



healthcare financial management association

Issue Analysis: Revenue Recognition Implications Under Topic 606 for Capitation and Risk Sharing Arrangements

Principles and Practices Board

Issue Analysis

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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. Issue analyses are factual but nonauthoritative. To expedite information to the industry, issues analyses are not sent out for public comment. The purpose of this issue analysis is to provide some clarity to healthcare providers on certain accounting and reporting issues resulting from FASB Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers* (Topic 606) (“FASB ASC 606”). This issue analysis highlights the current issues and considerations in accounting for revenue resulting from healthcare providers entering into contracts that obligate the healthcare providers to provide healthcare services to patients (i.e., enrolled qualified beneficiaries) in exchange for payments established under a variety of methods. These payment model arrangements expose the healthcare providers to the uncertainty of financial gain or loss. Additional interpretive guidance may be released as circumstances evolve. Consultation on these matters with independent auditors is highly recommended.

Overview

Healthcare providers operate in a highly regulated industry where complex contracts are commonplace. The many pieces of revenue recognition guidance that were developed over the years specifically for this industry are now being replaced by a single revenue recognition standard that applies to all industries (other than those specifically identified as out of scope). To assist in exercising judgment when applying this guidance to the healthcare industry, preparers will want to look to the AICPA's *Revenue Recognition: Audit and Accounting Guide*. The healthcare-specific guidance within Chapter 7 of this guide was developed by the AICPA Healthcare Revenue Recognition Task Force. The Task Force comprises both preparers and auditors, and its issue papers offer technical discussion of many of the topics discussed herein, as well as other topics (continuing care retirement communities and significant financing components of contracts, for example).

The following table outlines the accounting implementation issues discussed in Chapter 7, "Health Care Entities," in the AICPA's *Revenue Recognition Audit and Accounting Guide*.

Issue Description	Paragraph Reference
Identifying performance obligations Step 2: Identify the performance obligations in the contract	7.2.01–7.2.09
Determining the timing of satisfaction of performance obligations Step 5: Recognize revenue when (or as) the entity satisfied a performance obligation	7.5.01–7.5.08
Arrangements for healthcare services provided to uninsured and insured patients with self-pay balances, including copayments and deductibles Revenue streams	7.6.01–7.6.43
Third-party settlement estimates Revenue streams	7.6.44–7.6.72
Risk sharing arrangements Revenue streams	7.6.73–7.6.108
Application of FASB ASC 606 to continuing care retirement community contracts Revenue streams	7.6.109–7.6.162
Application of the portfolio approach Other related topics	7.7.01–7.7.15
Presentation and disclosure Other related topics	7.7.16–7.7.59
Accounting for contract costs Other related topics	7.7.61–7.7.73

A continuing transformation that is shaping American healthcare is the increasing shift toward value. Quality and patient satisfaction scores are being factored into government payments, and private health insurance plans are pushing for performance and risk-based payment structures. Rising healthcare costs are creating more price sensitivity among healthcare 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 healthcare 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.

Healthcare providers are increasingly entering into contracts with health plans (or, in the case of governmental programs, assuming new payment models) that obligate the healthcare providers to provide healthcare services to enrolled qualified beneficiaries of the plans in exchange for payments established under a variety of methods. When the contract exposes the healthcare 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 healthcare 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 healthcare 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 and financial gain or loss, designed to create financial incentives to the healthcare providers and, in some instances, to the health plan, to improve quality and control costs. Other risk contracts may be any combination of the above examples.

Capitated Arrangements

Healthcare providers may receive payments under an agreement with a prepaid health plan,¹ or another risk-transferring entity, which obligate the healthcare provider to stand ready to provide goods and services to qualified beneficiaries (individuals who enroll with a risk-transferring entity, for example a managed care plan or a self-insured employer). In these situations, the qualified beneficiaries sign up with the risk-transferring entity to participate in such a health plan. These payments are generally referred to as capitation fees. As defined in the glossary of the AICPA's *Audit and Accounting Guide for Health Care Entities*, capitation fees are:

“A fixed amount per individual that is paid periodically (usually monthly) to a provider as compensation for providing comprehensive healthcare services for the period. The fee is set by contract between a

¹ Per the AICPA's *Health Care Entities Accounting and Audit Guide*, a prepaid health plan is defined as, “(A) plan in which the provider is compensated in advance by the sponsoring entity. The sponsoring entity pays or compensates the provider based on either a fixed sum or a per-enrollee amount. Prepaid health care plans include health maintenance organizations, preferred provider organizations, eye care plans, dental care plans, and similar plans. Under such plans, the financial risk of delivering the health care is transferred to the provider of services.”

prepaid health plan and the provider. These contracts are generally with medical groups, independent practice associations, hospitals, and other similar providers. Capitation fees may be determined actuarially or negotiated based on expected costs to be incurred.” The term “contract” as used in the definition above, is not the same as the “contract” as defined in FASB ASC 606 for a prepaid health plan or a healthcare provider.

