Principles and Practices Board

ISSUE ANALYSIS

Risk Accounting: What are the issues and trends in these revenue arrangements?

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About P&P Board Issue Analyses

The Healthcare Financial Management Association through its Principles and Practices (P&P) Board publishes issue analyses to provide short-term practical assistance on emerging issues in healthcare financial management. To expedite information to the industry, issues analyses are not sent out for public comment. Therefore, they are factual but not authoritative. The purpose of this issue analysis is to provide some clarity to the healthcare industry about certain accounting and reporting issues resulting from providers, payers, and other organizations entering into contracts (or, in the case of governmental payers, assuming new payment models) that obligate the providers to provide healthcare services to patients/enrollees in exchange for payments established under a variety of methods. These payment model arrangements expose the parties to the uncertainty of financial gain or loss. This issue analysis highlights the current issues and considerations in accounting for risk arrangements, and additional interpretive guidance may be released as circumstances evolve. Consultation with independent auditors on these matters is highly recommended.

Overview

Of all the transformations reshaping American health care, none is more profound than the shift toward value. Quality and patient satisfaction are being factored into government payment, and private payers are pushing for performance and risk-based payment structures. At the same time, rising healthcare costs are creating more price sensitivity among health-care purchasers, including government agencies, employers, and, of course, patients themselves, who are being asked to pay higher premiums, copayments, and deductibles for their care.

Patients, employers, government agencies, and health plans increasingly want to know what they can expect to receive for what they pay for care. They are seeking out providers who will give them this information and follow through with high-quality and cost-effective care. The ability to develop and manage high quality and effective care networks and predict and manage different forms of patient-related risk is a key competency for a value-based healthcare system.

Providers are increasingly entering into contracts with payers (or, in the case of governmental payers, assuming new payment models) that obligate the providers to provide healthcare services to enrollees of the plans in exchange for payments established under a variety of methods. When the contract exposes the provider to the uncertainty of financial gain or loss, it is generally referred to as a risk contract. Uncertainty of financial gain or loss in this sense relates to the adequacy of contract revenues relative to contract costs—it does not include other types of business risk.

Under a risk contract, the provider agrees to furnish specified healthcare services for a negotiated price, which may be an amount per episode, case, bundle, service, or day; the price may vary based on the volume of services furnished during the contract period. Or, the provider may contract to provide all defined healthcare services to a specific beneficiary group in return for a predetermined fee. A risk contract may also provide for a sharing of risk, designed to create financial incentives to the providers and, in some instances, to the payer, to improve quality and control costs. Other risk contracts may be any combination of the above examples.

For many organizations, risk contracts and the resulting accounting implications are an emerging area, where the types of contracts and applicable accounting guidance are changing rapidly. P&P Board Statement No. 11, *Accounting and Reporting by Institutional Healthcare Providers for Risk Contracts* (issued 1989, revised 1997), dealt with the unique accounting considerations providers of healthcare services confront when entering into risk contracts, and many of those concepts remain relevant today. This paper has been prepared to build upon that guidance, given the current environment, and to address the accounting by providers for recognizing revenues and expenses and accruing losses for these risk contracts. Only the Financial Accounting Standards Board (FASB) can establish generally accepted accounting principles (GAAP) and, therefore, this paper is intended to summarize existing viewpoints and describe the underlying basis for each. In the absence of authoritative guidance from FASB, it is up to accountants and their auditors to determine whether a particular point of view is supportable under GAAP, based on their individual facts and circumstances, and to be prepared to justify it.

In May 2014, the FASB issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers*. The standard will eliminate the transaction- and industry-specific revenue recognition guidance under current U.S. GAAP and replace it with a principle-based approach for determining revenue recognition. This standard has the potential to affect every entity's day-to-day accounting and, possibly, the way business is executed through contracts with customers. In August 2015, the FASB issued ASU No. 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*, formally delaying for one year the effective date of its new revenue recognition standard until 2018. The new standard may have a significant impact on how healthcare entities account for risk-based contracts. This paper will be updated as interpretive guidance for the new standard evolves.

