the appropriate timing of recognition of expense under that guidance. For contractual arrangements accounted for under ASC 606, the event that triggers a healthcare provider's recognition of expenses for medical services is the provision of those services to a patient, not the occurrence of an accident or illness. In accordance with ASC 954-405-25-2, the costs of providing health care services to patients should be reported in the periods in which those services are actually rendered. This is true even if the patient is being treated for an illness that requires long-term treatment. It is not appropriate to estimate and accrue the expense of the entire episode of care in the period in which the diagnosis is made. This model differs from the insurance accounting under ASC 944, which would require that the costs of the patient's entire expected course of treatment be estimated and reported as an expense of the period in which the diagnosis is made. This is because the event that triggers an insurance company to recognize claims expense is the occurrence of a particular accident or illness (the insured event). In certain situations, however, it is appropriate for the organization to accrue the costs of health care services, as described below.

□ Contractual or regulatory obligation

ASC 954-405-25-2 requires that an accrual be made in situations when a contract or prevailing regulations obligate the health care provider to continue to provide care to covered patients after the end of the contract period. For instance, if a hospital is contractually obligated to continue to provide coverage for hospital stays that are "in progress" at the end of the contract period, the hospital will have to bear the costs of those hospitalization services regardless of whether they will receive any compensation for services provided following the current contractual term. Therefore, providers with these types of contractual or regulatory obligations should accrue, at the end of the contract period, the cost of any services expected to be rendered after the end of the contract period.

□ IBNR accruals

Incurred but not reported (IBNR) accruals may be required for services that have been rendered by third-party providers during the contract term but not reported to the health care organization with the ultimate obligation under the capitation contract as of the financial statement date. For example, providers that accept a capitated health care contract may be required to "subcontract" to other facilities any ancillary services it cannot perform (such as CT scans or MRIs), or specialized inpatient services, such as cardiac surgery or burn treatment, for which the provider is not licensed. Similarly, a capitated provider may pay for subcontracted care when a health plan member requires medical care outside of the provider's service area (such as while traveling). Non-institutional providers may also subcontract the provision of care for its attributed members. In these cases, the organization must accrue the estimated costs of any services subcontracted to other providers for which payment has not been made as of the close of the fiscal period, even if the subcontracting provider has not submitted an invoice for those services.

Example HC 4-4 illustrates when a health care provider may need to accrue expenses at the end of a contract period.

### **EXAMPLE HC 4-4**

#### **Expense accrual at conclusion of contract term**

Hospital and Insurance Company have an agreement under which Hospital agrees to provide inpatient services for all members of Insurance Company's health plan for calendar 20X1. As part of the

contract, Insurance Company requires Hospital to continue to provide inpatient services to hospitalized Insurance Company health plan members until they are discharged regardless of whether the contract expires or is renewed. On December 29, 20X1, an Insurance Company health plan member is admitted to Hospital and is discharged on January 10, 20X2.

How should Hospital account for the expenses incurred to treat the Insurance Company health plan member from January 1, 20X2 to January 10, 20X2?

#### *Analysis*

Hospital must estimate and accrue the costs of services provided from January 1, 20X2 to January 10, 20X2 in its December 31, 20X1 financial statements because Hospital is obligated to continue to provide services to Insurance Company's member under the contract, regardless of whether a new contract is entered into in 20X2.

If, on the other hand, the contract did not obligate Hospital to bear the cost of inpatient services that extend into subsequent contract periods, the costs of the services rendered from January 1, 20X2 to January 10, 20X2 would be reflected in the period in which they were rendered (that is, in the 20X2 financial statements).

#### **4.4.1.1 Loss contracts**

Risk contracts between a provider and a sponsoring entity (e.g., payer) typically require the provider to either provide or arrange for the provision of health care services for the entity's members for a specified period of time in exchange for an established monthly capitated payment. These capitated payments are established at a level that is estimated to be sufficient to at least cover the cost of providing services to the members during that period. If the capitated payments do not cover the cost of providing services to the members, the provider will sustain an economic loss in fulfilling that particular contract.

ASC 954-450 addresses the types of costs to be considered and when they should be recognized.

##### **ASC 954-450-30-3**

The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred shall include fixed and variable, direct and allocable indirect costs.

##### **ASC 954-450-30-4**

Losses under **prepaid health care services** contracts shall be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts.

To determine the need to recognize a loss, contracts shall be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred.

The determination of which costs to include is judgmental. The costs considered should include all direct costs of the contracts along with indirect costs identifiable with or allocable to the contracts, and

generally requires inclusion of all costs other than general and administrative, selling, marketing, and interest. AAG-HCO 13.16 recommends that entities also consider investment income that is expected to be earned on premiums received in advance of health care costs incurred during the contract period for the group of contracts.

Statement 11 of HFMA's Principles & Practices Board, *Accounting and Reporting by Institutional Health Care Providers for Risk Contracts*, provides additional discussion of the types of costs that would be considered direct and allocable indirect costs (e.g., medical records, claims processing, billing). The guidance on loss contracts in ASC 954-450-30 was originally developed by analogizing to the accounting guidance for construction-type and production-type contracts, which is now codified in ASC 605-35-25-45 and ASC 605-35-25-46 (and still applicable after the adoption of ASC 606). Therefore, we believe that entities may look to the guidance for loss contracts in ASC 605-35.

Contracts should be grouped in the manner specified in ASC 954-450-30-4 and the aggregate health care costs, maintenance expenses, anticipated future revenue, and stop-loss recoveries projected for the contracts in each group. Furthermore, if any of the contracts in a "loss group" have guaranteed renewal provisions, and the organization is constrained by statutory requirements or community rating practices from increasing the amounts charged on those contracts, the organization should also accrue any losses it expects to incur attributable to the guaranteed renewal periods.

The groupings used for loss determination should correspond with the groupings used by the organization in establishing its capitation rates. For organizations that use community-rating (i.e., one capitation rate is established for all members in a given enrollment population; for instance, a particular geographic area or actuarial class), the contracts grouped together for loss determination would be those considered to be part of the same enrollment "pool" as was used to determine the capitation rate. Contracts that utilize experience-rating would be grouped in the same manner as that used for rate-setting purposes, such as by type of employer.

At the end of each reporting period, the entity should estimate future costs to determine if expected costs exceed future revenues and stop-loss recoveries. An organization will need to analyze the unexpired contracts in force, as well as noncancellable, executed contracts that are not yet in force. No specific guidance is available with regard to the reporting of losses on risk contracts that cover a period of several years. Because the guidance on loss contracts in ASC 954-450-30 was originally developed by analogizing to the accounting guidance for construction-type and production-type contracts, we believe it is reasonable to apply the GAAP for long-term construction contracts in accounting for risk contracts that cover more than one year. In such cases, the full loss estimated for the contract duration should be recognized in the year in which it is determined that an economic loss will be sustained under the contract as a whole.

Losses should be reported consistent with other patient care expenses in the income statement.

Example HC 4-5 illustrates the timing of accruing a loss on a contract.

### **EXAMPLE HC 4-5**

#### **Loss contracts**

Hospital and Insurance Company have an ongoing agreement in which Hospital agrees to provide inpatient services for all members of Insurance Company's health plan in exchange for \$1,000 per

member per month. The contract period is from January 1, 20X1 to December 31, 20X1. Hospital's fiscal year-end is June 30.

On June 30, 20X1, Hospital forecasts an average of \$6,500 in medical and administrative costs for each member through December 31, 20X1, which exceeds the remaining \$6,000 that will be collected in capitation payments (6 months times \$1,000).

How should Hospital account for the forecasted losses through the remainder of the contract period at June 30, 20X1?

### *Analysis*

Based on Hospital's forecast, the total losses for the remainder of the contract term (July 1, 20X1 – December 31, 20X1) are estimated to be \$500 per member (\$6,000 revenue less \$6,500 in costs). Hospital should accrue the estimated \$500 per member loss at June 30, 20X1. The loss accrual should be updated each reporting period through the end of the contract term.

#### **4.4.1.2 Stop-loss insurance**

Many health care providers that enter into capitation agreements with payers will transfer a portion of their financial risk to an outside insurer by purchasing stop-loss insurance. Such arrangements may be direct (in which case the provider purchases the coverage from a commercial insurance company or a captive insurance subsidiary) or indirect (in which case the coverage is obtained by the payer and the premiums are withheld from the capitation fees paid to the provider).

Two accounting issues arise with regard to stop-loss insurance. The first concerns whether stop-loss insurance premiums should be recorded as an expense or as a reduction of the provider's revenue, particularly if the premiums are charged indirectly. ASC 954-720-45-1 states that stop-loss premiums should be included in health care costs; this allows the revenue and expenses reported in the income statements of entities to be comparable regardless of whether that coverage is obtained directly or indirectly.

The second issue is whether stop-loss insurance recoveries should be reported as revenue or as a reduction of the related health care costs. ASC 954-720-45-1 states that stop-loss insurance recoveries should be reported as a reduction of health care costs. Because providers can influence their premium expense and the amount of recoveries they expect to receive by taking higher or lower deductibles and risk provisions, this treatment allows the net effect to be comparable between entities.

Amounts recoverable from insurers under stop-loss policies should be reported as assets, reduced by appropriate allowances for credit losses.

#### **4.4.2 Disclosures**

In assessing disclosure requirements for risk contracting arrangements, organizations should consider disclosures required under ASC 606 (see FSP 33).

In addition, while the guidance does not outline specific disclosures for risk contracts, we believe the following disclosures are appropriate in financial statements of health care providers that enter into such contracts:

- The nature and terms of risk contract arrangements and the basis of recording revenues, expenses, and losses under those arrangements.
- If the contract period is different from the provider's fiscal year, the estimate recorded for the final settlement and the significant assumptions supporting the estimate.
- The nature, amounts, and effects of stop-loss insurance contracts.

#### **4.4.3 Statutory reporting**

Most MCOs and health plans that provide insurance coverage and bear financial risk are regulated by state departments of insurance. The National Association of Insurance Commissioners (NAIC) is the US standard-setting and regulatory support organization created and governed by the chief insurance regulators from the states and territories. For additional information regarding the NAIC, see IG 13.

Among other responsibilities, the NAIC promulgates statutory accounting principles (SAP) that must be used in preparing financial statements used for financial regulatory purposes. IG 13 provides a comprehensive discussion of SAP and highlights differences between SAP and GAAP. HMOs and health plans within the scope of ASC 954 should be mindful that the GAAP references in IG correspond to ASC 944, *Financial Services -- Insurance*, rather than to the ASC 954 requirements discussed in this guide. Therefore, differences that exist between the requirements of ASC 944 and ASC 954 should be kept in mind.

For additional information on statutory accounting and other regulatory matters specific to HMOs and health plans, see AAG-HCO 2.112 through AAG-HCO 2.115.

## **4.5 Physician practice management companies**

Physician practice management companies (PPMs) provide non-clinical practice management services to physician practices. In addition to the revenue recognition considerations discussed in HC 4.3.1.2, there are additional accounting considerations that should be considered for PPMs.

### **4.5.1 Consolidation guidance**

Because PPMs are typically prohibited from outright ownership of physician practices, they will normally execute a long-term management services agreement under which the physicians convey rights to effective economic control of their practices to the PPM that are similar to those that would be obtained through outright ownership. When a PPM enters into a long-term management services agreement with a physician practice, the PPM first considers whether the *Variable Interest Entities* (VIE) subsections of ASC 810, *Consolidation*, apply. If so, the PPM applies that guidance in evaluating whether it should consolidate the physician practice. If the VIE guidance does not apply, the PPM assesses the need for consolidation in accordance with the provisions of the *Consolidation of Entities Controlled by Contract* subsections of ASC 810-10. A physician practice that is controlled by contract is typically a VIE. Refer to CG 7.4 for discussion of the control by contract guidance applicable to certain PPM arrangements.

