



healthcare financial management association

Revenue Recognition, Including Implicit Price Concession and Bad Debt Considerations, for Healthcare Organizations: Accounting Issues and Trends

**Principles and Practices Board
Issue Analysis**

January 2019

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 on certain accounting and reporting issues resulting from FASB Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts (Topic 606)*. In addition to the rules to calculate revenue, one of the more significant changes accompanied by the revenue recognition standard affects the assessment of bad debts. This issue analysis highlights the current issues and considerations in accounting for revenue. Additional interpretive guidance may be released as circumstances evolve. Consultation on these matters with independent auditors is highly recommended.

Calendar year 2018 marks the first of the implementation periods for Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)*. Originally issued in May of 2014, this ASU has been the subject of much attention in healthcare finance industry groups over the past few years. Opinions have ranged from those who believe this standard does not impact their organization at all, to those who believe this standard will drive fundamental changes in revenue recognition. For many healthcare providers, the impact may be a bit of both.

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 Audit and Accounting Guide, *Revenue Recognition*. 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 revenue recognition standard defines a five-step model for revenue recognition:

1. Identify the contract(s) with the customer.
2. Identify the performance obligations in the contract.
3. Determine the transaction price.
4. Allocate the transaction price to the performance obligations.
5. Recognize revenue when (or as) the entity satisfies a performance obligation.

AICPA Healthcare Revenue Recognition Implementation Issues

- Issue #8-1: Application of step 1, (determine if there is a contract) and step 3, (determine the transaction price) for healthcare services provided to self-pay patients, including uninsured patient balances and self-pay balances arising from copayments and deductibles
- Issue #8-2: Application of the portfolio approach to contracts with patients
- Issue #8-3: Application of FASB ASC 606, *Revenue from Contracts with Customers*, to Continuing Care Retirement Community Contracts
- Issue #8-6: Disclosure requirements of ASU No. 2014-09
- Issue #8-7: Accounting for Contract Costs
- Issue #8-8: Consideration of FASB ASC 606, *Revenue from Contracts with Customers*, for third-party settlement estimates
- Issue #8-9: Risk Sharing Arrangements
- Issue #8-10: Performance Obligations

Net Patient Service Revenue Accounting

In applying the revenue recognition standard, in most cases healthcare providers will consider their patients to be the customers. Contracts with third-party payers should be evaluated under the standard for variable consideration impacts, as well as possible constraints of revenue. To evaluate net patient service revenue under the new standard, providers will want to consider the following:

- Contract existence
- Application of portfolio approach
- Implicit price concessions
- Timing for recognition of price concessions
- Variable consideration
- Financial statement display of revenues

Contract existence. The new standard provides criteria to determine when a contract is within the scope of Topic 606. For healthcare providers, the most relevant considerations will likely be the requirement that the parties have approved the contract and are committed to perform their respective obligations, as well as the requirement that the entity will collect substantially all of the consideration to which it will be entitled. In healthcare settings, the patient's commitment to the contract may not always be apparent – particularly in the case of care provided in an emergency department, and when the patient presents as unconscious or with mental health issues. Providers should look to the relevant customary business practices when considering whether a contract is within the scope of Topic 606. Providers may determine that certain instances of care provided are not within the scope of the standard; however, the volume of such instances may be insignificant, and these situations may generally resolve as the patient is stabilized and communications with the patient and family result in meaningful discussion of financial responsibility. In these circumstances, the contract may be determined to be within the scope of Topic 606 at a point in time after the services are provided.

Providers then need to consider the requirement that it is probable that the entity will collect substantially all of the consideration to which it will be entitled. There are unique challenges for healthcare providers relative to this requirement. The price of the services to be provided is not necessarily known at contract inception. The patient's insurance status may be unknown or unverified at contract inception, and the financial means of the patient also may be unknown. In these situations, providers may look to past experience with similar patients to assess probability of collection.

