



healthcare financial management association

# Issue Analysis: Revenue Recognition Under Topic 606 for Provider Tax Programs and Similar Arrangements

## Principles and Practices Board

### Issue Analysis

October 2019

---

#### About this P&P Board Issue Analysis

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. . Issues analyses are factual but nonauthoritative. To expedite information to the industry, issues analyses are not sent out for public comment. ", issues analyses are not sent out for public comment. The purpose of this issue analysis is to provide some clarity to the healthcare industry on certain accounting and reporting issues resulting from Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. This issue analysis highlights the following issues and considerations in accounting for revenue from provider tax programs and similar arrangements. Additional interpretive guidance may be released as circumstances evolve. Consultation on these matters with independent auditors is highly recommended:

- Revenue recognition considerations associated with pending approvals of a program
- Revenue recognition in the year federal approval is received and during the program period
- Gross vs. net presentation in the financial statements of program revenue and associated expenses

This issues analysis is not intended to address the following:

- Revenue recognition considerations for Government Accounting Standards Board reporters
- Timing and amount of expense recognition for program expenses, including provider taxes or quality assurance fees
- Transactions that are not within the scope of Topic 606, including revenue that is considered non-reciprocal contributions

## Considerations Related to the Contract with the Customer

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 (for example, a government program) will pay for some or all of the services provided on the patient's behalf. **For purposes of FASB ASC 606, Revenue from Contracts with Customers, the "contract with the customer" refers to the arrangement between the healthcare provider and the patient as discussed in Chapter 7 of the AICPA's Revenue Recognition Audit and Accounting Guide.**

However, separate agreements often exist between healthcare providers and third-party payers which establish amounts the third-party payer will pay on behalf of a patient for covered services rendered. When the third-party payer is a government program (for example, Medicare or Medicaid), the contractual arrangement between the healthcare provider and the government program is commonly referred to as an entity's "provider agreement." While those separate 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 payer. Thus, in determining the transaction price for services provided to a given state's Medicaid beneficiaries, the terms of the "provider agreement" executed between the healthcare provider and the state Medicaid program must be considered.

The scope of payments under this analysis are supplemental payments received from provider tax programs that represent additional payment for healthcare services the healthcare provider has performed for patients covered under a given state's Medicaid program. (Note that each state develops its Medicaid payment model, with federal approval, and accordingly there is diversity in the applicability of supplemental payments from provider tax programs.) Services provided to Medicaid patients are exchange transactions subject to revenue recognition guidance under FASB Topic 606. The estimated additional supplemental payment would be considered to be variable consideration and a component of the total transaction price with the customer, subject to the constraint as described in FASB ASC 606-10-32-11 and 12, as determined below. A healthcare provider that receives supplemental payments from a similar program for something other than healthcare services performed for patients, such as direct "grants" for health and wellness educational outreach for example, are outside the scope of this analysis and the provider should evaluate whether these are more appropriately evaluated based on revenue recognition guidance for non-exchange transactions such as grants and contributions.

## Determining the Transaction Price for Medicaid Services Provided

FASB ASC 606-10-32-2 states, "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)."

**Variable Consideration.** FASB ASC 606-10-32-6 states, "An amount of consideration can vary because of discounts, rebates, refunds, credits, price concessions, incentives, performance bonuses, penalties, or other similar items. The promised consideration also can vary if an entity's entitlement to the consideration is contingent on the occurrence or nonoccurrence of a future event." As described [above](#), "a contract with a customer" refers to an arrangement between the healthcare provider and the patient. Funds received by

a provider from a state under a provider tax program represent additional payments from a third party (e.g., the state's department that administers the Medicaid program) on behalf of a Medicaid beneficiary for some or all of the services provided to that patient. These funds, and an entity's entitlement to them, can vary based on a variety of factors, including approval of the provider tax program, amounts available for redistribution to a pool of providers and eligibility of the healthcare entity to participate or continue to participate in the program. (For general considerations related to third-party payment settlements under Topic 606, see Chapter 7 of the AICPA's *Revenue Recognition: Audit and Accounting Guide*).