#### **4.5.2 Acquisition accounting considerations**

If a PPM has entered into a long-term management services agreement with a physician practice that qualifies as a business under ASC 805-10-55 and under which the PPM is required to consolidate that physician practice, the transaction is a business combination that would be accounted for in accordance with ASC 805, *Business Combinations*.

If the criteria for consolidation are not met, the transaction is accounted for as an asset acquisition, with a significant portion of the cost of the acquisition likely allocated to intangible assets. In evaluating the appropriate amortization period for the intangible assets, the PPM should use the contract term as a starting point, but also consider factors inherent in the nature of the business that might indicate a shorter economic life. Those factors include:

- the unproven ability of a PPM and its new physician practice to perform under the terms of the services arrangement over an extended period;
- the uncertain continuity of revenues upon departure of key owner/physicians of the practice;
- the existence of short-term employment contracts with key owner/physicians; and
- the uncertain ability to withstand legal challenges related to the corporate practice of medicine.

When these factors are given appropriate consideration, it may be difficult to assert that the management arrangement with the physician practice will survive and provide a competitive advantage throughout the period of time indicated by the contract term. Therefore, use of a relatively short amortization period for the management services agreement intangible is generally appropriate.

#### **4.5.3 Stock-based compensation**

ASC 718-10-55-85A provides guidance on whether an employee of a physician practice should be considered an employee of the PPM for purposes of determining the appropriate method of accounting for that employee's stock-based compensation. An employee of a practice that is consolidated by the PPM should be considered an employee of the PPM for stock compensation purposes; an employee of a practice that is not consolidated by the PPM is not considered an employee of the PPM.

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***Chapter 5:  
Other topics in provider  
revenue recognition***

## **5.1 Other topics in provider revenue recognition - overview**

This chapter provides an overview of special topics that are unique to the health care revenue cycle. It covers the accounting considerations of uncompensated services as well as the related disclosure requirements associated with those services. In addition, this chapter addresses accounting and financial reporting for provider tax programs, contract assets and liabilities, and government assistance to health care organizations.

## **5.2 Uncompensated services**

Health care services provided under fee-for-service arrangements are typically billed to the patient (and if applicable, to the patient's third-party payer) after the services are provided. In the normal course, certain amounts billed will ultimately not be collected. Some of those uncollected amounts may be revenue adjustments attributed to charity care or implicit price concessions (see HC 3.2.3), while others may be credit losses (bad debts). Collectively, these three classes of write-offs constitute what is generally referred to as "uncompensated care." This section will explain the three types of adjustments and the financial reporting implications of each type.

Charity care refers to free or discounted services provided to patients who are unable to pay and who meet specified criteria related to their income and assets. If a patient lacks a private health plan or government program coverage for health care services, providers that offer charity care will typically first consider whether the patient will qualify for care at reduced or no charge under its policy. IRS regulations require tax-exempt hospitals to have charity care policies as a condition of their tax-exempt status; other types of providers may voluntarily establish such policies. Patients whose services are designated as charity care are not billed for those services (or if they are billed, the amount is reduced by a charity care adjustment). For additional information on charity care, see HC 5.2.1.

If a patient does not qualify for charity care, amounts that are owed by a patient will typically be designated as "self-pay," and the provider will bill and attempt to collect from the patient the amounts to which it is contractually entitled. In these situations, revenue should be reduced for amounts the provider does not expect to be able to collect and a provision against the notional amount of the receivable should be established such that accounts receivable is similarly reduced for these implicit price concessions.

Once the revenue and receivables have been reduced by the amount of the implicit price concessions, any portion of the amount to which the provider expected to be entitled that they expect will ultimately become uncollectible would be considered a credit loss. Credit losses are reported as an expense (e.g., bad debt expense or credit losses) and revenue is not subsequently adjusted.

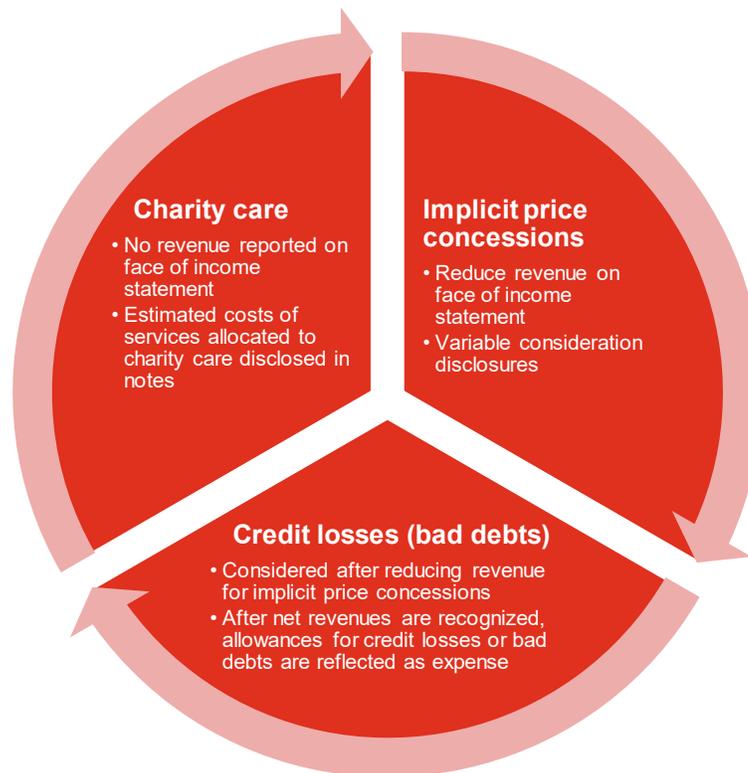
### **5.2.1 Distinguishing between implicit price concessions, charity care, and credit losses**

Charity care, implicit price concessions, and credit losses (bad debts) are all attributable to instances when a provider renders services but ultimately receives less consideration than the amount to which it is contractually entitled. While they are sometimes described in a general category of "uncompensated care," the financial statement presentation and disclosure requirements for charity care, implicit price concessions, and credit losses (bad debts) differ significantly (see Figure HC 5-1). The provision for credit losses (bad debts) is a period expense that is reported separately from the

revenues that gave rise to the uncollectible receivables. On the other hand, implicit price concessions represent reductions of revenue. For services provided that qualify in full as charity care, no consideration is received (services are provided for free); therefore, no revenue is recognized and only the costs of that care appear in the income statement. ASC 954-605-50-3 requires specific disclosures regarding charity care, and, while implicit price concessions are not explicitly addressed in ASC 954, because they are considered a form of variable consideration, a healthcare provider should consider the requirements of ASC 606-10-50-20. Refer to HC 5.2.3 for additional details.

### Figure HC 5-1

#### Uncompensated care components – presentation and disclosure



The services provided as charity care can be specifically identified by an organization's charity care policy. However, the distinction between implicit price concessions and credit losses (bad debts) may be less clear. In the Basis for Conclusions to ASU 2014-09 (codified in ASC 606), the FASB acknowledged that in some cases it may be difficult to determine whether the entity has implicitly offered a price concession or whether the entity has chosen to accept the risk of default. That judgment may be even more challenging under the current expected credit loss (CECL) model under ASC 326, *Financial instruments – Credit Losses*. As described in HC 5.2.4, the CECL model requires consideration of expected future losses, which may be difficult to distinguish from additional price concessions.

AAG-REV 7.6.24 provides factors to consider in determining whether a health care entity intends to provide an implicit price concession. One of the factors is whether the health care entity has a history of performing credit assessments. In practice, many providers do not perform credit assessments on patients prior to treating them. In those situations, the providers are not extending credit to a customer in the traditional sense. Instead, they are providing services with the knowledge and understanding that they likely will not receive all of the compensation to which they are entitled. Thus, in most healthcare revenue transactions, anticipated uncollectible amounts are viewed as implicit price concessions, estimated as variable consideration under ASC 606, and, as a result, are excluded from reported amounts of revenue and receivables.

The distinction between whether a health care entity has offered an implicit price concession or suffered a credit loss is important because it affects the timing and classification of recognition in the income statement. Under ASC 606, subsequent changes to estimates of implicit price concessions are accounted for as changes (increases or decreases) in the transaction price for the revenue transaction and are recorded as an adjustment to revenue. However, a credit loss on a receivable recognized pursuant to ASC 326 is an expense. The key consideration is whether the adjustment is due to a change the amount the provider was willing to accept in exchange for services provider (implicit price concession) or if the adjustment is a write-off of an amount to which the provider believed they were entitled, but ultimately were unable to collect due to a credit loss. Providers will need to apply judgment to determine whether an amount that ultimately becomes uncollectible is truly a credit loss or an additional implicit price concession. Refer to HC 5.2.3 for further discussion of implicit price concessions and HC 5.2.4 for further discussion of credit losses.

For additional information, see AAG-HCO chapter 10, *Health Care Service Revenue and Related Receivables* and AAG-REV chapter 7, *Health care entities*. Two publications by the Healthcare Financial Management Association—an issue summary titled *Revenue Recognition, Including Implicit Price Concession and Bad Debt Considerations, for Healthcare Organizations: Accounting Issues and Trends*, and Principles & Practices Board Statement 15, *Valuation and Financial Statement Presentation of Charity Care, Implicit Price Concessions and Bad Debts by Institutional Healthcare Providers*, provide further commentary.

### 5.2.2 **Charity care**

Providers often render services free of charge or at discounted rates under a formal charity care (or “financial assistance”) policy established by the entity. The GAAP requirements for reporting charity care in financial statements are contained in ASC 954-605, *Health Care Entities – Revenue Recognition—Charity Care and Related Fundraising Entities*. For financial reporting purposes, charity care is defined in the ASC Master Glossary.

#### **ASC Master Glossary**

**Charity care.** Charity care represents health care services that are provided but are never expected to result in cash flows. Charity care is provided to a patient with demonstrated inability to pay. Each entity establishes its own criteria for charity care consistent with its mission statement and financial ability.

ASC 954-605-25-11 discusses the timing of charity care determinations. It explicitly states that a facility does not have to determine that a patient meets the criteria at the time of admission in order to classify services provided to them as charity care for financial reporting purposes.

**ASC 954-605-25-11**

Although it is not necessary for the entity to make this determination on admission or registration of an individual, at some point the entity must determine that the individual meets the established criteria for charity care.

Because no cash flows are expected to arise from charity care services, charges pertaining to charity care do not qualify for recognition as revenue (or receivables) in a provider's financial statements (ASC 954-605-25-10). In some circumstances, a patient may receive a partial reduction in their charges for services, rather than a full reduction. In these instances, the partial adjustment is considered a price concession and is recorded as a reduction of revenue. If the provider does not plan to seek any payment for services rendered (i.e., the patient is receiving a full reduction in their charges for service), the contract with a charity care patient is not considered a "contract with a customer" under the ASC 606 revenue model (AAG-REV 7.6.15).

**Excerpt from ASC 954-605-25-10**

Charity care does not qualify for recognition as revenue in the financial statements ... Only the portion of a patient's account that meets the entity's charity care criteria shall be recognized as charity.

**ASC 954-310-25-1**

The provision of charity care does not qualify for recognition as receivables in the financial statements.

Services provided to patients are considered charity care only after attempts to seek compensation from other sources (such as health insurance or Medicaid) have been rejected or exhausted. In many cases, providers may first see if uninsured patients can retroactively be enrolled in Medicaid. If that is not an option, patients will be encouraged to apply for charity care. The process requires the patient to supply personal, financial, and other information relevant to determining financial need.

Patients may apply for charity care at the time services are provided or thereafter. Normally there is no time limit on when the application must be filed; patients may even be able to apply after their bills have been sent to collection agencies. Because charity care determinations may not be made by the provider until well after the services have been provided, entities that routinely provide charity care will typically estimate and record a provision for charity care in the same period that the services are provided (similar to the provisions established for implicit price concessions discussed at HC 5.2.3).