Application of the portfolio approach. The new standard allows entities to use a portfolio approach to account for patient contracts as a collective group rather than individually, if the financial statement effects are not expected to materially differ from an individual contract approach. Most healthcare providers are expected to utilize this practical expedient, due to the sheer number of patients served in any given accounting period. Judgment will be required in establishing portfolios. Healthcare providers will likely consider matters, such as the type of service provided or the type of insurance coverage the patient carries. Historical cash collections, as well as changes to established reimbursement rates, should be utilized in developing estimates of price concessions and collectability. It also will be important for an entity to make a determination on whether it will apply the portfolio at a system-wide basis or tailor a separate approach for each individual healthcare facility in the system. This decision may depend on whether the facilities have similar contracted insurance rates, mix of services, pricing, etc.

In applying the new standard to net patient service revenue, the patient is generally considered the customer, and portfolios may be established to reflect patient characteristics such as: “Patients with Medicare,” “Patients with Commercial Insurance,” or “Uninsured Patients.” Providers may consider other possible portfolio structures, such as service type (inpatient, outpatient, home health patient, etc.) Explicit and implicit price concessions should be recognized in their entirety when revenues are recorded, and as such, providers typically will not use an aging of service dates to establish an estimate for price concessions. However, as a practical matter, providers likely will continue to monitor aging information within individual portfolios to evaluate the ongoing adequacy of the estimate of the transaction price of a portfolio.

It may take several weeks after providing service to a patient for a healthcare entity to determine the payer for the contract. Some healthcare entities may initially classify a patient as “Medicaid-pending” and then subsequently reclassify the patient to Medicaid, charity care, or self-pay once eligibility is determined. Healthcare entities may utilize their historical experience for their Medicaid-pending population to estimate classification outcome and related revenue recognition. However, if a healthcare entity does not have historical experience to estimate the outcome for a pending Medicaid account prior to receiving the Medicaid eligibility determination, it may determine that a contract does not exist because it has not met the requirements of FASB ASC 606-10-25-1.

Implicit price concessions. In addition to the many and varied pricing arrangements in healthcare providers’ contracts with payers, amounts that are expected to be paid directly by patients are subject to variability, which may be impacted by the amount of the billed charges relative to a patient’s financial status, as well as other factors. The provider should determine whether an implicit price concession has been provided to a patient with a self-pay balance. To evaluate for the existence of an implicit price concession, the provider should consider whether either: (1) the patient expects that the entity will accept less than the stated price, or (2) facts and circumstances would point to the entity offering a price concession to the customer. In determining expectations and intentions, the provider should consider whether a credit assessment is performed prior to providing service, and whether the entity continues to provide services to patients in certain classifications, even when experience indicates it is not probable that substantially all of the billed amount will be collected.

For illustration, assume a patient with commercial insurance is discharged from a hospital with incurred charges of \$24,000. The hospital records an explicit price concession (as defined by the agreement with the insurance company) of \$13,000, collects \$10,000 from the insurance company and finally sends a \$1,000 bill to the patient. The hospital historically has collected 30 percent of the amount billed to patients in this portfolio, and thus records an estimated \$700 implicit price concession when revenue is recorded.

If the actual amount collected from this patient varies from the estimated amount to be received of \$300, that difference would typically be recorded as an adjustment to the implicit price concession. Hospital financial records will reflect the following:

Charges for services.....	\$24,000
Explicit price concession.....	(13,000)
Billed to and paid by insurance.....	<u>(10,000)</u>
Billed to patient	1,000
Implicit price concession	<u>(700)</u>
Estimated amount to be collected from patient	<u>\$300</u>

This activity would be reflected in the financial statements of the hospital as follows:

Prior to Topic 606		Under Topic 606	
Net patient service revenue	\$11,000	Net patient service revenue	\$10,300
Less provision for doubtful accounts	700		
Net patient service revenue, less provision for doubtful accounts	\$10,300		

Timing for recognition of price concessions. The implicit price concession concept looks to the ultimate collection expectation for an individual contract or an established portfolio of contracts. Healthcare providers should ensure that the practices utilized to establish allowances for implicit price concessions are designed to appropriately record implicit price concessions as revenue is recognized. Providers typically will have detailed collection data which may indicate fairly predictable swings in collection experience. For instance, collections may be minimal in the first 30 days after discharge as bills are prepared and submitted for payment. This period may be followed by a predictable period of stronger collection experience as payers process claims and patients receive explanation-of-benefits documents, as well as bills. Finally, collections again will taper off as the remaining amounts pursued generally will be due from patients who have varying levels of financial wherewithal. These anticipated swings in collection percentages should be considered as price concessions are recorded in connection with revenue so that only the ultimate amount expected to be collected is recognized. Providers likely will not want to abandon their practices of analyzing receivables as they age, however the cumulative allowances should be adequate so that receivables are recorded only to the extent that collection is ultimately expected at any point in the revenue cycle. As healthcare providers implement the new standard, the timing of implicit price concession may create an adoption impact for some providers.