As noted in the AICPA's *Revenue Recognition: Audit and Accounting Guide*, 7.6.46, “A unique aspect of healthcare is the involvement of multiple parties in healthcare service transactions. In addition to the patient and the healthcare provider, often a third party (an insurer, managed care company, or government program) will pay for some or all of the services on the patient’s behalf. For the purposes of FASB ASC 606, FinREC believes that the ‘contract with the customer’ refers to the arrangement between the healthcare provider and the patient. However, separate contractual arrangements often exist between healthcare providers and third-party payors which establish amounts the third-party payor will pay on behalf of a patient for covered services rendered. Although those separate contractual agreements are not themselves considered ‘contracts with customers’ under FASB ASC 606, those agreements should be considered in determining the transaction price for services provided to a patient covered by that third-party payor.”

For purposes of this issue analysis, the agreement between the healthcare provider and prepaid health plan or other risk-transferring entity will be referred to as the “agreement for services.” The agreement for services defines the scope of services for the patient (i.e., enrolled qualified beneficiary, hereafter referred to as “qualified beneficiary” or “beneficiary”).

Generally, capitation payments are received at the beginning of each month and obligate the healthcare provider to stand ready to provide covered goods and services during the period of coverage and pay for the costs of covered goods and services provided by other unrelated healthcare providers to qualified beneficiaries, subject to copayments and deductibles that the qualified beneficiary may be required to pay. Capitation revenue is earned as a result of agreeing to provide goods and services to qualified beneficiaries, not as a result of actually providing the patient care services to beneficiaries. The copayments and deductibles represent revenues that are earned as a result of providing goods and services to the qualified beneficiaries.

Qualified beneficiaries generally enroll for covered services each year for a specified period of time, which is generally for a year. Under these agreements for services, healthcare providers are generally obligated to stand ready to provide covered goods and services to the qualified beneficiaries for the specified period of time and generally do not have a unilateral right to terminate such agreements for services. However, the qualified beneficiary may terminate his/her coverage during any month during the specified period of time due to a change in employment, change in marital status or other reasons. Therefore, the contracts between the qualified beneficiaries and the healthcare provider generally do not contain a unilateral enforceable right for both parties to terminate the contract and as such, the contract is considered enforceable in accordance with FASB ASC 606-10-25-3 and 25-4.

If the healthcare provider’s accounting system records patient standard charges and establishes patient receivables as services are rendered for patient care services to beneficiaries, appropriate explicit price concessions, implicit price concessions or adjustments are recorded, such that only the amount of capitation revenue and patient copayments and deductibles are reported in the financial statements.

Key Considerations Under FASB ASC 606

The considerations that will affect revenue recognition under FASB ASC 606 include:

- Identifying the performance obligations in the contract, including quality and safety targets as well as cost savings targets
- Determining whether the performance obligations are satisfied at a point in time or over time
- Assessing how the constraint on variable consideration could limit the revenue recognized under the contract

Considerations

Related to Step 1: Identify the Contract with a Customer. A healthcare provider must first determine that the five criteria in FASB ASC 606-10-25-1 have been met in order for there to be a contract with a customer within the scope of FASB ASC 606. For purposes of FASB ASC 606, the “contract with the customer” refers to the arrangement between the healthcare provider and the qualified beneficiary, even though there is an agreement for services between the healthcare provider and a prepaid health plan or another risk-transferring entity. The assessment of Step 1 in FASB ASC 606-10-25-1 by a prepaid health plan, other risk-transferring entity or an entity that consolidates either of these entities to identify the contract with the customer, may result in a different conclusion than the conclusion reached by a healthcare provider. The Step 1 assessment by a prepaid health plan, other risk-transferring entity, or an entity that consolidates either of these entities, is outside the scope of this issue analysis.

In accordance with FASB ASC 606-10-25-1(a-e), a contract with a customer exists only when all of the criteria in that paragraph are met. Healthcare providers should consider the criteria in FASB ASC 606-10-25-1 to determine that a contract with a qualified beneficiary exists and that the contract is legally enforceable. A healthcare provider should evaluate if the following criteria in FASB ASC 606-10-25-1 are met:

- Parties have approved the contract (in writing, orally or in accordance with other customary business practices) and are committed to perform their respective obligations of the contract.* A healthcare provider should consider if it has a written contract with the patient by considering whether the patient signed any forms, such as a patient responsibility form, which would be considered a written contract. If the healthcare provider determines it does not have a written contract, the healthcare provider may consider if it has an oral or implied contract. A healthcare provider should also consider if it has an agreement for services with a prepaid health plan or other risk-transferring entity that obligates it to stand ready to provide goods and services to qualified beneficiaries. A healthcare provider generally receives a listing of the qualified beneficiaries on a periodic basis (e.g., monthly) to which it has agreed to stand ready to provide goods and services.
- Each party’s rights regarding the goods or services to be transferred can be identified.* A healthcare provider should consider if it has a right to payment for services provided to a patient based on the contract. A healthcare provider should also consider if it has a right to payment for standing ready to provide goods and services to a qualified beneficiary based on the terms of the agreement for services.