These funds should be considered a variable component of consideration for services provided by the healthcare provider to the patient.

**Estimates of Variable Consideration.** In accordance with FASB ASC 606-10-32-8, "An entity shall estimate an amount of variable consideration by using either of the following methods [the expected value method and the most likely amount method], depending on which method the entity expects to better predict the amount of consideration to which it will be entitled." In accordance with FASB ASC 606-10-32-8(b), "...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)." As such, a healthcare entity can use either the expected value method or the most likely amount method in determining the amount of consideration to which it will be entitled. In accordance with FASB ASC 606-10-32-8, the healthcare entity should use the method to estimate the amount of variable consideration that it believes will better predict the amount of consideration to which it will be entitled. That is, the selection of an estimation method is not intended to be a "free choice" and the method selected must be applied consistently for similar types of contracts. Healthcare entities may apply the most likely amount method to estimate provider tax program revenue even if there is a range of possible supplemental payment amounts as long as that entity believes it will better predict the amount of consideration to which it will be entitled. Federal approval, or not, of the program could be considered a binary outcome. Healthcare entities may apply the expected value method to estimate provider tax program revenue. This estimate will include a series of potential scenarios and an assumed likelihood or probability for each potential scenario. For general considerations related to the use of the most likely amount method and the expected value method related to third-party payment settlements under Topic 606, see Chapter 7 of the AICPA's *Revenue Recognition: Audit and Accounting Guide*.

Whichever method (the expected value or the most likely amount) a healthcare entity uses to determine the amount of variable consideration, certain factors available to the entities may include the following:

- a. Historical provider tax program activity
- b. Current modeling information provided by the state or a coordinating organization
- c. Statistical data relevant to the distribution of provider tax program funds
- d. Nature and expected timing of the required approvals

FASB ASC 606-10-32-11 requires a healthcare entity to include in the transaction price some or all of an amount of variable consideration estimated in accordance with FASB ASC 606-10-32-8 only to the extent 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. Each healthcare entity will need to evaluate their facts and circumstances in order to determine if the potential reversal in supplemental payment revenue from a provider tax program is probable. To assist with that determination,

FASB ASC 606- 10-32-12 provides factors for an entity to consider. Below are some factors to consider with examples of how a healthcare entity may apply them to funds available to be received from provider tax programs.

- a. *The amount of consideration is highly susceptible to factors outside the entity's influence.* The amount and timing of funds available from a provider tax program can be highly susceptible to factors outside the entity's influence. For example, a healthcare entity may consider whether a waiver of the broad-based and uniform requirements of the provider tax regulations must be requested by a state and approved by the Centers for Medicare & Medicaid Services (CMS) in order for provider taxes collected to be eligible for a federal match. Additionally, the provider tax program may be subject to conditions or requirements from state legislation or other regulators that are outside of the entity's influence. Also, the finalization of the approvals may be out of the control of the entities, which can impact their ability to recognize variable consideration.
- b. *The uncertainty may not be resolved for a long period of time.* Several years may elapse before all potential administrative, contractual and regulatory matters are resolved, all matching funds are received and all amounts are distributed to providers. This time period may be more extended for portions of the program that are distributed through non-fee-for-service methodologies, such as increased managed care plan capitation rates.
- c. *The entity's experience with similar types of contracts.* Experience with a provider tax program in the same state that has been structured similarly or identically in each renewal period may allow for estimates of future amounts to be received. Previous results may not be predictive, though, for matters involving regulatory approval, which will be a factor included in the evaluation of the constraint.

CMS approval of a requested waiver of the broad-based and uniform federal requirements by the state is legally necessary for a state provider tax program to receive matching federal funds. Additionally, specific program elements are often included in state legislation that are tied to certain federal approvals. For example, some state legislation may require programs to “unwind” if approval of the federal waiver or other federal approvals are not received or received by a certain date.