Variable consideration. Under the new standard, variable consideration should be recognized as part of the transaction price only to the extent that it is probable that a significant reversal will not occur. To estimate variable consideration, entities should use either the “expected value” method or the “most likely amount” method. Entity management should choose the method which is expected to be a better predictor of the amount of consideration to which the entity will be entitled. The most likely amount is the single most likely amount in a range of possible consideration amounts. This method may be appropriate if a contract has only two possible outcomes (for example, a bonus is either achieved or not); however, this method also may be used in circumstances which include more than two possible outcomes. The expected value

method is a probability-weighted approach which lends itself to situations in which multiple outcomes are possible. For example, a provider may have a payer contract which will result in payment of one of four possible supplemental amounts to a provider. Each possible outcome is assigned a probability in order to determine the amount to be recorded.

Possible supplemental payment	Probability	Probability-weighted amount
\$0	30%	\$0
200,000	35%	70,000
500,000	25%	125,000
1,800,000	10%	180,000
		\$375,000

Using this expected value approach, the provider would record \$375,000 as the estimated amount expected as supplemental payments.

When the principles for variable consideration are implemented, healthcare providers may see a difference in the amounts recorded. However, even if the recorded amounts do not vary, entities should plan to document their analysis of the variable consideration constraint implications, and the underlying documentation supporting the estimates should be prepared using that method described in the standard, which is the better predictor of expected compensation.

Accounting for variable consideration also will apply to many risk-sharing arrangements. In addition to considering the probability of revenue reversal, providers will need to identify the performance obligations within contracts, including any implied promises to patients. Distinct performance obligations entail the transfer of a good or service to the patient or another customer. Certain activities, such as care coordination, may be considered administrative in nature and would not constitute a distinct performance obligation.

Financial statement display of revenues. Once a provider has completed the analysis to address contract existence, price concessions recording, portfolio development/substantiation, and variable consideration, the provider will be well positioned to consider financial statement display of revenues. In adopting the new standard, providers are expected to net all price concessions within the patient service revenue line on their financial statements. However, if a healthcare entity evaluates the credit risk of a customer (e.g., elective surgery), the entity may determine that it has not provided an implicit price concession but that it has chosen to accept the risk of default by the patient. Any subsequent default in payments would be considered an impairment loss and reported as bad debts within expenses on the financial statements. For further examples of what constitutes an impairment loss or bad debt see Chapter 7, of the AICPA Audit and Accounting Guide, *Revenue Recognition*.

For many providers, this will mean that most (or all) of the bad debt expense amounts historically reported adjacent to net patient service will be subsumed into the revenue line on the face of the financial statements. Detailed information regarding price concessions may be disclosed in the provider's notes to the financial statements. Similarly, capitation revenue may be disclosed separately on the face of, or in the notes to, the financial statements. However, there is no explicit requirement to display this revenue separately from net patient service revenue.

Accounting for Other Revenues

Many healthcare systems report significant revenues in addition to net patient service revenues. Providers should determine which revenue streams are within the scope of Topic 606. For example, investment income and leasing revenues would typically be outside of the scope of the new revenue recognition standard. The contracts supporting other revenues may be numerous and quite diverse. These contracts will need to be analyzed for recording under the new standard, and may require substantial attention to detail, as the number and nature of performance obligations likely will be unique to each contract. In arrangements where the healthcare entity engages an outside party to provide services to the customer of the healthcare entity, a review of the principal versus agent requirements of the standard should also be considered.