This paper will explore the following accounting considerations and the basis for determination:

- Fee-for-service and capitated arrangements
- Revenue recognition
- Expense recognition
- Loss recognition
- Stop-loss insurance
- Financial reporting and disclosures

Types of Risk Contracts

The contractual arrangement between the payer and the provider determines the extent to which each entity bears the financial risk (or reward) for unfavorable (or favorable) experience. The contract generally describes covered and noncovered services, payment arrangements, responsibilities of the parties, and administrative policies and procedures, and may subject providers to risks they may not have previously assumed. For example, a hospital may agree that, under the terms of the contract, a participating physician will furnish all covered services to enrollees who are authorized to receive them. Where the hospital is also responsible for services furnished to enrollees by other healthcare providers (for example, when enrollees are outside the area served by the hospital and they require emergency services), the contract specifies the approval and payment process for those services.

Payment terms are also set forth in the contract and, where applicable, other risk-bearing arrangements and settlement terms are also described. The contract identifies the party responsible for holding risk-pool assets and usually requires that settlement be administered by the payer. It also describes rights and responsibilities for collecting payments from sources other than the payer. For example, the payer usually is responsible for collecting and has the right to retain payments from an enrollee's primary insurer under coordination of benefits provisions, and providers may be responsible for collecting copayments and deductibles from patients who are enrollees.

Examples of contracts that hospitals typically execute include the following:

- *Fee-for-service:* Under fee-for-service contracts, the provider earns revenue for providing patient services.
- *Discounted fee-for-service and per diem payments:* These arrangements may call for varying rates of payment based on the volume generated under the contract. If the amount of the payment is contingent upon factors that are not determinable until the end of the contract term, an estimate may be required. For example, a contract may state that a hospital will be paid $750 per day for the first 5,000 patient days under the contract, $675 for the next 3,000 patient days, and $600 for all patient days in excess of 8,000. The revenue earned under the contract, therefore, is dependent upon the total volume of patient days rendered during the contract period.
- *Bundled payments:* Under bundled payment arrangements, providers receive payment for an episode of care rather than for each service performed. The services performed in the episode may include treatment by others outside of the provider's control (for example, a non-employed physician), in which case the bundled payment must be apportioned to all parties involved.

- *Capitation or prepaid healthcare services:* Revenue under these arrangements is earned as a result of agreeing to provide services to enrollees for a per member, per month fee without regard to the actual amount of services provided.

- *Pay-for-performance contracts, including Medicare's hospital value-based purchasing program:* Under pay-for-performance contracts, providers will be rewarded financially for achieving certain quality standards. The contract is generally in addition to a standard fee-for-service, but the percentage of the total revenue earned for performing versus reporting can vary and change over time.

- *Shared savings/shared loss contracts:* In a shared savings arrangement, the payer creates financial incentives for the provider to meet specific contract metrics such as controlling costs or improving quality of a predetermined patient population by sharing a percentage of the savings obtained for achieving or exceeding certain benchmarks. Generally, in a shared-savings contract, the provider still receives a fee-for-service or similar payment arrangement for healthcare services provided.

- *Risk pools:* Risk pools provide a vehicle for sharing favorable and unfavorable financial experience among providers (generally, the prepaid healthcare plan, physicians, and the hospital). Final settlements of risk pools typically occur at the end of the contract term. Risk pool settlement arrangements may, in some cases, be relatively straightforward, but in other cases they may be complex. For instance, settlement of a risk pool may be dependent upon utilization levels, actual costs incurred, amounts available in the physicians' risk pool, and other factors.

Accounting Considerations

FEE-FOR-SERVICE AND CAPITATED ARRANGEMENTS

The accounting and reporting considerations for fee-for-service, discounted fee-for-service, per diem and capitated arrangements (prepaid healthcare services and bundled payments) are specifically addressed in the FASB Accounting Standard Codification (ASC) Topic 954, *Health Care Entities*, and will not be the subject of this paper. The American Institute of CPAs (AICPA) audit and accounting guide, *Health Care Entities*, also provides additional illustrative guidance for accounting for these arrangements.

