AICPA Addresses Health Care Revenue Recognition Issues

Health care entities face unique challenges in applying the new revenue recognition standard, Accounting Standards Update (ASU) No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, due to the variety of revenue streams common in the industry. To address industry concerns, the American Institute of CPAs (AICPA) has organized 16 industry-specific task forces, including health care. AICPA plans to develop a revenue recognition guide to provide nonauthoritative guidance, including hints and examples, to aid entities in implementing the new standard; the final guide is expected to be issued in 2017.

On July 1, 2016, AICPA released working drafts on two significant revenue implementation issues impacting health care entities related to (1) self-pay balances and (2) application of the portfolio approach. Feedback is requested by September 1, 2016. The drafts' key points are summarized below, but you are encouraged to review the full documents and provide feedback to AICPA.

I. Self-Pay Balances

Determining if an Enforceable Contract Exists

The ASU requires customer arrangements to meet all the following criteria to be considered a contract within the scope of the new standard:

- Approval and commitment of all parties—this can be written, verbal or implied by an entity's customary business practices
- Identifiable rights, obligations and payment terms for each party to the contract
- Contract has commercial substance, defined as the expectation that the entity's future cash flows will change as a result of the contract
- Collectible, *i.e.*, probable that the entity will collect the consideration to which it will be entitled in exchange for the goods or services that will be transferred to the customer

AICPA's working paper proposes that a health care entity may consider involvement of internal or external legal counsel when determining if a patient contract exists. A health care entity may consider whether the patient signed any forms, such as a patient responsibility form, that would be considered a written contract. If the health care entity determines it does not have a written contract, *i.e.*, the patient refuses to sign a patient responsibility form, it may consider if it has an oral or implied contract based on the entity's customary business practices. If the patient schedules health care services in advance, *i.e.*, elective surgery, the health care entity may consider if it has an oral or implied contract.

Patient Committed to Perform & Probability of Collection

The ASU contained several health care examples, but did not illustrate situations where the entity obtains some patient information but needs additional time to determine if, and how much, insurance coverage exists, *e.g.*, unresponsive patients. The working draft clarifies that although the party responsible for payment has not yet been determined, the health care entity may have historical information for pending Medicaid patients to determine the transaction price based on the percentage of those contracts it estimates will:

- Qualify for Medicaid
- Qualify for the health care entity's charity care policy (not within the scope of the revenue model)
- Become uninsured self-pay

A health care entity may estimate the transaction price for an individual contract (or portfolio basis if the outcome is not materially different) by considering the likelihood of each outcome for the contract, *e.g.*, Medicaid, self-pay and charity care, and the expected reimbursement rate for each. If a health care entity does not have historical experience to estimate the outcome for a pending Medicaid account prior to receiving the Medicaid approval, it may determine a contract does not exist.

Services previously provided to the patient without payment provides strong evidence the patient does not have the intent or ability to pay. However, if no such evidence exists, the health care entity may be able to conclude its expectation related to collectibility for that patient is no different than for any other patient in the customer class.

Bad Debt Versus Implicit Price Concessions

To determine if it is probable the health care entity will collect substantially all of the consideration to which it will be entitled, a health care entity will need to first determine the transaction price. If the transaction price includes an estimate of variable consideration, *i.e.*, a price concession, the transaction price may be less than the contract's stated price. There are two methods for estimating variable consideration (the expected value method and the most likely amount); selection is dependent on the best prediction of the amount of consideration to which the entity will be entitled. Estimated variable consideration should be reflected in the transaction price only to the extent that it is probable a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is resolved. A health care entity should consider the historical cash collections from an identified customer class to estimate the transaction price for a patient.

The ASU does not provide detailed guidance for differentiating between a price concession and impairment losses. Health care entities must use judgment and consider all relevant facts and circumstances to determine if it has implicitly offered a price concession or has accepted patient default risk. Implicit price concessions do not have to be specifically communicated or offered to the patient by the entity. Health care entities need to determine, if the customer had a valid expectation—arising from an entity's customary business practices, published policies or specific statements—that the entity will accept an amount of consideration less than the contract's stated price. A health care entity may consider these factors to determine whether it intends to provide an implicit price concession:

- The health care entity has a customary business practice of not performing a credit assessment prior to providing services, *i.e.*, required by law, regulation or organization's mission.
- The health care entity continues to provide services to a patient even when historical experience indicates it is not probable the entity will collect substantially all of the billed amount.