Even though the provider expects no compensation, providers typically record gross patient charges related to charity care in the patient accounting system for recordkeeping purposes (see HC 2.1.2). Similarly, in the patient accounting system, the provision for charity care will be netted against the related gross charges so that for financial statement purposes, no revenues for charity care will be included in patient service revenue. The gross charges related to charity services will often be used in developing the disclosures of the estimated cost of charity care required by ASC 954-605-50-3, discussed in HC 5.2.2.1.

While not authoritative GAAP, HFMA Principles & Practices Board Statement 15, *Valuation and Financial Statement Presentation of Charity Care, Implicit Price Concessions and Bad Debts by Institutional Healthcare Providers*, provides useful commentary on matters related to charity care policies, accounting practices, and reporting.

### 5.2.2.1 **Disclosure requirements for charity care**

The fact that charity services do not result in recognition of revenue is generally disclosed in either the summary of significant accounting policies or a separate charity care note. Also, because users cannot obtain information about the provision of charity care from the face of the income statement, ASC 954-605-50-3 requires disclosure of the level of charity care provided.

#### **ASC 954-605-50-3**

Management's policy for providing charity care, as well as the level of charity care provided, shall be disclosed in the financial statements. Such disclosure shall be measured based on the provider's direct and indirect costs of providing charity care services. If costs cannot be specifically attributed to services provided to charity care patients (for example, based on a cost accounting system), management may estimate the costs of those services using reasonable techniques. For example, one such estimation technique might involve calculating a ratio of cost to gross charges, and then multiplying that ratio by the gross uncompensated charges associated with providing care to charity patients. Other reasonable techniques also are permitted. The method used to identify or estimate such costs shall be disclosed. Funds received to offset or subsidize charity services provided, for example, from gifts or grants restricted for charity care or from an uncompensated care fund, also shall be separately disclosed.

These disclosures are required for all entities that provide charity care, whether that care is provided under a regulatory requirement (in the case of tax-exempt hospitals) or voluntarily. Key elements of the disclosures include:

- *A statement of management's policy regarding charity care.* Typically, entities disclose that they provide services without charge (or at amounts less than their established rates (gross charges), if applicable) to patients who meet charity care criteria established by the entity. Some also include a brief description of the criteria (such as family income, net worth, extent of financial obligations for healthcare services) and, if applicable, the criteria for application of sliding scale discounts based on financial need.
- *The amount of charity care provided during each period covered by the financial statements.* Measurements of the cost of charity care are based on the fully-loaded costs (i.e., direct and indirect costs) of providing the services. Although this measurement basis is generally consistent with the basis used by not-for-profit hospitals for the "financial assistance" component of community benefits reporting in IRS Form 990 Schedule H, the amount reported for GAAP purposes might differ from the amount determined using IRS rules. Entities can supplement the required disclosure with measures of charity care expressed in terms of the gross value of the care at established rates, if desired.
- *The method utilized to identify or determine the costs.* Costs should be identified or determined using the best information available. An entity may obtain the information directly from a cost accounting system or using reasonable estimation techniques, such as multiplying the gross charges associated with charity patients by a cost-to-charge ratio.
- *The amount of funds received to offset or subsidize charity services provided during the period (if any).* This might include, for example, contributions that are donor-restricted for charity care, or local government grants for indigent care. These amounts must be separately disclosed as

contributions and not netted against the cost of the charity care provided (see paragraph BC7 of the Basis for Conclusions in ASU 2010-23, *Measuring Charity Care for Disclosure*, which is the standard that is codified in ASC 954-605).

Figure HC 5-2 illustrates these disclosures.

**Figure HC 5-2**  
Illustrative disclosures –charity care

*Example 1*

Health System provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. Because Health System does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Of Health System's total expenses reported (\$125 million and \$100 million in 20x1 and 20x0, respectively), an estimated \$20 million and \$15 million arose during 20x1 and 20x0, respectively, in connection with services provided to charity patients. The estimated costs of providing charity services are based on data derived from Health System's cost accounting system. Health System received \$100,000 and \$75,000 in contributions that were restricted for the care of indigent patients during 20x1 and 20x0, respectively.

*Example 2*

Hospital provides care without charge or at amounts less than its established rates to patients who meet certain criteria under its charity care policy. Because Hospital does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. Of Hospital's \$80 and \$75 million of total expenses reported in 20x1 and 20x0, respectively, an estimated \$12.5 and \$10 million arose from providing services to charity patients. The estimated costs of providing charity services are based on a calculation which applies a ratio of costs to charges to the gross uncompensated charges associated with providing care to charity patients. The ratio of cost to charges is calculated based on the Hospital's total expenses associated with patient care (less bad debt expense) divided by gross patient charges. During 20x1, Hospital received a grant of \$2 million from ABC County to help defray the costs of indigent care.

**5.2.3 Provision for implicit price concessions**

When a patient is assigned to a "self-pay" payer class, the provider will bill and attempt to collect from the patient the amounts to which it is contractually entitled. At the time the services are provided, the provider will need to estimate the amounts that it does not expect to be able to collect, which constitute implicit price concessions. See HC 5.2.1 for a discussion about distinguishing between implicit price concessions and credit losses.

In many self-pay situations, the provider chooses to provide services without knowing whether the patient would be able or willing to pay, which essentially constitutes a practice of granting implicit price concessions. Evaluating arrangements to determine whether a provider is offering implicit price concessions is discussed in HC 3.3.1; the approach for estimating the amount of the provision is described at HC 3.3.1.1.

Implicit price concessions will directly reduce the amounts of both patient service revenue and the related receivables that can be recognized. This is a fundamental presentation difference from the

provision for credit losses (bad debts), discussed further in HC 5.2.1 and HC 5.2.4, which is recognized as an expense and an allowance against the receivable corresponding to the amount of revenue recognized.

In developing the estimate of implicit price concessions, the provider should consider its expectations of cash collections based on all information (historical, current, and forecast) that is reasonably available to the provider. If the actual collection experience differs from the initial expectation for reasons other than the creditworthiness of a patient, the subsequent changes are accounted for as increases or decreases in the transaction price—that is, as additional revenue, or as a reduction of revenue—in the period in which the estimate changes, consistent with the guidance in ASC 606-10-32-43 (see discussion at HC 3.3). Judgment is required to determine whether subsequent changes in the estimated amount expected to be collected are due to credit losses or should be considered an additional implicit price concession.

Question HC 5-1 addresses whether additional allowances for credit risks (credit losses) are required for receivable balances that incorporate implicit price concession reductions.

### Question HC 5-1

Provider provides services to self-pay patients without knowing if the patient is willing or able to pay. When Provider initially recognizes revenue and receivables from self-pay patients, the amounts recognized are reduced by amounts that Provider does not expect to collect (i.e., implicit price concessions).

Does the guidance on impairment losses related to customer credit risk in ASC 326, *Financial instruments – credit losses*, apply to Provider’s receivables that have already been reduced to incorporate implicit price concessions?

#### ***PwC response***

Yes. The credit loss considerations in ASC 326 apply to all receivables. However, providers should apply judgment in determining if subsequent adjustments to a patient account are due to changes in implicit price concession estimates under ASC 606 or credit losses under ASC 326. In instances when health care providers administer care regardless of a patient’s ability to pay and have a history of accepting less than the full contractual amount, it may be appropriate for a health care provider to consider all adjustments to patient care collections to represent an implicit price concession.

#### **5.2.3.1 Presentation and disclosure for implicit price concessions**

ASC 606 does not explicitly require disclosure of the amount by which revenues were reduced for implicit price concessions provided during a reporting period. However, as implicit price concessions, and changes in estimates related thereto, are often significant factors in determining the overall transaction price, additional disclosures may also be required under ASC 606-10-50-2. Under this guidance, health care organizations will also need to disclose information about the methods, inputs, and assumptions utilized in estimating implicit price concessions. Refer to FSP 33 for additional information on specific disclosures required by ASC 606.

#### 5.2.4 **Provision for credit losses (bad debts)**

While providers often render services to self-pay patients without the knowledge of the patients' willingness or ability to pay, there are also instances when services are only performed if the provider believes that it is probable the patient will pay the full amount for services. This is often the case with elective procedures. When a patient is assigned to a "self-pay" payer class, and the provider believes it is probable they will be paid for the related services (either by the patient or a third-party payer), and, therefore, determines that they have a contract with the patient, the provider recognizes revenue for the amount to which it expects to be entitled. ASC 326 requires a provision for credit losses (bad debts) to be recognized at the same time the receivable is recognized. Unlike implicit price concessions, the provision for credit losses (bad debts) and subsequent changes in estimate thereto are reflected as an expense. Consequently, in fee-for-service healthcare, the provision for credit losses (bad debts) is associated with write-offs of amounts receivable from patients who originally had been determined to have the willingness and financial capacity to pay for services but who ultimately are unwilling or unable to settle the claims. The provider initially recognizes revenue and receivables at the billable amounts, and then subsequently accounts for the receivable pursuant to ASC 326; revenue is not affected.

In the income statement, the provision for credit losses (bad debts) is shown as a period expense that is reported separately from the revenues that gave rise to the uncollectable receivables. HC 5.2.4.1 describes how the provision is estimated.

Example HC 5-1 illustrates a fact pattern in which estimated uncollectible amounts would be reflected as an allowance against recognized receivables and as provision for credit losses (bad debt expense). For additional information, see AAG-REV 7.6.36.

#### **EXAMPLE HC 5-1**

##### **Contract results in credit loss (bad debt expense)**

Ambulatory Surgery Center (Center) performs elective procedures and does not have a history of providing price concessions to patients. As part of their admissions process, Center performs credit checks on all patients wishing to schedule elective surgeries to verify that it is probable they will collect consideration for services rendered. Center's collection experience indicates that it collects substantially all of the amounts it bills to customers receiving elective surgeries. Thus, revenue and corresponding receivables are recorded for the gross amounts billed to patients. An allowance for uncollectible accounts is separately assessed under ASC 326.

Patient contacts Center to schedule an elective surgery that is not covered by their insurance. The charges for the surgery will be \$4,000. Center performs an assessment on Patient's credit and agrees to schedule the surgery. Patient pays \$500 up front and signs a promissory note for the remaining \$3,500, payable in seven monthly installments of \$500.

After receiving the surgery and paying five monthly installments, Patient ceases to make payments. After several attempts at collections, Center determines that it will not be able to collect the \$1,000 remaining balance.

How should Center reflect the write-off of the uncollectible receivable?

## *Analysis*

The \$1,000 write-off would be charged against Center's allowance for credit losses. At the inception of the contract with Patient, Center expected to collect substantially all of the consideration to which it was entitled so recognition of revenue for the full \$4,000 transaction price is appropriate.

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### **5.2.4.1 *Estimating the allowance for doubtful accounts***

Prior to the adoption of ASU 2016-13, *Measurement of Credit Losses on Financial Instruments* (codified in ASC 326), entities typically estimated their allowance for doubtful accounts using historical loss data such as aged accounts receivable trial balances, collection trends, and subsequent period write-offs. This methodology is referred to as the "incurred loss" model for receivables, and it is described in ASC 310-10-35-7 through ASC 310-10-35-11. Under this approach, recognition of impairment losses (bad debts) occurs when it becomes probable that receivables are impaired (and thus, that losses have been incurred).

ASC 326 supersedes the guidance in ASC 310-10-30 for impairments associated with extensions of credit. It replaces the incurred loss model with a current expected credit losses (CECL) model. The CECL model eliminates the backward-looking threshold of "losses that are probable of having occurred." Instead, it requires recognition on day 1 (i.e., at inception of a revenue contract) of credit losses that are expected to occur in the future. In addition to historical loss information, CECL requires entities to consider current conditions and reasonable, supportable forecasts when estimating the allowance for uncollectible accounts. For additional information on how the CECL model is applied to receivables, see LI 7.7.