These types of regulatory requirements should be included in the entity's facts and circumstances that they consider when concluding if the variable consideration related to these programs needs to be constrained or not. An entity may conclude that after evaluation of the specific facts and circumstances of the program, there may be sufficient evidence that exists for it to determine that it is not probable of a significant revenue reversal so the variable consideration may not be constrained at the inception of the program or at some point during the duration of the program. For example, a state may be seeking to renew an existing program with similar or identical attributes to its previous programs that have been approved by CMS. Prior to CMS approval of that program, an entity that receives payments from it might be able to conclude that, based on its historical experience with the earlier programs, a significant revenue reversal based on CMS failing to approve the broad-based and uniform waiver is not probable. Additionally, a requirement of CMS approval of amendments to rates of managed care contracts subsequent to the approval of a broad-based and uniform waiver may be a perfunctory administrative component of the funding mechanism, not a legal or regulatory hurdle, so an entity may not need to constrain the estimate of variable consideration prior to the CMS contract amendment approval, due to the overall program waiver already being approved. The healthcare entity may consider various factors in its evaluation, such as the reasonable predictability that administrative components will be properly executed consistent with CMS requirements based on previous experiences.

**Reassessment of Variable Consideration.** Differences between original estimates and subsequent revisions to amounts under the provider tax program, including program model changes and final payments, represent changes in the estimate of variable consideration and should be included in the period in which the revisions are made in accordance with FASB ASC 606-10-32-14. These differences should be disclosed in the financial statements. These differences are not treated as restatements of prior periods unless they meet the definition of an error in previously issued financial statements, as defined in FASB ASC 250, *Accounting Changes and Error Corrections*.

**Existence of a Significant Financing Component in the Contract.** Paragraph 15 of FASB ASC 606-10-32 states, “(I)n determining the transaction price, an entity shall adjust the promised amount of consideration for the effects of the time value of money if the timing of payments agreed to by the parties to the contract (either explicitly or implicitly) provides the customer or the entity with a significant benefit of financing the transfer of goods or services to the customer.”

Payments of supplemental revenues often occur in lump sums in periods subsequent to the period designated by the program, primarily due to the time involved in obtaining required federal and state approvals for various components of a provider tax program. As described in section 7.6.67 of the AICPA’s *Revenue Recognition: Audit and Accounting Guide*, the Financial Reporting Executive Committee (FinREC) believes that although the timing between the service to a Medicare or Medicaid beneficiary and final settlement or payment is often more than one year, a significant financing component likely does not exist for third-party settlements because the timing of the payment is at the discretion of the third-party payer and does not involve the patient (that is, the customer).

**Recognizing Revenue as Performance Obligations are Satisfied.** As noted [previously](#), the “contract with the customer” refers to the arrangement between the healthcare provider and the patient. Consequently, performance obligations related to the contract would be satisfied when services have been delivered to the patient. Although provider tax program supplemental payments may be determined based on retrospective data (e.g., provider tax program revenue is distributed to providers in the statewide pool based on each entity’s relative Medicaid patient days to the total in a retrospective year), that retrospective data is used for the purpose of supplemental payment calculations and is not considered to be revenue for the specific services related to that data set. Rather, similar to other governmental payment add-on methodologies (e.g., Medicare disproportionate share payments), supplemental payments from provider tax programs represent additional revenue to providers for services to beneficiaries provided prior to and during the program period. Provider tax programs run for a specific period of time. These programs generally require tax payments from providers and make additional supplemental payments at determined intervals over that period of time (quarterly, for example). As such, it would be appropriate for entities to recognize revenue as services are provided to Medicaid patients over the period specified in the program, once variable consideration constraints are determined to be appropriately overcome. Assuming services are generally provided relatively consistently to Medicaid patients over a period of time, it may be practically expedient to recognize supplemental revenue ratably over the program quarter to which the designated supplemental payments relates.

Supplemental revenue for periods of the program during which the estimate of variable consideration is constrained (for example, pending CMS approval of the broad-based and uniform waiver for a new program) would be recognized at the point in time when the constraint is removed. Waiver approval subsequent to the end of a fiscal period but prior to the issuance of financial statements would require an

evaluation of the applicable facts and circumstances to assess whether the variable consideration was not constrained at the end of the period.