If one of those factors is present, AICPA believes the health care entity has implicitly provided a price concession to the patient, even if it will continue to attempt to collect the full amount of billed charges.

Below are factors for health care entities to consider when evaluating if it is probable there will not be a significant revenue reversal when the cash is collected in contracts with patients with self-pay balances:

- Whether the amount of consideration from patients with self-pay balances is highly susceptible to factors outside the entity's influence, *e.g.*, current economic conditions in the market it serves
- The entity's experience with similar types of contracts
- How long it generally takes to collect from similar patients
- Its practice of offering price concessions or changing payment terms, *i.e.*, uninsured or prompt-pay discount policy
- The number of possible consideration amounts—a health care entity may consider the historical range of collection history with similar patients and whether the range is broad (significant differences from reporting period to reporting period) or narrow (insignificant differences from reporting period to reporting period)

For self-pay patients who schedule an "elective" procedure in advance, the health care entity may be able to assess the patient's intent and ability to pay prior to or at the time of service and determine if it is probable it will collect substantially all of the consideration to which it is entitled—concluding the health care entity did not provide an implicit price concession.

If the health care entity determines it has not provided an implicit price concession, it is still required to assess whether it is probable that it will collect substantially all of the consideration to which it is entitled for determining whether a valid contract exists.

Subsequent Changes in the Estimate of the Transaction Price

If the entity concludes it has provided an implicit price concession for the amount it doesn't expect to collect, *e.g.*, variable consideration, the entity also must consider how to account for subsequent changes in its transaction price estimates. At each reporting date, the ASU requires an entity to update the estimated transaction price, including any constrained variable consideration. Factors that may change the transaction price estimate prior to payment include receipt of obtained additional information about the insured patient's deductible, copayment or co-insurance coverage or the patient's personal financial situation, *i.e.*, an uninsured patient qualifies for Medicaid or charity care.

For implicit price concessions, AICPA believes subsequent changes to the variable consideration estimate should generally be accounted for as adjustments to patient service revenue. Because the assessment of the implicit price concession inherently considers the amount the entity expects to collect from the patient, AICPA believes changes in the entity's expectation of the amount it will receive from the patient will be recorded in revenue, unless there is a patient-specific event known to the entity that suggests the patient no longer has the ability and intent to pay the amount due, and therefore, the changes in estimate better represent an impairment (bad debt).

An entity with frequent subsequent adjustments should re-assess whether its estimation process, including the constraint, is appropriate. If an entity subsequently collects significantly less than its original estimate of variable consideration, there may be facts and circumstances that indicate there has been an adverse change in the patient's credit worthiness, *e.g.*, the patient filed for bankruptcy or lost their job, and the difference may be better classified as an impairment loss (bad debt) rather than a change in the transaction price. However, entities should not wait for subsequent cash collections before updating transaction price estimates.

Determining What Constitutes an Impairment Loss or Bad Debt

In estimating the transaction price, a health care entity may determine it has not provided an implicit price concession, but rather has chosen to accept patient default risk and that uncollectible amounts are impairment losses or bad debts. A health care entity would consider the effects of customer credit risk after concluding all contract criteria are met and revenue and a receivable are recognized for the services provided. An impairment loss may be recorded after contract inception for a self-pay patient balance due to the subsequent inability of a patient to pay, *i.e.*, unemployment or bankruptcy, and for which the health care entity had assessed the patient's ability to pay prior to providing the service and expected to collect substantially all of the amount billed.

Other Considerations

For patient arrangements that do not meet the contract criteria, the health care entity should continually reassess the arrangement as facts and circumstances change. If partial payment is received, the health care entity should reassess whether the contract criteria are met, including whether it has provided an implicit price concession.

When a contract with a customer does not meet the contract criteria and an entity receives consideration from the customer, the entity should record revenue if the consideration is nonrefundable and when one or more of these events has occurred:

- Patient services have already been performed and all or substantially all of the consideration promised by the patient has been received
- The contract has been terminated
- The health care entity has stopped performing services to the patient and has no obligation to perform additional services under the contract

If a health care entity does not meet the guidance to recognize revenue, it would recognize the consideration received from the patient as a liability until one of the above events occurs or the contract criteria are subsequently met.