Calendar year-end providers that are public business entities (except for smaller reporting companies as defined by the SEC) were required to adopt ASC 326 in calendar 2020 financial statements. All other entities (smaller SEC reporting companies, all NFP entities, all private companies) will be required to adopt the CECL model in fiscal years (and interim periods within those fiscal years) beginning after December 15, 2022.

### **5.2.5 *Disclosure of "community benefits" information***

Many US hospitals operate as not-for-profit organizations and, as such, are exempt from most federal, state, and local taxes. This favored tax status is an acknowledgement of the benefit these institutions are expected to provide to the communities they serve ("community benefit").

Community benefit encompasses a broad range of services and activities a tax-exempt hospital might carry out in meeting such expectations. In addition to providing free or discounted services to patients who qualify under the hospital's financial assistance policy (i.e., charity care), such activities might include participation in low-paying government programs such as Medicaid, operating costly services at a loss (e.g., a trauma unit), sponsoring community health programs, helping to train health professionals, and performing health research, among others.

Community benefits provided must be quantified in annual reporting to the IRS (on Schedule H of Form 990, the annual information return filed by not-for-profits). When calculating the values of benefits provided, hospitals use definitions and costing methodologies prescribed by the IRS.

Charity care is one type of community benefit reported on Schedule H for which GAAP prescribes disclosure in general-purpose financial statements, which is set forth in ASC 954-605. As discussed in HC 5.2.1, differences can exist between charity care amounts determined for financial reporting purposes and charity care quantified under IRS regulations due to differences in FASB and IRS reporting requirements.

Similarly, differences may exist in how uncollectible amounts are reported for regulatory and financial reporting purposes. For example, in Medicare cost reports and IRS Form 990 filings, providers whose uncollectible accounts are considered implicit price concessions for financial reporting purposes will continue to report those amounts in accordance with instructions provided by those regulators (generally, reflecting all uncollectible accounts as bad debt expense).

Some organizations may wish to augment their financial statement charity care disclosures with additional disclosures related to other types of community benefit. Because the FASB has not developed any standards with respect to community benefit information other than charity care amounts, disclosures of community benefit amounts are likely to be either non-GAAP measures or key performance indicators.

According to the FASB's conceptual framework, not all information that might be useful to users of financial statements is incorporated into financial statements. Information reported in the financial statements and notes generally is limited to that for which standards have been specified by FASB and which FASB considers necessary for fair presentation. However, other information that management believes would be useful might appropriately accompany the financial statements through including it in management's discussion and analysis, or in a separate supplemental schedule.

If quantitative information about community benefits calculated using the IRS framework is presented in a supplemental schedule that accompanies the financial statements, it typically would be accompanied by a note that explains to the user the nature of the information and the basis under which it has been prepared (for example, in accordance with IRS reporting requirements for Schedule H of Form 990).

### **5.3 Medicare provider taxation programs**

As discussed in HC 2.2.2.1, most states will augment the base payment rates for services provided to Medicaid-enrolled patients with additional supplemental payments. Often, supplemental payments are made through one or more provider taxation programs established by the state. Under these programs, states impose a fee or tax on a class of providers and redistribute all or a large portion of those taxes back to Medicaid providers in the form of increased rates for fee-for-service care. The supplemental payments will be funded through a combination of the taxes collected from providers and federal matching funds.

These supplemental payments enter into the determination of patient service revenue under ASC 606 and are a form of variable consideration associated with services to Medicaid patients, as discussed in HC 3.3.2. The unique structures of the programs that generate these payment streams and the ongoing regulatory approvals required to operate them must be considered when estimating and constraining estimates of variable consideration under ASC 606. Specific considerations related to these payment streams discussed in this section are:

- accounting considerations for reporting periods in which regulatory approval is received,
- revenue recognition when regulatory approvals have not been received as of a reporting date,
- income statement presentation of supplemental payment revenues, and
- income statement presentation of expenses (e.g., taxes) associated with the program assessments

An HFMA Principles & Practices Board Issue Analysis, *Revenue Recognition Under Topic 606 for Provider Tax Programs and Similar Arrangements*, provides regulatory background information on these programs along with nonauthoritative commentary on the accounting and reporting matters discussed in this section.

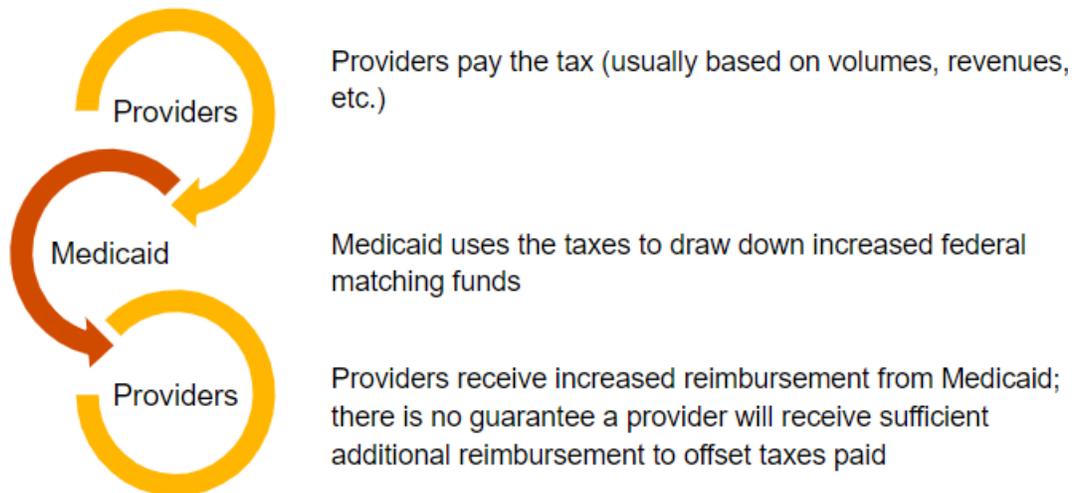
### 5.3.1 *Mechanics of a provider tax program*

As discussed in HC 2.2.2, Medicaid is a government-sponsored health insurance program that is jointly funded by each respective state and the federal government. The federal Centers for Medicare & Medicaid Services (CMS) provides matching funds in a specified percentage for every dollar spent by a state Medicaid program on health care services.

A provider tax program can be used to obtain additional federal matching funds from CMS in order to increase payments to providers. The process is depicted in Figure HC 5-3.

**Figure HC 5-3**

## Provider tax program basics



Provider tax programs are generally implemented through state legislation that imposes a tax or similar fee on a certain class of providers. The programs operate for a specified period (usually three years). Taxes assessed are collected from providers, and the state Medicaid program will then use that pool of tax revenues to increase the payments made to providers for services to Medicaid patients.

Each dollar of additional expenditure by a state (e.g., payments by the state to providers for services to a Medicaid patients) will automatically trigger an additional inflow of federal funding arising from the statutory federal financial participation matching percentage (FFP). For example, if the FFP is 65%, every \$100 of taxes collected from providers and used to increase Medicaid payments will result in \$65 of federal matching funds flowing into the state's program. Thus, the state will have a total of \$165 to compensate health care providers for treatment of Medicaid patients, funded in part from taxes collected from the providers and in part from federal matching funds.

A fundamental tenet of these programs is that there can be no guarantee that individual providers will recoup the amount that they pay into the program in the form of taxes. Since the taxes remitted by providers are not directly correlated with supplemental payments received from the state, they should be presented as operating expenses. The revenue (i.e., supplemental payments) and expense (i.e., provider tax) amounts should not be netted. For additional information, see the HFMA Principles & Practices Board Issue Analysis, *Revenue Recognition Under Topic 606 for Provider Tax Programs and Similar Arrangements*.

### **5.3.2 CMS approval of provider taxation programs**

As described in HC 2.2.2, each state has a formal agreement with CMS (referred to as the Medicaid "state plan") detailing how that state's program is administered and entitling the plan to receive the federal matching funds. To make significant changes in benefits or how they pay providers, state agencies must submit and receive CMS approval of a "state plan amendment" (SPA). While it is possible for a provider tax program to be designed in a manner that does not require amendment of the state plan, in most cases states will need to request a waiver of certain federal requirements (through submitting and obtaining CMS approval of a SPA) in order to establish or renew a provider tax program.

Before approving the waiver, CMS will perform various analyses to determine whether the program is broad-based and generally redistributive among the "taxpayers" (i.e., the providers) who will take part in it. In addition, states are prohibited from a direct or indirect guarantee that providers receive their money back. The focus is on the funds flowing into the program from the tax assessments and their redistribution among providers in the form of increased Medicaid payments. If a proposed program is structured in a manner that directly or indirectly guarantees that taxpayers will receive their money back, CMS will not approve it.

Typically, the legislation establishing a provider tax program will state that if CMS does not approve the program, it will be unwound. In that case, any increased payments made provisionally to providers while awaiting approval would be recouped and used to refund the taxes paid by the providers.

### **5.3.3 Provider tax programs – general revenue recognition considerations**

As discussed in HC 5.3, supplemental payments arising from provider tax programs function as adjustments to Medicaid base rates and enter into the determination of a provider's transaction price for patient service revenue under ASC 606. Such payments represent variable consideration for services provided to Medicaid patients and, therefore, an estimate of that consideration will need to be made at the time revenue for the services is recognized. In the context of provider tax program supplemental payments, the variability may arise from two sources: (1) the status of regulatory approval of the program and (2) the provider's ability to estimate the amount of the reimbursement to which it is entitled (for an approved program) or to which it will be entitled (assuming the program is approved). See HC 5.3.4 for additional considerations when regulatory approval is pending).

As discussed in HC 3.2.5, step 5 of the ASC 606 model requires that revenue be recognized when (or as) the entity satisfies the performance obligation by transferring services to the patient. All payment streams included in the transaction price should be recognized according to the identified measure of progress, regardless of the timing of payment. Even though providers typically receive the supplemental payments in quarterly or annual lump sum amounts, this consideration should be recognized in the same pattern as the other components of the transaction price. Thus, providers will need to estimate (see HC 3.3) their supplemental payments and, in concept, allocate a portion of those anticipated payments to the transaction price for each service provided to a Medicaid patient. A portfolio approach is likely to be an appropriate technique to apply in these circumstances.

#### **5.3.4 Revenue recognition considerations in periods when program approval is pending**

When a state applies to CMS for approval of a new provider tax program (or renewal of an existing program in a significantly different form), it might take several years for CMS to grant the approval.

If a provider participates in a program that is awaiting CMS approval at the provider's reporting date, additional uncertainty exists with respect to the amount of consideration that should be included in the transaction price for services provided to Medicaid patients during periods covered by that program. The uncertainty regarding approval is binary—that is, the provider will be entitled to receive all of the expected supplemental payments if the program is approved and will receive none if CMS fails to approve the program. In some instances, there may also be uncertainty related to the determination of the amounts that will be received under the program.

HC 3.3 describes the approach required by ASC 606 for estimating consideration that is variable. That approach involves selecting an appropriate estimation methodology (either the “expected value” method or the “most likely amount” method) and considering the need to constrain the resulting estimate to avoid recognizing a significant amount of revenue that could be reversed if the ultimate outcome is different than the estimate.

When the uncertainty regarding the supplemental payments has only two possible outcomes (that is, either CMS approves or fails to approve the program), the “most likely amount” approach should be used because it would produce a better estimate of the consideration the provider expects to receive. Using the expected value approach in a situation involving only two outcomes would produce an estimate of transaction price that is significantly different than either of the two possible outcomes.

In these instances, a key consideration is whether the pending approval pertains to a new program or to renewal of an existing program.