**Gross vs. Net Presentation of Supplemental Revenues and Tax Expenses.** The presentation of tax payments by providers to the state in a provider tax program is a financial statement presentation issue, not a revenue recognition issue. Provider tax regulations prohibit provider tax programs from holding providers harmless for tax payments or to directly or indirectly guarantee the return or offset of a portion or all of the provider tax payments. Consequently, the payment of provider taxes is not directly correlated with the receipt of supplemental revenue and such payments would not be considered payments to customers under a pay-to-play model to obtain a contract contemplated by Topic 606. Instead, the payments more appropriately represent an expense of the period to which they relate. FASB *Statement of Financial Accounting Concepts 6* identifies “revenues” and “expenses” as transactions associated with an entity’s ongoing major or central operations (as opposed to gains/losses, which are peripheral or incidental) and states that those amounts should be presented gross. Because supplement payments from the state on behalf of patients to providers under provider tax programs represent consideration for services provided to Medicaid beneficiaries, such receipts are considered to be revenues and are presented as such in the statement of operations. Also, since the tax payments are unrelated to the receipts, they are presented as operating expenses. For other associated arrangements where a commitment exists for specific monies given to the state by the provider to be returned to the provider, net presentation may be appropriate.

## Illustrative Examples

**Scenario 1.** The following example is intended to be illustrative, and the actual determination of the amount and timing of revenue recognition for a provider tax program may differ based on the facts and circumstances of a healthcare entity’s specific situation.

State A passes legislation in October 2017 to implement a new program to assess all hospitals in the state a provider tax. The tax is based on a certain amount per inpatient day using admission data and is assessed on a quarterly basis for the two-year period beginning January 1, 2018, and ending December 31, 2019. Assessments will be pooled by the state and subject to federal matching dollars based on the state’s Federal Medical Assistance Program (FMAP) percentage. The state will allocate 10% of the total pool of assessments and matching funds to the state’s general fund. The remaining 90% of the pool will be redistributed to hospitals based on their pro-rata Medicaid inpatient days. Fifty percent of the redistribution amount will be paid as supplemental fee-for-service payments and the remaining 50% of the redistribution amount will be paid through increases in Medicaid managed care capitation rates with hospitals. The state will need to apply for a waiver of the broad-based and uniform requirements from CMS. Additionally, the managed care contract amendments and adjusted capitation rates will require CMS approval. Collection of provider tax assessments begins in June 2018. CMS waiver approval, federal matching and supplemental fee-for-service revenue payments begin in September 2018. Managed care capitation rates have not been adjusted or approved by CMS at the time the waiver is approved. State legislation for the authorization of the program provides that any assessments will be returned and any supplemental revenue will be recouped should the waiver not be approved by CMS.

Due to multiple factors related to the fee-for-service component of the program, including uncertainty about when the program will be approved, the approval being out of the entity's control and the lack of historical experience with the program, Hospital B determines that it cannot assert that it is probable that a reversal that is significant to cumulative revenue will not occur at the time the program began (January 1, 2018) but prior to CMS waiver approval. Because all assessment and supplemental revenue payments would be reversed in that case under state law and no federal matching would be available, the impact would be significant to the transaction price and cumulative revenue. Accordingly, Hospital B does not recognize variable consideration related to the program. In September 2018, when CMS approval of the waiver is received by the state, Hospital B evaluates the new facts and circumstances, including the uncertainties related to the timing and amounts of the payments, and concludes that the estimated variable consideration is no longer constrained. Upon approval, estimated revenue from the fee-for-service component of the program for the period from January 2018 to September 2018 is recognized in September 2018 as variable consideration when the waiver is approved, as it is no longer constrained and all performance obligations with respect to services provided to Medicaid beneficiaries have been met. Hospital B will recognize revenue for the fee-for-service variable consideration (based on the state's program model) for the remainder of the program as the hospital provides healthcare services to Medicaid beneficiaries over the program's remaining duration.