REVENUE RECOGNITION

It is not clear if the guidance contained in ASC 954-605, *Health Care Entities, Revenue Recognition*, was intended to apply to certain risk contracts executed by the provider for which revenue is not directly derived from "fees charged for patient care." That is, in pay-for-performance arrangements and shared savings/shared loss contracts, revenue is not earned by providing care to the patient, but rather by achieving certain quality and/or cost-saving metrics related to patient care. Likewise, in risk pools, the prepaid healthcare plan may be receiving capitated payments, but the provider participants in the pool receive only an allocation of those capitated payments based on the overall cost of care, which they may not be able to directly link to the services they provided to the enrolled beneficiaries.

In some circumstances, it may be difficult to determine if the executed contract or arrangement represents participation in a risk pool or participation in a shared savings/shared loss contract. In many regards, these arrangements are very similar – both provide a vehicle for sharing favorable and unfavorable financial results among various parties. However, the one distinguishing factor between the arrangements may be that in a risk pool, the provider's only compensation for the services they provide is their distribution from the pool, whereas in a shared savings/shared loss contract, the provider is generally receiving a fee-for-service payment in addition to any financial incentive or penalty for achieving or failing to achieve the required metrics. Given that the revenue recognition treatment may vary based on the type of contract, this analysis must be given careful consideration.

The following section will discuss the revenue recognition considerations for each of these arrangements.

Risk Pools

The HFMA Principles and Practice Board, Statement 11 (P&PB 11), first addressed the accounting for risk pools, and stated:

> When the contract term coincides with the provider's fiscal period, the actual settlement of the risk pool should be recorded if available. When those periods are different or when the actual settlement is not known, the provider will be required to estimate the settlement. The estimate should be made using actual year-to-date experience and other data concerning factors that may affect the final settlement. Subsequent adjustments based on the actual settlement should be treated as a change in the accounting estimate that is recognized in the period of the change.
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> Actual risk pool settlements, if known, should be recorded when the contract term coincides with the provider's fiscal period. When those periods are different or when actual settlement is not known, the provider should record an estimate of the settlement based on actual year-to-date experience and other relevant data.

HFMA's views are consistent with the guidance in ASC 944-605, *Financial Services – Insurance, Revenue Recognition,* which provides guidance on estimating revenue for experience-rated insurance premiums:

> If premiums are subject to adjustment (for example, retrospectively rated or other experience-rated insurance contracts for which the premium is determined after the period of the contract based on claim experience, or reporting-form contracts for which the premium is adjusted after the period of the contract based on the value of insured property), premium revenue shall be recognized as follows:
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> - If the ultimate premium is reasonably estimable, the estimated ultimate premium shall be recognized as revenue over the period of the contract. The estimated ultimate premium shall be revised to reflect current experience.
> - If the ultimate premium cannot be reasonably estimated, the cost-recovery method or the deposit method may be used until the ultimate premium becomes reasonably estimable.

Pay-for-Performance Arrangements and Shared Savings/Shared Loss Contracts

The scope of transactions including in the healthcare subtopic of ASC 605, *Revenue Recognition*, includes the following:

a. Patient service revenue, which is derived from fees charged for patient care. This may be based on diagnosis-related group payments, resource-based relative value scale payments, per diems, discounts, or other fee-for-service arrangements.

b. Premium revenue, which is derived from capitation arrangements.

c. Resident service revenue, which may be related to maintenance fees, rental fees, or amortization of advance fees (ASC 954-605-05-2).

Because neither pay-for-performance arrangements nor shared savings/shared loss contracts appear to be included in the scope of ASC 954-605, we should generally look to the guidance in ASC 605 for revenue recognition guidance.

FASB Concepts Statement No. 5, "Recognition and Measurement in Financial Statements of Business Enterprises," (CON 5) states that "revenues are considered to have been earned when the entity has substantially accomplished what it must do to be entitled to the benefits represented by the revenues."

While CON 5 sets forth the fundamental concepts for revenue recognition, one comprehensive revenue recognition standard currently does not exist. The SEC sought to fill the gaps in the accounting literature relating to revenue recognition with the issuance of *Staff Accounting Bulletin No. 104, Revenue Recognition* (SAB Topic 13). Though SEC guidance is applicable to registrants, these SEC rules provide concepts that may be useful for all entities to consider applying. SAB Topic 13 provides general revenue recognition guidance based principally on interpretations of the concepts of CON 5. However, if a transaction falls within the scope of specific authoritative revenue recognition literature, such as ASC 954-605, that specific guidance should be followed instead of SAB Topic 13.