- c. *Payment terms can be identified for the goods or services to be transferred.* Under an agreement for services, healthcare providers receive payments for standing ready to provide goods and services to qualified beneficiaries and not as a result of actually providing goods and services to patients. Generally, payment terms are described in the agreement for services with the prepaid health plan or other risk-transferring entity. There may also be a copayment or deductible due from the patient that factors into assessing the transaction price.
- d. *The contract has commercial substance.* The healthcare provider may consider if it expects its future cash flows to change as a result of agreeing to stand ready to provide goods and services to qualified beneficiaries.
- e. *It is probable 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.* A healthcare provider may consider if it is probable that it will collect substantially all of the consideration to which it is entitled in exchange for agreeing to stand ready to provide goods and services to qualified beneficiaries; this includes copayments and deductibles due from patients.

Related to Step 2: Identify the Performance Obligations in the Contract. Standing ready to provide services is considered a promise in a contract under ASC 606-10-25-18e. Paragraph 9 of [TRG Agenda Paper 16](#) states the following: “The staff think that whether the obligation is to provide a defined good or service (or goods or services), or instead, to provide an unknown type or quantity of goods or services might be a strong indicator as to the nature of the entity’s promise in the contract. The staff note, however, that in either case the entity might be required to ‘stand ready’ to deliver the good(s) or service(s) whenever the customer calls for them or upon the occurrence of a contingent event (for example, snowfall).”

The healthcare provider does not know which qualified beneficiaries will need healthcare services or the extent of the goods and services that may be required to treat the medical condition. The healthcare provider will only be required to provide goods and services when a qualified beneficiary requests goods and services that are determined by the healthcare provider to be covered services as defined in the agreement for services. The healthcare provider must therefore stand ready to provide goods and services to qualified beneficiaries as needed over the specified period in the agreement for services.

While there is no contractual requirement, some healthcare providers may perform certain additional care coordination activities or case management services for patients. A healthcare provider may choose to perform these activities as it may be in the best interest of the healthcare provider in an effort to control costs. A healthcare provider should evaluate the nature of the care coordination services or case management services that are provided to the patient (qualified beneficiary). These activities may include, for example, the following:

- Providing notification to the patient that the patient is a participant in an agreement for services
- Providing coordination of the post-acute care plan
- Calling the patient to ensure the patient is taking prescribed medications

FASB ASC 606-10-25-17 provides that promised goods or services do not include activities that an entity must undertake to fulfill a contract unless those activities transfer a good or service to the customer. Generally, these types of care coordination activities do not transfer an additional good or service to the patient and are administrative in nature and would not be considered separate performance obligations. A healthcare provider should, however, consider if there are implied promises to the patient to provide post-acute transitional services or coordination of care with other post-acute providers. These implied promises

could be considered performance obligations if the promises are considered distinct. Based on each healthcare provider's facts and circumstances regarding arrangements in place, a healthcare provider should evaluate if care coordination activities should be considered separate performance obligations in its contracts with customers based on the criteria in FASB ASC 606-10-25-19.

Related to Step 3: Determine the Transaction Price. These considerations include monthly fees and retroactive adjustments, incentive payments and other risk pool adjustments.

Monthly Fees. In determining the transaction price, the per-member-per-month (PMPM) amount (generally referred to as capitation fees) are earned as a result of agreeing to provide goods and services to qualified beneficiaries and not as a result of actually providing the care. The capitation fees are fixed payments that are made to the healthcare providers regardless of the volume of goods and services provided and exclusive of patient copayments and deductibles under their respective plan(s). Therefore, the healthcare provider bears the risk of providing goods and services or contracting for services that the beneficiary is entitled to receive.

In addition to the PMPM amount, it is possible that a healthcare provider is responsible to collect copayments and deductibles from the patient as a part of the agreement for services. The copayments and deductibles represent an additional fee-for-service payment that is collected from the patient either at the time of service or when billed. Refer to the "Arrangements for Healthcare Services Provided to Uninsured and Insured Patients with Self-Pay Balances, Including Co-Payments and Deductibles" section (paragraphs 7.6.01 – 7.6.43) in the AICPA's *Revenue Recognition: Audit and Accounting Guide*, for factors to consider when recognizing revenue from patients. The copayments and deductibles represent a fee-for-service component of the overall transaction price that is collected from patients and is considered variable consideration subject to the constraint. (See below for discussion of the constraint.)