When the waiver is received in September 2018, Hospital B reassesses the variable consideration estimates and related constraints, as described above. In this example, the managed care contract adjustments have not been approved by CMS and no capitation rate increases have been paid. As CMS approval of the contracts is required for distribution of increased capitation rates but not for the approval of the program and federal matching funds, Hospital B also evaluates the uncertainties over the managed care component of the program and determines that no constraint to variable consideration exists for the managed care portion of the program once the waiver is approved. Accordingly, revenue is recorded for the managed care component from January 2018 through September 2018 in September 2018. Hospital B plans to continue to recognize the estimated variable consideration over the remainder of program. However, the estimate of variable consideration for the managed care component of the program will continue to be reassessed to determine whether any factors, such as additional length of time without contracts amendment approvals, would constrain the estimate of variable consideration.

**Scenario 2.** Assume the same fact pattern in Scenario 1, except that State A is not attempting to implement a new program but rather renew an existing program with similar or identical attributes to previous programs approved and administered by State A for multiple years. Under this scenario, Hospital B determines that, based on previous experience with the program, the expected approval in the near future and its predictive value to this program renewal, it can assert that a significant revenue reversal based on CMS not approving the broad-based and uniform waiver is not probable and a constraint on variable consideration does not exist based on the various facts and circumstances related to the program. Consequently, Hospital B recognizes revenue at the inception of the program (January 1, 2018) based on modeling that is part of the program approval submission and has been provided to hospitals in the state by the state hospital association. Additionally, Hospital B would adjust its revenue recognition at each reporting period based on the most recent facts and circumstances and records the updated estimated variable consideration.

**Scenario 3.** Assume the same fact pattern in Scenario 1, except that State A is seeking to renew an existing program. However, program attributes have changed from previous programs. Due to changes in CMS regulations regarding distribution of supplemental revenue through managed care plans, that supplemental revenue is now determined based on concurrent data submitted by hospitals and is paid as augmented capitation rates directly to hospitals with contracts with those specific plans. Under this scenario, Hospital B determines that previous experience with the state's provider tax program is not reliably predictive of approval of the broad-based and uniform waiver from CMS, due to significant changes to the program as well as uncertainty surrounding how long it may take to get CMS approval because of the significant changes to the program. Consequently, Hospital B concludes that it cannot assert that it is probable that a significant reversal of variable consideration will not occur so the variable consideration is constrained until the qualitative factors, including the timing of waiver approval from CMS, are overcome in September 2018. Accordingly, Hospital B does not recognize variable consideration related to the program until September 2018 when CMS approval of the waiver is received by the state and Hospital B evaluates the new facts and circumstances, including the related uncertainties of the expected amounts, and the hospital determines that the variable consideration is no longer constrained. Additionally, because of the significant changes to the managed care portion of the program and the related uncertainties around the timing and amount of variable consideration for this portion of the program, Hospital B determines that waiver approval removes the constraint only for the fee-for-service component of the program and related supplemental payments as of September 2018 but not for the managed care supplemental payments related to the program. Thus, Hospital B will begin recognizing revenue for the managed care component of the program when it determines that there are enough facts and circumstances that allow Hospital B to reliably predict the variable consideration and overcome the need to constrain the variable consideration related to augmented capitation rates.

## Appendix. Provider Tax Program Background

Currently, many states use provider taxes to finance a portion of their state's share of Medicaid expenditures. Federal statute and regulations define a provider tax as a healthcare-related fee, assessment or other mandatory payment for which at least 85% of the burden of the tax revenue falls on healthcare providers. In order for states to be able to draw down federal Medicaid matching funds, the provider tax must be both broad-based (that is, imposed on all providers within a specified class of providers) and uniform (that is, the same tax for all providers within a specified class of providers). States are not allowed to hold the providers harmless for the cost of the provider tax (that is, they cannot guarantee that providers receive their money back).