SAB Topic 13 requires that all of the following four basic criteria (the Basic Criteria) be met before revenue can be considered realized (or realizable) and earned:

- Persuasive evidence of an arrangement exists
- Delivery has occurred or services have been rendered
- The seller's price to the buyer is fixed or determinable
- Collectability is reasonably assured

Persuasive evidence of an arrangement. SAB Topic 13 defines an arrangement as "the final understanding between the parties as to the specific nature of the terms of the agreed-on transaction." The standard looks to the normal policy and business practices of a company for determining when persuasive evidence of an arrangement exists. Persuasive evidence of an arrangement should describe the following pertinent terms and conditions of the arrangement:

- All the products and services included in the arrangement
- Fees and the payment terms
- Delivery terms
- Rights of return, price protection, or cancellation provisions
- Warranties, rights, obligations and termination provisions
- Other pertinent contractual provisions

Persuasive evidence of an arrangement documents all of the final terms and conditions agreed to by a vendor and the customer, including all the elements in an arrangement. The arrangement also must be signed or otherwise agreed to by representatives of both parties having the relevant authority to bind their respective companies.

Generally, an agreement is executed in these types of risk arrangements, and this criterion is easily met.

Delivery. The second basic revenue recognition criterion is that revenue should not be recognized until the product is delivered or the service is rendered to the customer. The delivery criterion relates to the concept of revenue being earned (i.e., whether the vendor has substantially completed the performance obligations imposed on it by the arrangement) in CON 5.

CON 5 paragraph 83(B) states "revenues are considered to have been earned when the entity has substantially accomplished what it must do to be entitled to the benefits represented by the revenues." In SAB Topic 13, the SEC staff stated that even if a vendor has not yet completed all activities related to a delivered item, delivery may be deemed to have occurred and revenue for that item recognized (assuming all other recognition criteria have been met for the delivered item) if the vendor's remaining obligation(s) are inconsequential or perfunctory. SAB Topic 13 contains very specific criteria, all of which must be met, for an element to be considered inconsequential and perfunctory.

In most pay-for-performance or shared savings/shared loss contracts, the actual amount of the payment is contingent upon factors that are not ultimately determinable until the end of the contract term; however, a provider can estimate the amount of payment based on interim assessments of the actual performance relative to the benchmark using actual performance year-to-date experience and other data concerning factors that may affect the final settlement.

ASC 270, "Interim Financial Reporting," states, "When quarterly discounts are allowed to customers based upon annual sales volume, the amount of such discounts charged to each interim period should be based on the sales to customers during the interim period in relation to estimated annual sales." Accordingly, the provider should estimate its anticipated payment under the agreement based on factors such as current and prior period experience, seasonal trends, changes in the beneficiary population base, and other significant factors that may affect volume.

Throughout the performance period, previously recorded revenue may be determined to be inaccurate. Any necessary adjustment should be accounted for as a change in estimate at the time such determination is made. Prior interim and annual periods should not be adjusted or restated.

Fixed or determinable fees. The fixed or determinable criterion refers to whether the total consideration in an arrangement is either known or estimable with reasonable certainty. Fixed or determinable does not evaluate the ability of the customer to pay the fees contained in the arrangement, but rather depends on whether the fees will be reduced by a future action of the vendor or by the buyer's exercise of explicit or implicit rights of return or refund. If a vendor cannot conclude at the outset of an arrangement that the fee is fixed or determinable, then the revenue generally is recognized either as payments from the customer become due or as rights of return or refund lapse, if all of the other Basic Criteria have been met. Factors that should be considered when making this assessment include whether a vendor has the ability to estimate refunds and/or returns, whether a contract includes customer cancellation or termination provisions, and whether a vendor will grant a concession to a customer.

Certain providers may find it difficult to estimate the consideration in a pay-for-performance or shared savings/shared loss contract. The availability and accuracy of data used to determine if the financial or quality criteria has been met may vary by provider or arrangement. Additionally, although data are available to calculate an estimated payment, providers should consider the possibility that the data provided are incorrect or may be adjusted at a later time. Further, relying on historical experience to estimate current experience may not be appropriate given that benchmarks and attributable beneficiaries change over time. Consideration should be given to whether revenue can be recognized in the arrangement.