If the pending approval relates either to a new program or to renewal of an existing program for which substantial changes have been proposed (in other words, the existing program would take on a substantially different form in the future), the provider would likely conclude that they should not record an estimate for amounts expected to be received under the program because the regulatory approval process is subjective and outside the entity's control. Experience with previous programs would unlikely be predictive with respect to a program with different features. In that situation, the estimated transaction price for services provided to Medicaid patients would exclude any estimated but unapproved supplemental payments, and recognition of revenue associated with the supplemental payments would be deferred until the approval is obtained.

Conversely, if the approval relates to renewal of an existing program with similar or identical attributes, a provider might be able to conclude, based on its historical experience with approvals of

the earlier program, that the most likely outcome is that the program will be approved. In that case, the provider would include in the transaction price any provisional payments received from the state related to that period and accrue any additional amounts due to it under the program (including amounts to which the provider expects to be entitled from the federal match).

In addition to uncertainty over program approval, there may also be uncertainty over the ultimate amount a provider will receive under these programs. The “expected value” approach may be more appropriate in estimating the amount of the pending supplemental payments if they are unknown, which could be the case with a new program or if a health care organization does not have access to other participant data.

In addition to the selection of the appropriate estimation methodology, under the ASC 606 variable consideration framework, uncertainties related to regulatory approval or the amounts of supplemental payments require the evaluation of whether those estimates need to be constrained to an amount such that a significant reversal of cumulative revenue is not probable in the future. When assessing the need for a constraint, both the likelihood and magnitude of a future revenue reversal if the approval is not received would be considered. An estimate of variable consideration is not constrained if the potential reversal of cumulative revenue recognized would not be significant, or if a potentially significant reversal is not probable of occurring. ASC 606-10-32-12 identifies factors that could increase the risks of a reversal; these are discussed in RR 4.3.2. The “Estimates of variable consideration” section of the HFMA Principles & Practices Board Issue Analysis, *Revenue Recognition Under Topic 606 for Provider Tax Programs and Similar Arrangements* also provides relevant commentary when evaluating the need for a constraint in these situations.

In assessing whether an estimate of revenue from an unapproved provider tax program should be constrained, providers should consider the method utilized to record the estimated supplemental payments. If the estimate is determined using the most likely amount method, typically it would not need to be constrained as the provider either determined it likely that the program will be approved (i.e., not probable of significant reversal) or they did not record an amount due to uncertainty. However, if the provider utilized the expected value method, they should consider if the estimate should be constrained.

In some cases, a state program may make provisional supplemental payments to providers while awaiting CMS approval. If the provider has concluded that the that program approval is not likely or if the variable consideration should be constrained, any such payments that are subject to clawback or recoupment if CMS does not ultimately approve the program would represent a refund liability (e.g., refundable advances) until the program is approved and the constraint is no longer necessary.

#### **5.3.4.1 Accounting for CMS approvals that are retroactive to a prior reporting period**

When CMS approval is delayed beyond a provider tax program’s scheduled start date, the approval granted typically is retroactive to the start date. For example, a program that was scheduled to begin on October 1 that is not approved until the following March will often mean that providers will receive a lump-sum payment in March or April that includes amounts retroactive to October 1. If the start date and the approval date fall within different financial reporting periods, questions can arise regarding the accounting for supplemental payments approved that are attributable to a prior reporting period.

This section discusses situations when the approval is received after financial statements for the prior period have been issued (or became available to be issued). If the approval is received during a

reporting period's subsequent events period, special considerations apply that are discussed in HC 5.3.4.2

When CMS approval for a program is retroactive to a date in a prior reporting period, the accounting differs depending on whether the estimate of the transaction price for services provided to Medicaid patients in the prior reporting period was constrained due to uncertainty regarding the CMS approval, as discussed in HC 5.3.2.

If that estimate was constrained, the supplemental payments retroactively approved that are attributable to the prior period(s) would be accounted for as revenue of the period in which the constraint was removed, as required by ASC 606-10-32-14 and ASC 606-10-32-43 (i.e., as a change in the transaction price for the services provided in the prior period).

#### **ASC 606-10-32-14**

At the end of each reporting period, an entity shall update the estimated transaction price (including updating its assessment of whether an estimate of variable consideration is constrained) to represent faithfully the circumstances present at the end of the reporting period and the changes in circumstances during the reporting period. The entity shall account for changes in the transaction price in accordance with paragraphs 606-10-32-42 through 32-45.

#### **Excerpt from ASC 606-10-32-43**

An entity shall allocate to the performance obligations in the contract any subsequent changes in the transaction price on the same basis as at contract inception.... Amounts allocated to a satisfied performance obligation shall be recognized as revenue, or as a reduction of revenue, in the period in which the transaction price changes.

Conversely, if that estimate was not constrained, an estimate of revenue associated with the portion of the supplemental payments attributable to the prior period would have been included in revenue of the prior period (through provisional payments received and/or accruals made). Any difference between the amount estimated for the prior period and the amount actually received for the prior period in connection with the approval is reflected in the period the approval is received as a change in the transaction price associated with the prior period services. Example HC 5-2 illustrates the application of this model.

### **EXAMPLE HC 5-2**

#### **Accounting for retroactive CMS approval received in a subsequent reporting period**

Hospital is located in a state that applied to CMS for approval of a new provider tax program that was scheduled to begin on October 1, 20x0. Hospital expects to be entitled to lump sum supplemental payments of \$250,000 in each of its quarters ending December 31, 20x0, March 31, 20x1, June 30, 20x1, and September 30, 20x1, based on modeling done by the state. Historically, Hospital's Medicaid patient base has stayed relatively consistent through the reporting year. During November 20x0, while it awaited CMS approval, the state made provisional payments to Hospital of \$100,000 with the condition that if the program is not approved by CMS, the funds must be returned to the state. As of December 31, 20x0 (the close of Hospital's fiscal year), CMS approval had not been received.

Due to the uncertainty regarding the program's approval, Hospital constrained its estimate of revenue associated with services provided to Medicaid patients in the year ending December 31, 20x0 to

exclude any amounts expected to be received from the provider tax program attributable to services rendered in that quarter. Thus, its financial statements for the fiscal year did not include any revenue from the provider tax program for services rendered to Medicaid patients during the first three months of that program. As a result, the \$100,000 provisional payment received was reported as a refundable advance (a liability).

Hospital issued its financial statements for the year ended December 31, 20x0 on February 15, 20x1. Five days later (on February 20, 20x1), CMS approved the provider tax program retroactive to October 1, 20x0.

On March 1, 20x1, Hospital received a \$150,000 lump sum payment from the state to catch up the supplemental payments to which Hospital was entitled for the fiscal ended December 31, 20x0.

How would Hospital account for the payment?

### *Analysis*

The uncertainty associated with the CMS approval was resolved on February 20, 20x1 and thus, the constraint on the estimate of variable consideration attributable to the provider tax program was no longer needed. According to ASC 606-10-32-14, this is a change in transaction price associated with services provided to Medicaid patients in 20x0 that would be reported in the period in which the constraint was lifted (i.e., the quarter ended March 31, 20x1). Hospital would make the following accounting entries on February 20, 20x1:

Due from Medicaid	\$150,000	
Refundable advances	\$100,000	
Patient service revenue		\$250,000

*To reflect approval of provider tax program and anticipated receipt of catch-up payment.*

Hospital would then make the following entry on March 1, 20x1:

Cash	\$150,000	
Due from Medicaid		\$150,000

*To reflect catch-up payment received.*

If Hospital had not constrained the estimate of variable consideration at December 31, 20x0 (for example, if the amount of revenue was deemed insignificant or if the pending approval pertained to renewal of an existing program, rather than approval of a new program), the accounting in March 20x1 would have been significantly different. In that scenario, Hospital would have included \$250,000 of patient service revenue in its financial statements for the fiscal year ended December 31, 20x0. The \$100,000 cash payment received in November would have reduced the corresponding receivable for

services rendered and a remaining receivable from the Medicaid program of \$150,000 would have been reflected on the December 31, 20x0 balance sheet. In that scenario, Hospital's accounting entries upon receipt of the \$150,000 payment on March 1, 20x1 would have been:

Cash	\$150,000	
Due from Medicaid		\$150,000

*To reflect receipt of catch-up payment.*

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#### **5.3.4.2 CMS approval received during subsequent events period**

In some cases, notification of CMS regulatory approval might be received after the end of the reporting period but before the date on which financial statements are issued or available to be issued. Guidance for those situations is provided in ASC 855, *Subsequent Events*. Generally, the determination of whether to recognize the subsequent event in the financial statements is based on whether that event provides additional evidence about conditions that existed at the balance sheet date. If so, it is recognized in the financial statements; if not, it is treated as an event of the period in which it occurs. FSP 28 discusses ASC 855's framework for evaluating and categorizing subsequent events as recognized or nonrecognized.

ASC 855 does not directly address situations when information about regulatory approval is received during the subsequent events period (the period extending from the balance sheet date through the date when the statements are issued or are available to be issued – see FSP 28 and NP 1.6). When approval is received during the subsequent events period (for either quarterly or annual reporting), the evaluation of whether the approval is “pushed back” into the financial statements is affected by whether the estimate of the transaction price for services provided to Medicaid patients was constrained at period-end due to uncertainty regarding the CMS approval, as discussed in HC 5.3.4.

If the estimate of the transaction price at quarter-end or year-end was not constrained due to uncertainty regarding the CMS approval, we believe the approval notification simply provides validation of the expectation of approval. The financial statements would be adjusted for any difference between the actual amount to be received (if known) and the estimated amount accrued (a recognized subsequent event).

For providers that constrained their estimates based on the regulatory uncertainty, the determination of whether the approval should be recognized (i.e., pushed back to the unissued financial statements) or not recognized (i.e., recognized in the ensuing reporting period) will be based on facts and circumstances and may require significant judgment. Because the regulatory approval process is a subjective determination that is totally within the control of CMS (and outside of the provider's influence), and the provider previously concluded that there was sufficient uncertainty that the estimate should be constrained, we believe that it may be difficult to assert that the subsequent approval relates to conditions that existed at the balance sheet date. In that case, the approval would be considered an event of the period in which it is received (i.e., it would be a nonrecognized subsequent event). Regardless of whether a provider determines that regulatory approval is recognized or nonrecognized in any particular circumstance, disclosure of the amount of variable consideration

related to the program and the manner and period in which it has been, or will be, reported should be disclosed.

## 5.4 *Contract assets and liabilities*

In health care services arrangements accounted for under ASC 606, the entity agrees to provide the services requested by the customer (the patient or resident) and the customer agrees to pay for those services. Contract assets and contract liabilities can arise when the timing of receipt of consideration from the customer (or the payer(s)) differs from the timing of when services are rendered and/or when invoices are issued.

When performance by a customer (i.e., payment) lags behind performance by the health care entity, the difference represents a contract asset that is reflected in the balance sheet. Alternatively, if the customer pays before the health care entity performs, the balance sheet would reflect a contract liability. The basic rule is set forth in ASC 606-10-45-1.

### **ASC 606-10-45-1**

When either party to a contract has performed, an entity shall present the contract in the statement of financial position as a contract asset or a contract liability, depending on the relationship between the entity's performance and the customer's payment. An entity shall present any unconditional rights to consideration separately as a receivable.

### 5.4.1 *Contract assets*

Contract assets arise from revenue earned for goods or services provided that is not yet billable to a customer (for example, because the seller or service provider's performance is not yet complete). A contract asset becomes a receivable when only the passage of time is required before payment of consideration is due (ASC 606-10-45-4); said differently, there's nothing else the provider must do to be entitled to the consideration.

### **Excerpt from ASC 606-10-45-4**

A receivable is an entity's right to consideration that is unconditional. A right to consideration is unconditional if only the passage of time is required before payment of that consideration is due.