II. Application of the Portfolio Approach

The ASU offers a practical expedient to account for contracts collectively if the impact does not materially differ from an individual approach. Entities may use a "reasonable" approach in determining the portfolios. Significant judgment will be required and AICPA's working paper provides some considerations for health care entities:

- Type of service—inpatient, outpatient, skilled nursing, home health, emergency room, elective procedures, non-elective procedures, physician practice, etc.
- Type of payors—insurance contract (Blue Cross, Aetna, Emblem Health, etc.), governmental programs (Medicare, Medicaid, etc.), uninsured self-pay, etc.
- Type of patient responsibility—uninsured self-pay, co-pay, deductible, etc. Health care entities also may consider the size of copay or deductible, *e.g.*, high deductible
- Whether contracts are entered into at or near the same time (for example, the same quarter)

The portfolio approach may be adopted on a system-wide basis or for each individual health care facility. Entities may decide to apply the portfolio approach to one class of patients, but not to another.

A contract can be added to a portfolio when it has similar characteristics with the portfolio's other contracts if the financial statement impact would not differ materially. Likewise, a contract should be removed from a portfolio if the contract does not have similar characteristics with other contracts in the portfolio. Since it takes several weeks after patient care has been provided to determine the contract's payor, *e.g.*, Medicaid, charity care or uninsured, AICPA's working paper proposes health care entities may initially classify a patient as pending Medicaid and subsequently reclassify the patient to Medicaid, self-pay or charity care once eligibility has occurred.

Portfolio Data Versus Portfolio Practical Expedient

An entity is not required to apply the portfolio practical expedient when considering evidence from other, similar contracts to develop an estimate of variable consideration. An entity could choose to apply the portfolio practical expedient, but it is not a requirement. At each reporting period, a health care entity should compare the characteristics of the contracts included in the historical experience to the characteristics of the portfolio or individual contract that the historical evidence is being applied to. The entity's considerations of the applicable historical experience to apply to a contract (or portfolio) may be similar to its determination of which portfolios it may use.

Additional Outstanding Issues

The working drafts address several issues, but many concerns remain for the health care industry in adopting the new revenue standard. The health care task force has generated a list of implementation issues and will develop recommendations to be reviewed by AICPA's Revenue Recognition Working Group (RRWG) and Financial Reporting Executive Committee (FinRec) before being referred to FASB. The table below summarizes the current status of identified issues.

Health Care Industry Revenue Recognition Task Force – Issues List (As of July 20, 2016)		
Issue #	Description of Implementation Issue	Status
1	**Implicit price concessions** This implementation issue provides two views over the initial accounting for implicit price concessions for services provided to uninsured patients, and two views for the subsequent accounting for these types of contracts and whether changes in the estimates of variable consideration represent changes in price concessions or impairments.	Submitted to FASB Transition Resource Group
2	**CCRC: Identifying and satisfying the performance obligation(s) and recognizing the monthly/periodic fees and nonrefundable entrance fees under Type A or "life care" contracts for continuing care retirement communities** This implementation issue will discuss the performance obligations under a typical Type A (life care) continuing care retirement community (CCRC) resident agreement and, given these performance obligations, how a Type A CCRC will estimate a transaction price and recognize nonrefundable entrance fees and monthly/periodic fees received from residents under the new model.	Resubmitted to AICPA RRWG
3	**CCRC: Identifying and recognizing the performance obligation(s) to provide future services and use of facilities** This implementation issue will describe the changes to a CCRC's calculation of the obligation to provide future services and use of facilities as a result of the new model.	Submitted to AICPA RRWG
4	**Significant financing component—CCRC contracts and patient and third-party payor amounts in arrears** How should CCRCs assess whether a significant financing component exists in determining the transaction price for its resident contracts? How should CCRCs and other health care entities assess whether a significant financing component is applicable to patient and third-party payor amounts in arrears?	Submitted to AICPA RRWG
5	Disclosure requirements	
6	Accounting for contract costs	Submitted to FinREC – September 2015
7	Third-party settlement estimates	

Additional Resources

BKD has prepared several papers on the new revenue recognition standard and will continue to monitor updates. These resources are collected in our Hot Topics webpage on revenue recognition. For more information, contact your BKD advisor.

Contributor

Anne Coughlan
Director
317.383.4000
acoughlan@bkd.com