Some providers record supplemental payments from state programs as a component of patient service revenue, while others report this separately from patient service revenue. Additionally, many providers are subject to assessments which are used to help support the state or local programs in either a direct or indirect manner. These payments may currently be reported as expenses, or possibly as revenue deductions. There is currently discussion underway among members of the AICPA Healthcare Expert Panel and the HFMA Principles and Practices Board to establish considerations for recording this activity under the requirements of ASC 606. Providers should remain alert for upcoming industry information relative to accounting considerations for these programs.

Disclosures

ASC 606 requires entities to disclose “sufficient information to enable users of the financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers.” Providers will be expected to disclose significant judgments made in applying the guidance and will be expected to disaggregate revenue recognized sufficiently to “depict how the nature, amount, timing, and uncertainty of revenue and cash flows are affected by economic factors.” Healthcare entities may disclose revenue by major payer type, by geographical area, by service line or in other categories, as appropriate. Entities also will disclose contract assets and liabilities if they are significant. A discussion of items to be disclosed by healthcare entities may be found within the AICPA paper, *Issue #8-6 – Presentation and Disclosure*.

While there is no stated requirement to disclose implicit price concessions, healthcare entities should consider whether such a disclosure may be useful to readers and may further consider the terminology they use in such disclosures. Some users of financial statements (including Medicare and Medicaid auditors) routinely may look for uncompensated care and bad debt amounts to obtain some measure of the level of direct patient care community benefit provided by a healthcare entity, and certain reimbursement amounts may be defined in existing payer contracts as “bad debts” rather than an “implicit price concession.” As the implicit price concessions will not be displayed on the face of the financial statements, healthcare entities should consider whether it would be useful to disclose in the notes the aggregate implicit price concessions recorded within the accounting records. However, as this is new terminology, providers should take care to disclose enough information to enable users to understand the nature of the price concession. Entities may use the Topic 606 terminology with supporting discussion, or they may choose to use terminology such as “uncollectible amounts due from patients” to link the amounts to patients’ inability to pay, rather than contractual adjustments, published discounts, or charity care.

Accounting System Implications

Healthcare entities should determine whether accounting system modifications are necessary to support the requirements of the new standard. For example, what was historically treated as bad debt expense may now be considered an implicit price concession, and thus a component of the pricing of services provided to patients. Some providers are adding new general ledger accounts so that the implicit price concessions will be reported as revenue deductions by payer category rather than in a single general ledger line. Similar changes may be made for other deductions, such as denials. For providers that add new revenue accounts, further underlying system changes will be necessary in order to properly map the revenue deductions by payer into the new detailed general ledger account.

Key Performance Indicators

Many healthcare entities have preliminarily concluded that adoption of the new standard will not materially impact their operations. While the “bottom line” for many providers may not change as a result of adopting the standard, changes in classification of certain items could have a significant impact on key performance indicators utilized by management. For instance, contract assets as defined under Topic 606 and presented separately from receivables, could impact days in receivables ratios.

Healthcare entities also will need to ensure that any key performance indicators using revenue as an input either are not impacted by the accounting change or are appropriately considered in establishing targets. Many providers closely monitor the net patient service revenue per equivalent discharge by payer. With the adoption of implicit price concession accounting, some providers may spread certain revenue deductions to payer categories which once were captured as a single aggregate amount. This type of change could have a significant impact, as amounts previously separately recorded as bad debt now are pushed into the net revenue per discharge metrics.

Operating margin percentages may be impacted if providers classify uncollectible amounts as bad debt expenses (which will be recorded as an expense under Topic 606). The margin percentages also would be impacted by any change in the gross versus net reporting of provider tax assessments and supplemental payment revenues.

Accounting Policy Documentation

Internal accounting policy documentation likely may need to be overhauled to ensure compliance with the new standard, to reference any new accounts established within the accounting systems, and to update any descriptions of calculated performance indicators.

Summary

So, how significant are the changes required by this new standard? The answer for any healthcare provider cannot be known until each provider completes the analysis and documentation necessary to determine impacts on some fairly significant—and sometimes judgmental—areas. For many providers, adoption of the standard will mean the development of some extensive documentation, the review of contracts, and some new disclosures and language in the financial statements. For other 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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Acknowledgments

Special thanks to Rich Daly and Karen Thomas