In healthcare services transactions, contract assets are rarely encountered outside of hospital inpatients that remain "in-house" on the last day of a reporting period (quarterly or annual). The hospital will have earned the revenue associated with the services provided up to that point, but because the patients' stays are still in progress, the unbilled amounts represent contract assets. Upon the patients' discharge (at which point the hospital's performance obligations will have been fully satisfied), the contract assets become receivables (i.e., financial assets). From a practical perspective, when the time frame from beginning to end of a patient service revenue transaction is very short, no contract asset will arise; the provider will simply recognize revenue and a receivable.

### 5.4.2 **Contract liabilities**

Contract liabilities arise for payments collected in advance from patients or third-party payers. They represent obligations that will be satisfied by providing goods or services. Many organizations may describe their contract liabilities as “deferred revenue” or “customer deposits.” It is important to note that refund obligations and third-party settlement liabilities are not contract liabilities, as they generally are settled by paying cash or other financial assets, rather than by providing services.

Healthcare-specific examples of contract liabilities include nonrefundable entrance fees received from residents entering into continuing care retirement communities (CCRCs) and advances received by providers or suppliers under Medicare’s accelerated and advance payment program (see Question HC 5-2).

#### **Question HC 5-2**

Under fee-for-service Medicare program rules, CMS can make accelerated or advance payments to eligible health care entities during periods of claims payment disruption or unusual operating circumstances (e.g., national emergencies or natural disasters). How should health care entities account for payments received under the Medicare Accelerated and Advance Payment Program?

#### ***PwC response***

These payments represent advances on payments for future claims that the health care entities expect to submit to CMS for services provided to Medicare patients. Thus, they would generally be reflected as contract liabilities. Once the recoupment period stipulated by CMS commences, the contract liability will be reduced over time as revenue is recognized for services provided to Medicare patients for which claims will be submitted.

If the advance has not been entirely offset by services provided through the end of the recoupment period, the health care entity must repay the remaining amount to CMS. Thus, if an entity does not expect to have sufficient Medicare volume to settle the liability by providing services, it may be appropriate to reclassify any amounts expected to be repaid to CMS from contract liability to a refund liability.

AICPA TQA 6400.68 provides further information about this program.

### 5.4.3 **Presentation and disclosure of contract assets and liabilities**

“Contract assets” and “contract liabilities” are conceptual terms, not prescribed financial statement captions. When these assets or liabilities are reported separately in the balance sheet, more descriptive titles (such as “deposits” or “deferred revenue” for a contract liability) are likely to be more useful to financial statement users.

ASC 606-10-50-8 through ASC 606-10-50-10 requires disclosures about the opening and closing balances of contract assets, contract liabilities, and receivables, if material. If such assets or liabilities are reported separately on the balance sheet, this information may be readily apparent from the face of the balance sheet if comparative statements are provided (in which case the disclosure requirement would be satisfied). Entities with significant contract liability balances that extend across multiple periods (for example, CCRCs and similar entities that report nonrefundable advance fees) may be

required to disclose additional information, such as reductions in those balances resulting from performance obligations satisfied during the reporting period.

## 5.5 **Government grants received by for-profit health care entities**

The volume of grants made by federal and state governments (and even some foreign governments) to business entities has increased in recent years. In particular, there has been significant federal government grant activity involving for-profit as well as not-for-profit health care providers.

ASC 958-605, *Not-for-Profit Entities — Revenue Recognition*, provides guidance on accounting for contributions made or received by business entities and NFP organizations, with one specific exception – it does not apply to “transfers of assets from governments to business entities” (e.g., government grants to business entities). Transfers of assets from governments to business entities can take many forms, such as grants, contracts, and cooperative agreements. If government assistance is determined to be an exchange transaction, business entities should follow the applicable guidance governing the transaction (e.g., ASC 606). However, there is no specific FASB guidance that addresses the accounting for non-exchange assistance from governments to business entities. Because of this, determining the proper accounting treatment can be challenging and will likely depend on an analysis of the nature of the assistance and the conditions on which it is predicated.

When selecting the appropriate accounting model to apply to government assistance received that is nonexchange in nature (see NP 12.2 for assessing whether it is an exchange transaction), a for-profit health care entity should consider the following:

- The guidance in ASC 105, *Generally Accepted Accounting Principles*, on selecting accounting principles for transactions or events for which no guidance exists
- The specific characteristics and facts and circumstances associated with the assistance
- Any preexisting accounting policies the entity may have established for government assistance.

ASC 105 describes the decision-making framework when no guidance exists for a particular transaction. Specifically, ASC 105-10-05-2 instructs entities to first look within the FASB codification for guidance for a similar transaction or event to apply by analogy. If no guidance for similar transactions is identified, an entity may consider analogizing to nonauthoritative guidance from other sources (for example, guidance issued by other standard setters, such as the International Accounting Standards Board (IASB)).

While government assistance provided to business entities is outside the scope of ASC 958-605, the FASB staff has stated in various public meetings that there is no prohibition on applying that guidance by analogy under ASC 105-10-05-2. See NP 6 and NP 7 for a comprehensive discussion of the ASC 958-605 accounting model.

In certain circumstances, business entities might also consider applying the guidance in ASC 450-30, *Gain Contingencies*, to government assistance received. Under that model, the earnings impact of a gain contingency is recognized when all the contingencies related to receipt of the assistance have been met and the gain is realized or realizable. Payments received in advance of meeting the contingencies

(e.g., the conditions contained in the grant) would be recorded as a liability (e.g., a refundable advance).

Alternatively, business entities might look outside US GAAP. In this context, an IASB standard (IAS 20, *Accounting for Government Grants and Disclosures of Government Assistance*) may be relevant. IAS 20 provides guidance for two types of grants—grants related to income (e.g., grants to cover specific types of costs or expenses), and grants related to assets (e.g., subsidies for acquisition of capital assets).

See FSP 3.10.3 for additional discussion of IAS 20, including a comparison to ASC 958-605, as well as a discussion of disclosures requirements for certain government assistance transactions for business entities.

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***Chapter 6:  
Health care – other  
accounting considerations***

## 6.1 *Other accounting considerations - chapter overview*

This chapter provides an overview of other accounting and reporting considerations relevant to health care organizations that are not covered in other chapters of this guide. This includes:

- disclosures of risks and uncertainties,
- accounting for physician recruitment arrangements,
- loss contingencies and insurance coverage, and
- reporting considerations for physician practice management companies.

## 6.2 *Disclosures of risks and uncertainties*

ASC 275, *Risks and Uncertainties*, requires entities to disclose information about significant risks and uncertainties specific to the entity, including information about estimates used in the preparation of the financial statements as well as information about current vulnerability due to certain concentrations. The requirements focus primarily on risks and uncertainties that could significantly affect reported amounts in the near-term.

Examples of estimates that often are significant in health care entity financial statements include the following:

- Variable consideration (e.g., contractual allowances, third-party settlements, implicit price concessions)
- Accruals for malpractice losses
- Obligations for future services (e.g., continuing care retirement communities)
- Accruals for incurred but not reported (IBNR) losses arising from prepaid health care arrangements
- Regulatory and audit-related contingencies (e.g., fraud and abuse actions)
- Estimated risk pool settlements
- Estimated net proceeds and/or the provision for expected losses to be incurred on disposition of a business or assets

### 6.2.1 *Regulatory investigations and audits*

Investigations or audits by government regulators, and the far-reaching nature of alleged fraud and abuse violations, may represent a significant risk and uncertainty that would require disclosure in accordance with ASC 275. Federal and state governments aggressively enforce Medicare and Medicaid anti-fraud and anti-abuse legislation. Most notable is the federal False Claims Act, which imposes criminal and civil penalties for making false claims and statements to Medicare and Medicaid. False claims include, but are not limited to, billing for services not rendered or for misrepresenting actual

services rendered in order to obtain higher reimbursement, billing for unnecessary goods and services, and cost report fraud. Broadening regulatory and legal interpretations in recent years has significantly increased the risk of penalties for providers; for example, broad interpretations of “false claims” laws can expose ordinary billing mistakes to penalty consideration. In addition to providers that bill the Centers for Medicare & Medicaid Services (CMS) directly for claims in traditional Medicare, this exposure can apply to providers that receive claims payments through Medicare Advantage health plans.

If the government believes that billing fraud may have occurred—for example, assigning inaccurate billing codes to a medical procedure or treatment in order to increase reimbursement, referred to as “upcoding”—it has the ability to conduct investigations that can result in civil monetary penalties or criminal penalties, in addition to recoupment of the underlying claims payments. If a provider is the target of a government investigation, the need for accruals or disclosures related to contingencies associated with the potential effect of illegal acts must be evaluated.

Settlements reached in such investigations may contain an element of retroactive revenue adjustments (e.g., denied claims) and an element of contingent liabilities associated with fines and penalties. The former is an uncertainty that must be considered in estimating revenue (i.e., variable consideration) for the period in which the services were provided, as discussed in HC 3.3.2. ASC 450, *Contingencies*, provides guidance in evaluating contingent liabilities, such as potential fines and penalties under applicable laws and regulations. Estimates of potential fines and penalties are accrued only if their payment is probable and reasonably estimable.

Providers also may have to incur costs in future years to demonstrate compliance with federal laws. When a provider enters into an agreement (e.g., corporate integrity agreement (CIA)) with the federal government to settle an investigation, such settlement agreements normally impose an obligation on the provider to engage an independent review organization to test and report on compliance with Medicare requirements each year for the following five years. ASC 954-405-25-5 stipulates that a provider should not accrue a liability for the expected costs of future Medicare compliance audits required as a result of settlement agreements. Those costs should be recognized as operating costs as the audits are conducted.

## **6.3 Physician recruiting arrangements**

Hospitals may use various types of financial incentives to recruit physicians who can provide needed, but unavailable, medical services in their communities. Several of these are described below. AAG-HCO 8.54 through AAG-HCO 8.61 provide additional commentary on these arrangements.

### **6.3.1 Start-up financing**

Health care providers sometimes provide loans to physicians who agree to relocate and establish a practice in the hospital's service area. Typically, the physician signs a loan agreement stating that they will be liable for the loan and will repay both principal and interest at terms defined in the agreement. The hospital may, at its discretion, forgive the loan if the physician stays in the community for a stipulated number of years. Assuming that the hospital has executed a formal, legally enforceable loan agreement with the physician, the hospital holds a financial instrument that meets the ASC Master Glossary definition of a loan (i.e., a contractual right to receive money on demand or on fixed or determinable dates). Thus, an asset should be recognized when the funds are advanced to the physician, even if the hospital's policy and practice is to forgive such loans.

ASC 310-10-35-16 indicates that a loan is impaired when, based on current information and events, it is probable that a creditor will be unable to collect all amounts according to the contractual terms of the loan agreement. In our view, "unable to collect" does not mean the same thing as "chooses not to collect." An inability to collect would exist if the physician is deemed unable to repay the loan (based either on the original terms of the note or on modified terms, such as if the payments are extended over a longer period). Therefore, physician loans should be assessed for impairment based on an evaluation of the physician's ability or inability to repay the outstanding balance of the loan. If the loan agreement provides for "milestones" which, upon attainment, would result in a forgiveness of a portion of the debt, the hospital would write off that portion of the loan to expense ("physician recruitment" or similar expense category, not impairment or bad debt expense) as the milestones are reached. If no milestones are specified, the receivable would be written off when the hospital forgives the loan (i.e., when the physician is formally notified that the loan, or a portion thereof, has been forgiven).

### ***New guidance***

ASU 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, introduces a new model for recognizing credit losses on financial instruments based on an estimate of current expected credit losses. The new guidance was effective for public business entities that are SEC filers for fiscal years beginning after December 15, 2019 (including interim periods). For all other entities, ASU 2016-13 is effective for fiscal years beginning after December 15, 2022, including interim periods.