Currently, 49 states and the District of Columbia are using at least one provider tax to finance their Medicaid programs. Many of these states use the provider tax revenue to increase Medicaid payment rates for the class of providers, such as hospitals, responsible for paying the provider tax. This financing strategy allows states to fund increases to Medicaid payment rates without the use of state funds because the increased Medicaid payment rates are funded with a combination of provider tax revenue and federal Medicaid matching funds.

In 1991, Congress passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) to limit states' ability to draw down federal Medicaid matching funds with provider tax revenue.

The 1991 law defines a provider tax as any licensing fee, assessment, or other mandatory payment in which 85% or more of the burden falls upon healthcare providers. In order for states to claim federal matching payments for provider tax revenues, the 1991 law requires provider taxes to:

- Be broad-based (that is, imposed on all providers within a specified class of providers).
- Be uniform (that is, the same tax for all providers within a specified class of providers, meaning states cannot limit the provider taxes to only Medicaid providers)
- Prohibit states from a direct or indirect guarantee that providers receive their money back (or be "held harmless").

The Secretary of Health and Human Services is authorized to waive the broad-based and uniform requirements of provider taxes. In order to waive either the broad-based or uniform requirement, a state needs to prove that the net impact of the tax is "generally redistributive" and the amount of the tax is not directly correlated to Medicaid payments.

"Generally redistributive" is defined as the tendency of a state's provider tax to derive revenues from non-Medicaid services in a class and to use these revenues as the state's share of Medicaid expenditures. According to the quantitative tests set forth in regulation, a provider tax is perfectly redistributive if the tax burden for Medicaid providers is the same under a tax without the waiver as under the tax with the waiver. The redistributive nature of a provider tax increases as the tax burden falls more heavily on providers with relatively fewer Medicaid patients.

Regulations describe three tests that are applied to provider taxes in order to determine whether taxpayers (that is, the providers paying the provider tax) are held harmless. Taxes that fail any of these tests are determined to have a hold harmless provision in violation of the law. The three tests are as follows:

- A positive correlation test is used to determine whether a state or other unit of government imposing the tax provides directly or indirectly for a non-Medicaid payment to the taxpayers in an amount that is positively correlated to either the tax amount or the difference between their Medicaid payment and the tax amount.
- The Medicaid payment test is violated if all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payments.
- The guarantee test is violated if the state or other unit of government imposing the tax provides directly or indirectly for any payment, offset or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax.

States' use of provider tax revenue varies from state to state, but states often use provider tax revenue to draw down federal Medicaid matching funds in order to increase Medicaid payment rates for the same providers that are responsible for paying the tax.

CMS is responsible for determining whether states abide by the statutory and regulatory requirements pertaining to provider taxes. States are not required to receive CMS approval for provider taxes that adhere to the federal requirements. However, states seeking waivers from the broad-based and uniform requirements do need CMS approval.

Provider tax programs are generally implemented at the state level through state legislation (imposing a fee or tax on providers). Typically, the legislation provides that these provisions become operative on the date that all federal approvals necessary for receipt of federal financial participation has been obtained. Prior to that point, the legislation is not operative. The programs are typically operative for a particular time period (e.g., three years).

### **2019-2020 Principles & Practices Board Members**

Norman Mosrie, FHFMA, CPA (Chair)  
Colleen M. Blye, CPA  
Anthony Frank, CPA  
Brian Green, FHFMA, CPA  
Kevin Holloran  
Kimberly McKay, CPA  
Julie Norton, CPA  
Mark Ross, CPA  
Dawn Stark, CPA, CHFP  
Timothy Weld, CPA  
David Wiessel, CPA  
Kurt Wroebel, FSA, MAAA

### **Expert Contributors**

Brian Conner, CPA (Workgroup Leader)  
Steven Blake, FHFMA, CPA  
Douglas Coffman, CPA  
Martha Garner, CPA  
William Love, CPA  
Lindsey Roe CPA  
Karen Van Compernelle, CPA

### **HFMA Staff**

Richard L. Gundling, FHFMA, CMA  
Charles R. Alsdurf, MAcc, MBA, CPA