Retroactive adjustments, incentive payments and other risk pool adjustments. In addition to the capitation fees, the amount of contract revenue may be affected by factors such as reinsurance recoveries and other adjustments. Capitation contracts may include retroactive adjustments for member eligibility, risk pools which provide for a sharing of financial incentives, usually to control costs, and other risk pool adjustments for items such as quality targets.

A healthcare provider will need to evaluate if the capitation contract includes variable consideration. An entity is required to estimate variable consideration using either the expected value method or the most likely amount method (as described in FASB ASC 606-10-32-8) and include some or all of that estimate in the transaction price to the extent it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the related uncertainty is resolved (as described in FASB ASC 606-10-32-11). This limitation on including variable consideration in the transaction price is referred to as the *constraint*. A healthcare provider should consider the factors in FASB ASC 606-10-32-12 when evaluating the extent to which variable consideration should be constrained.

In accordance with paragraphs 11–12 of FASB ASC 606-10-32, an entity is required to estimate the amount of variable consideration by applying the constraint guidance. If an entity determines that it cannot estimate this amount such that it is probable that a significant revenue reversal would not occur upon resolution of the final amounts, the portion of consideration that is variable should be excluded from the transaction price until it becomes probable that there will not be a significant reversal of cumulative revenue recognized.

However, if the organization has sufficient data such that it is probable that a significant revenue reversal would not occur upon resolution of the final amount, that amount should be estimated using one of the two methods described in FASB ASC 606-10-32-8 (whichever is the better predictor). In accordance with FASB ASC 606-10-32-14, a healthcare provider should update the estimated transaction price, including the assessment of whether the estimate of variable consideration is constrained, based on the available information. The healthcare provider should continue to evaluate and update the estimate as necessary each reporting period based on additional information that becomes known.

Refer to section 7.6.73–7.6.108 of the AICPA's *Revenue Recognition: Audit and Accounting Guide*, for additional information related to risk-sharing arrangements and factors to consider when estimating variable consideration.

Related to Step 4: Allocate the Transaction Price to the Performance Obligations in the Contract.

For considerations related to step 4, when more than one performance obligation is identified, refer to paragraphs 28–45 of FASB ASC 606-10-32.

Related to Step 5: Recognize Revenue When (or as) the Entity Satisfies a Performance Obligation.

As explained above, generally, capitation arrangements represent a stand-ready obligation to provide services to qualified beneficiaries. A healthcare provider should recognize monthly capitation fees as revenue over time when the periods for which the beneficiary is entitled to services are completed.

FASB ASC 606-10-25-27 states:

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 (see paragraphs 606-10-55-5–55-6).
- 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 (see paragraph 606-10-55-7).
- c. The entity's performance does not create an asset with an alternative use to the entity (see paragraph 606-10-25-28), and the entity has an enforceable right to payment for performance completed to date (see paragraph 606-10-25-29).

Accounting for Healthcare Costs

According to FASB ASC 954-405-25-2, healthcare costs should be accrued as services are rendered, including estimates of the costs of services rendered but not yet reported. Furthermore, if a healthcare provider of prepaid healthcare services is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs of such services to be incurred also should be currently accrued. Costs that will be incurred after a contract is terminated, such as guaranteed salaries, rent and depreciation, net of any anticipated revenue, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated. Amounts payable to hospitals, physicians or other healthcare providers under risk-retention, bonus or similar programs shall be accrued during the contract period based on relevant factors, such as experience to date.

For further guidance on accounting for healthcare costs see paragraphs 13.08 – 13.12 of the AICPA's *Audit and Accounting Guide for Health Care Organizations*.

Presentation and Disclosure

See section, "Presentation and Disclosure," in Chapter 7, "Healthcare Entities," in the AICPA's *Revenue Recognition: Audit and Accounting Guide*, for further information on presentation and disclosure. In addition, healthcare providers should consider the need for disclosures related to capitation payments on the statement of operations, if material or in the footnotes to the financial statements. As the capitation contract represents a stand-ready obligation to provide goods and services instead of providing goods and services, revenue earned under capitation arrangements should be reported separately.

Summary

So, how significant are the changes required by this new standard? The answer for any healthcare provider cannot be known until each healthcare provider completes the analysis and documentation necessary to determine impacts on some significant—and sometimes judgmental—areas. For many healthcare providers, adoption of the standard will mean the development of extensive documentation, the review of contracts and new disclosures in the financial statements. For other healthcare providers, implementation of the standard may result in a change in the timing of revenue recognition, and possibly some significant financial statement adjustments. For all healthcare entities, the new standard requires time and attention to revenue recognition practices, underlying contracts and the development of appropriate required disclosures.

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