ASU 2016-13, codified in ASC 326, requires a financial asset measured at amortized cost basis to be presented at the net amount expected to be collected. The measurement of expected credit losses is based on relevant information about past events, including historical experience, current conditions, and reasonable and supportable forecasts that affect the collectability of the reported amount.

Upon adoption, physician loans will be subject to the current expected credit losses (CECL) model prescribed by ASC 326. Health care entities should record lifetime expected credit losses for these loans in their allowance for credit losses. In estimating credit losses, a healthcare entity would include amounts it does not expect to collect due solely to credit risk (for example, amounts not collected from a physician who defaults on the loan). Amounts that a health care entity expects to forgive would likely be considered compensation or physician recruitment expense.

## **6.3.2 *Income guarantees***

Another common recruitment incentive used to attract physicians who will practice privately (i.e., rather than be employed by the hospital) is for the hospital to guarantee a specified level of income from the physician's private practice for a specified period subsequent to relocation.

### **6.3.2.1 *Guarantees in the scope of ASC 460***

Many physician income guarantees are within the scope of ASC 460, *Guarantees*. ASC 460-10-55-11 provides a specific example of a minimum revenue guarantee granted to a nonemployee physician by a not-for-profit (NFP) health care facility. In those situations, the health care facility (the guarantor) agrees to make payments to the nonemployee physician (the guaranteed party) at the end of specific periods of time if the gross revenues (gross receipts) generated by the physician's new practice during that period of time do not equal or exceed a specific dollar amount. Under ASC 460-10-25-2, a guarantee obligates the guarantor in two ways: there is a contingent portion—a liability that will be

recognized under ASC 450 only if the guarantor is called upon to perform under the guarantee—and a noncontingent portion—the guarantor's "obligation to stand ready to perform" under the guarantee. The "obligation to stand ready to perform" is recognized under ASC 460; the accounting for the contingent portion is subject to ASC 450.

At inception of the guarantee, the hospital would recognize a liability for the obligation to stand ready to perform (i.e., the noncontingent portion) based on the estimated fair value of the minimum revenue guarantee. Usually, the fair value of this obligation would be calculated based on the probability-weighted expected cash outflows during the guarantee period. ASC 460-10-25-4 does not prescribe where the offsetting debit should be reported (e.g., as an expense or an asset) but states that it depends on the circumstances in which the guarantee was issued. As indicated in AAG-HCO 8.59, in practice, most health care organizations recognize an intangible asset that is amortized into physician recruiting costs over the life of the contract. ASC 460-10-35 does not prescribe a method for subsequently measuring the guarantor's liability for the obligation to stand ready to perform but ASC 460-10-35-1 notes that the liability typically would be reduced by a credit to earnings as the guarantor is released from risk under the guarantee.

### **6.3.2.2** *Guarantees in the form of forgivable advances*

Rather than an outright guarantee, many "income guarantees" are structured as advances that the physician is required to repay after the end of the guarantee period. These are often subject to forgiveness if the physician stays in the community for a stipulated time (e.g., a specified portion of the advance is forgiven for every year the physician remains in the community). For example, assume that a hospital guarantees a physician a specific amount of income over a period of one year and at the end of the period, it advances the physician \$30,000 for the shortfall during the guarantee period. The hospital may require the physician to repay the advance if they leave the community before the end of three years. However, if the physician remains in the community, the hospital will forgive \$10,000 per year such that three years after the advance, no amount needs to be repaid.

If the guarantor hospital is a not-for-profit entity, IRS rules requires that any such "guarantee" arrangements be structured as an advance to comply with the prohibition on private inurement (i.e., the private use of not-for-profit assets).

If a physician income guarantee is formally a promissory note, the "income guarantee" is actually a financing arrangement. Financing arrangements are excluded from the scope of ASC 460, and generally would be accounted for in the same manner as physician loans (see HC 6.3.1). This conclusion is consistent with TIS 6400.45, which explicitly states that physician loans are not guarantee contracts within the scope of ASC 460.

### **6.3.3** *Mortgage guarantees*

Another common hospital recruitment incentive is a guarantee of a physician's personal home mortgage for his or her residence in the hospital's service area. Typically, the guarantee allows the physician to obtain a loan at a lower interest rate.

TQA 6400.46 indicates that if the recruited physician will be employed by the hospital, the arrangement is not subject to recognition, consistent with the scope exception in ASC 460-10-15-7 for employment-related costs. However, if the physician will be in private practice, such an arrangement would meet the scope of a guarantee contract outlined in ASC 460-10-15-4a. In that case, the contract requires the hospital (the guarantor) to make a cash payment to the mortgage lender (the guaranteed

party) based on the occurrence of a specified event (i.e., a scheduled payment under the mortgage is not made by the physician) that is related to an asset of the guaranteed party (the mortgage loan receivable). Thus, at the inception of the guarantee, the hospital must recognize a liability for the obligation to stand ready to perform based on the estimated fair value of the mortgage guarantee.

The fair value of a mortgage guarantee would be calculated based on the probability-weighted expected cash outflows during the guarantee period. Assuming that no loan default is expected to occur (and, as a result, no cash is expected to be paid out), the fair value of the guarantee may be relatively small. As discussed in HC 6.3.2.1, ASC 460-10-25-4 does not prescribe where the offsetting debit should go (e.g., expense, asset), instead stating that it depends on the circumstances in which the guarantee was issued. AAG-HCO 8.59 indicates that, in practice, most health care organizations recognize an intangible asset that is amortized over the life of the physician's contract.

ASC 460-10-35-1 also does not prescribe how the guarantor's liability would be measured subsequent to initial recognition but notes that the liability typically would be reduced by a credit to earnings as the guarantor is released from risk under the guarantee. In the situation described above, the hospital would be released from risk as the physician's outstanding mortgage obligation is reduced.

## **6.4 Loss contingencies and insurance coverage**

Due to the nature of their operations, health care organizations have significant exposure to loss arising from medical malpractice claims. Additionally, the labor-intensive nature of the business may expose them to losses associated with other types of insured or self-insured arrangements (for example, worker's compensation or employee health insurance). Organizations often manage such risks using alternatives to traditional occurrence-based casualty insurance, such as retrospectively rated policies, claims-made policies, captive insurance companies, risk-retention groups, or self-insurance arrangements.

This section focuses on contingencies associated with medical malpractice claims, which are typically the most significant exposure for health care organizations. However, the guidance may also be helpful in accounting for other liabilities, including workers' compensation and employee health insurance. The only area where the ASC specifically makes guidance applicable to both malpractice claims and similar liabilities is with respect to the presentation of the effects of insurance coverage, as discussed in HC 6.4.2.

### **6.4.1 Accruing the liability for claims**

The ultimate costs of asserted and unasserted claims (including costs of adverse judgments in litigation and settlements) should be accrued when the incidents occur that give rise to the claims. The general approach to estimating the accrual is described in FSP 23. With regard to unreported incidents/unasserted claims, AAG-HCO 8.22 states that the greater the volume of a health care entity's operations, the greater the likelihood that one or more unreported incidents will have occurred prior to the balance sheet date. As such, it would be unusual to have no accrual for incurred but not reported (IBNR) claims.

Estimates of losses should be based on all available evidence, which may include industry experience. However, ASC 954-450-30-2 indicates that providers should consider the relevance of industry data to their organization, including the size, operations, and past experience of peer organizations.

Additionally, industry data that is not current may not be relevant. In estimating claims, providers may need adjust industry data to develop an estimate specific to their entity.

Many providers use actuaries to assist in estimating the loss liability. AAG-HCO contains a section titled, *Use of actuaries and actuarial methods* (AAG-HCO 8.119 through AAG-HCO 8.122) that discusses actuarial techniques in evaluating medical malpractice claims. AAG-HCO 8.119 notes that the decision to use an actuary should contemplate whether the estimated claim liability is likely to be material to the financial statements and whether specialized knowledge will be required to make an estimate.

GAAP does not address whether accrued claims liabilities need to be discounted. In general, discounting is appropriate only when the aggregate amount of the liability and the timing of cash payments are fixed or reliably determinable. Refer to FSP 23.4.1.1 for additional discussion on the discounting of liabilities. Discounting is also discussed in AAG-HCO 8.25 through AAG-HCO 8.29. According to AAG-HCO 8.25, the accrued liability may be discounted if all of the following conditions are met:

- a) the amount of the liability, individually or in the aggregate, is fixed or reliably determinable;
- b) the amount and timing of cash payments for the liability, individually or in the aggregate, based on the entity's specific experience, are fixed or reliably determinable; and
- c) expected insurance recoveries, if any, are also discounted.

Considerations related to establishing a discount rate are discussed in AAG-HCO 8.26 and AAG-HCO 8.112. ASC 954-450-50-2 requires health care organizations to disclose the carrying amount of discounted malpractice claims, along with the interest rate(s) used to discount those claims. While not addressed in the guidance, we would also encourage health care organizations to disclose their policy concerning discounting along with disclosure of the undiscounted amount of the claims.

Estimated losses should be reviewed and the estimates changed, if necessary, at each reporting date, with the changes recognized currently as additional expense or reductions of expense (ASC 954-450-35-1 and AAG-HCO 8.05). Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle should be classified as current liabilities; all other accrued unpaid claims and expenses should be classified as noncurrent liabilities (AAG-HCO 8.06).

General GAAP disclosure requirements are summarized in AAG-HCO 8.48 through AAG-HCO 8.53. In addition, ASC 954-450-50-1 requires that a health care entity disclose its program of medical malpractice insurance coverage. Those disclosures should include the nature of the insurance coverage (for example, claims-made or occurrence based); related terms (for example, self-insured retention and excess levels); and expected insurance recoveries and the basis for any related loss accruals (AAG-HCO 8.50).

Health care organizations should also disclose the reasons for significant changes in the costs of incurred claims recognized in the income statement or statement of operations, including the costs associated with litigating or settling those claims. In addition to medical malpractice, this disclosure is recommended for all significant claims obligations, such as workers' compensation and employee health insurance (AAG-HCO 8.52).

### 6.4.2 *Assessing recognition and measurement of insurance recoveries*

ASC 954-450-25-2 specifies how a health care provider should account for insurance coverage.

#### **ASC 954-450-25-2**

The ultimate costs of malpractice claims or similar contingent liabilities, which include costs associated with litigating or settling claims, shall be accrued when the incidents that give rise to the claims occur. A health care entity shall evaluate its exposure to losses arising from claims and recognize a liability, if appropriate. The liability shall not be presented net of anticipated insurance recoveries. An entity that is indemnified for these liabilities shall recognize an insurance receivable at the same time that it recognizes the liability, measured on the same basis as the liability, subject to the need for a valuation allowance for uncollectible amounts. The provisions in Section 720-20-25 and Subtopic 944-40 discusses accounting for insurance claims costs, including estimates of costs relating to incurred-but-not-reported claims. Subtopic 450-20 discusses the accounting for loss contingencies.

Insured entities must report a liability for all claims outstanding as of the balance sheet date, including claims that are covered by insurance. To the extent that insurance coverage provides for recovery of claims, the insured entity should separately accrue the amount recoverable from the insurer as a receivable. The entity recognizes the insurance receivable at the same time that it recognizes the liability for the covered claims, and measures it on the same basis as the liability (i.e., using the same assumptions), subject to the need for an allowance for credit losses if there are concerns about the insurer's ability to pay. This generally results in reporting a receivable that mirrors the amount of estimated losses accrued that are covered by insurance. Considerations associated with recognizing the recovery are discussed at PPE 8.