Collectibility is reasonably assured. The last basic criterion for revenue recognition is that collectibility of arrangement consideration (fees) from the customer must be reasonably assured. Assessing whether collectibility is reasonably assured must be done at the outset of an arrangement. The assessment of collectibility generally should not be subsequently revised even if new information is obtained that supports collectibility. If the collectibility of all or a portion of the fee is not reasonably assured, all revenue recognition should be deferred until payment is received (assuming all of the other Basic Criteria have been met).

Assessing whether the collectibility criterion has been met relates to whether the vendor can demonstrate that the customer is "creditworthy." Creditworthiness is defined as the financial ability (i.e., wherewithal) to pay in accordance with the contractual payment terms. Additionally, even if a customer is considered creditworthy, the vendor must consider whether any indicators exist that an otherwise creditworthy customer may not remit payments pursuant to the contractual terms of the arrangement. If such an indicator exists, the collectibility criterion may not be met.

The payer in many of these arrangements should be evaluated for collectibility concerns before determining if it is appropriate to recognize revenue prior to the receipt of cash. At this time, governmental payers such as Medicare and Medicaid programs generally do not raise questions of collectibility. However, the graduated decreases in funding of the Medicaid expansion will create a need to periodically evaluate the collectibility of Medicare and Medicaid receivables.

Additional Considerations for SEC Registrants

SEC registrants may also need to consider the SEC staff's position regarding the recognition of performance-based incentive fees when evaluating the accounting treatment for their pay-for-performance or shared savings/shared loss contracts.

ASC 605-20-S99-1 provides the SEC staff's views relating to the recognition of revenue at an interim date on performance-based incentive fees that are not finalized until the end of a performance period (either the contractual term or a defined period within the contractual term). ASC 605-20-S99-1 notes that two methods are found in practice relating to the recognition of such fees:

1. No revenue is recognized relating to the contingent performance-based fees until the end of the measurement period.

2. Revenue is recognized during the measurement period based on the amount that would be due pursuant to the contractual arrangement if the contract were terminated at that date.

The SEC staff states in ASC 605-20-S99 that it will not object to either of the above methods, but that it believes Method 1 is preferable. Relating to Method 2, the staff notes that "the calculated revenue may be viewed as realizable at an interim date due to the termination provisions in the arrangement. Furthermore, this approach results in revenue recognition that reflects the performance of the manager—revenue is higher in periods in which the manager's performance has exceeded the specified performance target(s), while revenue is lower in periods in which the manager's performance has not exceeded the specified performance target(s). This method also does not involve a consideration of future performance, as it relies only on the calculated fee at the interim measurement date." The SEC staff's views would not change if the service provider did not have termination rights during the term of the contract.

In addition to the above, the SEC staff has commented on several variations of Method 2, as follows:

- The amount of revenue that would be recognized at an interim date should not be reduced to the extent management believes it is likely that a portion of the calculated amount will be lost due to future performance, because such a method explicitly considers future performance in determining how much revenue to recognize, which is inconsistent with the requirement that the fee must be fixed or determinable before revenue is recognized. The staff will object to such a variation.
- Amounts that would be receivable on termination pursuant to penalty or liquidated damage provisions (that is, amounts in addition to the amount that would be payable under the specified measurement formula) are not an appropriate basis upon which to recognize revenue, unless a termination has occurred.
- If the customer could avoid all or part of a payment by terminating the contract at will, revenue may only be recorded at an interim date up to the amount that the customer would be required to pay in the event of termination.
- If the incentive fee is a fixed amount rather than a variable amount, those applying Method 2 should only recognize revenue in an interim period when the target has been exceeded and should limit the amount of revenue to be recognized to a ratable portion of the fixed incentive payment.

Ultimately, the unique facts and circumstances of specific risk payment arrangements may drive the appropriate accounting. Entities entering into similar arrangements may conclude that different revenue-recognition policies are appropriate based on the availability of data and the ability of management to develop an estimate.