Most healthcare professional liability insurance is written as a "pay on behalf" contract (that is, the insurance carrier will pay the settlement directly to the plaintiff on behalf of the health care organization). Questions have arisen as to whether ASC 954-450-25-2 must be applied if the entity does not actually pay claims, and then receive reimbursement from the insurance company. This situation is discussed in TIS 6400.51, *Presentation of Insurance Recoveries When Insurer Pays Claims Directly*, and paragraph BC4 of ASU 2010-24, *Presentation of Insurance Claims and Related Recoveries*. In these situations, the guidance is applied "as if" the insured health care organization pays the claim out of pocket and is subsequently reimbursed by the insurer; that is, the health care organization should report the gross amount of its claims liabilities (including those that are covered by insurance) as its obligations and should record a receivable as if it were entitled to receive insurance recoveries to offset those obligations. Despite the fact that an insurance entity is paying for the defense of the claim, and ultimately paying for some or all of the award or settlement, the insured health care organization is the primary obligor for payment of the claim (because if the insurer was unable to pay, the health care organization would still be liable). This approach is consistent with the reporting required by organizations in other industries.

From an expense recognition perspective, the recovery associated with the insurance receivable will generally offset the losses associated with the incurred claim. The net effect on expense of a fully insured claim should be zero.

**Question HC 6-1**

ASC 954-450-25-2 refers to “malpractice claims and similar contingent liabilities.” What is meant by *similar contingent liabilities*?

***PwC response***

As discussed in TIS 6400.49, *Presentation of Claims Liability and Insurance Recoveries -- Contingencies Similar to Malpractice*, “similar contingent liabilities” refers to liabilities of a similar nature, such as workers' compensation claims or director and officers claims. If an entity has these types of liabilities, it should similarly report its gross claims liabilities separately from any insurance recoverable.

**Question HC 6-2**

A health care entity has a workers' compensation insurance policy that provides “first dollar coverage,” that is, the policy has no deductibles, and the insurer is responsible for paying the full amount of losses for all claims up to the policy limit. Does the requirement in ASC 954-450-25-2 to recognize a liability for the gross amount of the loss and an asset for the insurance recoverable apply in this situation?

***PwC response***

Yes. Even though the insurance policy is expected to cover all claims, the health care entity is still the primary obligor in the event the insurer is unable to pay. Thus, claims subject to “first-dollar coverage” must be reflected “gross” on the health care entity's balance sheet, that is, the balance sheet should reflect both a liability for all estimated claims outstanding as of the balance sheet date, and a separate receivable representing the amount recoverable from the insurer.

**Question HC 6-3**

A health care system's malpractice insurance coverage is provided through a policy that names the parent as the insured party. The parent, in turn, agrees to indemnify the subsidiaries (who are listed in the policy as “additional insureds”). Under this structure, the parent is bearing all of the risk for the system's consolidated operations. Does ASC 954-450-25-2 require a “gross-up” of claim liabilities and insurance recoveries in separately issued statements of the subsidiaries, or have the subsidiaries effectively transferred their risk to the parent?

***PwC response***

In this case, in the context of the separate financial statements of the subsidiaries, the parent is effectively acting as the insurer. Thus, the losses that arise from the health care operations conducted by the subsidiaries should be recognized as liabilities in the subsidiaries' financial statements along with a corresponding receivable, representing the amount recoverable from the insurer (via the parent).

**6.4.3 *Claims-made insurance policies***

See PPE 8 for a general discussion of accounting for claims-made insurance. A discussion specifically directed to providers of health care services is included in AAG-HCO 8.34 through AAG-HCO 8.36.

#### 6.4.4 *Retrospectively rated insurance policies*

A retrospectively rated insurance policy is one in which the premium is adjustable based on actual claims experience during the policy term. The total annual premium consists of a minimum premium and an additional amount for estimated claims that is adjusted based on actual loss experience (i.e., claim activity). Depending on the arrangement, the adjustment might be based solely on the insured entity's own experience, or instead it might be based on the collective experience of a group of insured entities. A general discussion of accounting for retrospectively rated insurance coverage is presented at PPE 8. A discussion specifically directed to providers of health care services is included in AAG-HCO 8.37 through AAG-HCO 8.40.

The amount of insurance expense recognized in any given year related to a retrospectively rated policy depends on how the total premium is determined under the policy's terms. If a provider's total premium will be determined based primarily on its own loss experience, the risk transferred is limited to the amount of the minimum premium paid, and the transfer of cash to the insurance company more closely resembles a funding mechanism for self-insured risk than the transfer of risk to a third party through an insurance policy. Therefore, the portion of the initial premium representing the minimum premium should be charged to expense over the policy term; the experience portion (additional amount above the minimum premium based the provider's actual claim activity) should be accounted for as a deposit. Regardless of the accounting for the payments to the insurer, the health care organization will still need to accrue the full amount of all estimated losses from asserted and unasserted claims. Insurance recoveries should not be recognized until the estimated losses exceed the stipulated maximum premium payable by the health care organization (ASC 954-720-25-1).

Example HC 6-1 illustrates the accounting for premiums that are based only on a health care organization's own loss experience.

#### **EXAMPLE HC 6-1**

##### *Retrospective policy – adjustable premium*

Hospital maintains an adjustable retrospective policy with Insurance Company. Under this policy, the adjustable portion of the premium is based on Hospital's own claims experience. At the end of each month during the policy period, Hospital pays Insurance Company a \$100,000 minimum base premium plus an amount based on Hospital's forecasted claim activity (the experience adjustment). In January 20X1, Hospital pays the \$100,000 minimum base premium and \$1,250,000 for the experience adjustment to Insurance Company.

How should Hospital record the premium payments made in January 20X1?

##### *Analysis*

The minimum base premium reflects Hospital's expense for Insurance Company's services to administer the policy and the maximum risk assumed by the Insurance Company. The adjustable portion of the premium represents a funding mechanism for claim payments during the policy term. Therefore, Hospital should record the \$100,000 minimum base premium as an expense and the \$1,250,000 experience portion as an asset (e.g., a deposit). Over the policy period, Hospital would also record a liability for an estimate of losses from asserted and unasserted claims. As these claims are paid by Insurance Company, Hospital should adjust the deposit asset and the outstanding claims liability.

If a provider's total premium will be determined based primarily on the experience of a group, the full premium, which includes the minimum base and the retrospective experience adjustment, should be charged to expense over the policy term. At period-end, any additional premiums or refunds should be accrued based on the group's experience to date, which includes provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported (ASC 954-720-25-2). In effect, this is an accrual of the estimated ultimate cost of unsettled claims. The provider records a liability for all claims outstanding as of the balance sheet and accrues an insurance receivable related to claims that will be covered by insurance. ASC 954-720-50-1 requires providers insured under this type to disclose that they are insured under a retrospectively rated policy, and that premiums are accrued based on the estimated ultimate cost of the experience to date of a group of providers.

### Question HC 6-4

A health care entity's malpractice risk management program utilizes a retrospectively rated insurance policy. The total annual premium consists of a minimum premium and an additional amount for estimated claims that is adjusted based on the health care entity's actual malpractice loss experience. The policy is also subject to a maximum premium amount. How should the health care entity consider the retrospective-rating feature of the policy in determining the amount of insurance recoveries to recognize?

#### ***PwC response***

The health care entity must determine the extent to which its retrospectively rated policy actually provides indemnification against risk of financial loss associated with malpractice claims. Because the premium is based on the entity's own loss experience, the economic substance of the arrangement may more closely resemble a claims funding mechanism (similar to self-insurance) than a contract that indemnifies the entity against risk of financial loss. As explained more fully in TIS 6400.52, *Insurance Recoveries From Certain Retrospectively Rated Insurance Policies*, the facts and circumstances of the terms of the insurance arrangement must be carefully evaluated in making this assessment. If all estimated claims would be payable from the entity's own resources on deposit with the insurer, there would be no insurance recoveries to report (because the liabilities would be payable from assets reported on the entity's balance sheet). However, if it is reasonably possible that the entity's ultimate loss experience will exceed the maximum premium (and thus, the insurer will actually indemnify the portion of the loss), a receivable for insurance recoveries associated with the amount in excess of the maximum premium would be accrued.

#### **6.4.5 Captive insurance companies**

A general discussion of accounting for claims insured under captive insurance arrangements is presented in IG 4.3. AAG-HCO 8.30 through AAG-HCO 8.33 provides a general discussion that is specific to malpractice coverage. AAG-HCO 8.41 through AAG-HCO 8.43 discusses retrospectively rated coverage provided by a captive insurer.

ASC 954-720-50-3 requires providers insured by multi-provider captive insurance companies to disclose that insurance is provided by a multi-provider captive, the provider's ownership percentage in the captive, and the method used to account for the provider's investment in the captive. If the captive issues a retrospectively rated policy based on group experience, ASC 954-720-50-2 requires providers to disclose that the premiums are accrued based on the captive's experience to date.

## Question HC 6-5

A health care system has a wholly-owned captive insurance subsidiary. The subsidiary writes malpractice insurance coverage for the parent and all of the subsidiary health care entities. How would this arrangement affect the recognition of insurance recoveries in the consolidated financial statements and in separately issued financial statements of the subsidiary health care entities?

### *PwC response*

The consolidated financial statements that include the captive insurance entity would reflect all of the insurer's claims liabilities and all assets available for payment of those claims. In effect, the consolidated entity is self-insured and, thus, the "gross-up" requirements under ASC 954-450-25-2 are not relevant—that is, there is no third-party insurer from which a receivable should be recognized and only the accrual for estimated losses would be recognized in the consolidated financial statements.

In the separately issued financial statements of the subsidiary health care entities, the insurance coverage obtained from the captive insurer would be reported in a manner similar to insurance obtained from an unrelated insurer. Thus, a liability for the subsidiary's estimated claims outstanding as of the balance sheet date and a separate receivable representing the amount recoverable from the affiliated captive insurer would be reflected in the separately issued balance sheets of the subsidiaries.

### 6.4.6 *Self-insurance programs*

AAG-HCO 8.17 and AAG-HCO 8.44 through AAG-HCO 8.47 include a general discussion of the accounting for self-insurance programs. To the extent that claims are self-insured, no receivables related to insurance recoveries should be accrued.

Some self-insured organizations pay claims from the organization's general assets. Others establish trusts (usually irrevocable) and undertake a funding program to formally set aside assets to pay for malpractice claims. In such cases, as discussed in ASC 954-450-25-2A and AAG-HCO 8.20, expense for a reporting period should continue to be based on the accrual of estimated losses and adjustments thereto, not on amounts funded to a self-insurance trust.

AAG-HCO 8.44 through AAG-HCO 8.47 and ASC 954-810-45-4 provide guidance on financial reporting issues related to malpractice trust funds. Malpractice trust fund assets should be included in the health care organization's financial statements. If any portion of the estimated asserted or unasserted claims are classified as current liabilities, a portion of the trust fund sufficient to satisfy those claims should correspondingly be classified in current assets. Otherwise, such funds should be classified as noncurrent. Not-for-profit providers classify self-insurance trust assets (whether revocable or irrevocable) as "assets whose use is limited" in accordance with ASC 954-210-45-4. ASC 954-720-25-5 discusses accounting considerations related to participation in multi-provider trusts.

ASC 954-810-50-1 requires disclosure of the existence of a trust fund and whether it is revocable or irrevocable.

### 6.4.7 *Legal costs*

ASC 954-450-25-2 requires health care entities to estimate and accrue the legal costs that are expected to be incurred in connection with litigating malpractice claims in the period the incident arises.

For contingency claims other than malpractice, no definitive guidance exists on whether the estimated loss should consider the expected legal costs of defending the claim. Some health care entities apply the malpractice claims guidance by analogy. Others follow guidance in ASC 450-20-S99-2 (discussed in FSP 23) that permits making a policy election to either (a) expense claims-related legal fees in the period(s) in which the costs are actually incurred; or (b) to estimate and accrue them in the period in which the associated claim arises. Although the latter guidance specifically applies to SEC registrants, non-registrants have also used it as a basis for establishing an accounting policy election in this area.