EXPENSE RECOGNITION

While obligations vary depending upon the specific terms of the contract or regulatory requirements, payers and providers participating in risk arrangements usually are not obligated to provide services to noninstitutionalized enrollees beyond the contract period or beyond the month for which the premium is paid. Continued service to institutionalized enrollees is, however, customary, irrespective of premium payment. According to P&PB 11, providers should recognize healthcare expenses as services are rendered, including estimates of the costs of services rendered but not yet reported and costs to be incurred for currently institutionalized enrollees until discharge. Amounts payable to physicians or other contracted providers under risk retention, bonus, or similar programs should be accrued during the contract period based on relevant factors such as experience to date. In addition, if specific circumstances, such as contractual provisions or regulatory requirements, obligate the provider for services beyond the period of the contract, the estimated cost of those services, net of any related anticipated revenues under the contract, should also be accrued.

To illustrate, assume that a hospital with a risk contract is preparing its financial statements as of December 31 of a given year. The hospital would accrue its obligation for all covered services actually provided through December 31, whether or not invoices have been received from physicians or outside contract providers entitled to payment for those services. The hospital would also accrue costs to be incurred for currently institutionalized enrollees until discharge. Therefore, it usually would not be appropriate for a hospital to record estimates of the costs of future services even though an incident has occurred. Further, under this conclusion, the hospital would not accrue costs for covered services rendered after December 31, unless it is obligated to render services to specific enrollees beyond the current period due to provisions in the contract or regulatory requirements.

Under certain shared savings or pay-for-performance arrangements, providers may incur costs related to the coordination of care for covered patients. These costs include organizational support (corporate administration and operational management), operational expenses (cost of member mailings and call center operations), and technology support. These costs should be recorded and expensed as incurred, regardless of whether any shared savings or quality incentive-based revenue is earned.

LOSS RECOGNITION

By contracting to provide services at discounted or capitated rates for the term of the contract, a provider may incur a loss on the contract. ASC 954-450-10, *Health Care Entities-Liabilities-Contingencies*, requires that losses be accrued when it is probable that an asset has been impaired or a liability has been incurred, and the amount of the loss can be reasonably estimated. Furthermore, anticipated gains are not recorded until realized.

Providers should record a loss on a risk contract if future costs (both fixed and variable), including contract-related administrative costs (such as medical records, claims processing, billing, and so on), are expected to exceed future revenues and stop-loss recoveries from the contract. The estimated future costs to be considered in determining whether an anticipated loss exists should include variable direct and allocable indirect costs. Anticipated gains should not be recognized in advance of realization.

STOP-LOSS INSURANCE

Some providers may purchase stop-loss insurance to limit their risk exposure. In accordance with ASC 954-720-45-1, stop-loss insurance premiums should be included in reported healthcare costs (in operating expenses) and stop-loss insurance recoveries should be classified as a reduction of reported healthcare costs. Receivables representing amounts recoverable from insurers should be classified as assets, reduced by appropriate valuation allowances. Providers should report any accrued health claims liabilities gross of stop-loss insurance receivables.

FINANCIAL REPORTING AND DISCLOSURES

ASC 954-605-45 requires that provider care entities report revenue based on the type of service rendered or contracted to be rendered. Significant revenue earned under capitated arrangements should be reported separately.

Providers should disclose the following information with respect to their risk contracts in the footnotes to the financial statements:

- The nature and terms of significant risk contract arrangements
- The policies for and methods of revenue recognition
- Whether the entity has recorded any revenue that is at risk due to future performance contingencies, the nature of the contracts giving rise to the contingencies, and, if material, the amount of any such revenue recorded
- The basis for recording expenses and losses under those arrangements
- The nature of significant stop-loss insurance contracts
- If the contract involves a related entity, the disclosures required by FASB ASC 850-10-50, *Related Party Disclosures-Overall-Disclosure*

Conclusion

As the transition to a more value-based payment and care delivery system continues, few healthcare organizations will be able to avoid exposure to some form of risk. The current accounting literature appears to address the various forms of risk contracts that are being executed. As the degree of risk and integration required by healthcare delivery systems continues to evolve, we will continue to monitor the accounting considerations.

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