NAVIGATING THE NEW HEALTHCARE REVENUE RECOGNITION MODEL

After years of fanfare, controversy, debate, and deferrals, the effective date of the new standard for revenue recognition is finally upon us. The new standard is effective for public entities (including not-for-profit entities with publicly-traded conduit debt) for fiscal years beginning after December 15, 2017, including interim reporting periods within that reporting period.

The new standard is found in Accounting Standards Codification (ASC) Topic 606 *Revenue from Contracts with Customers* and represents a complete overhaul of the existing guidance for revenue recognition. We advise healthcare providers and related organizations to take immediate action to 1) study the standard, 2) evaluate its potential impact, and 3) create a playbook for successful implementation at your organization.

Even with the effective date looming, many issues are still being debated about how to apply the standard to healthcare entities. This is largely due to the unique nature of the industry - unlike a typical commercial enterprise, the vast majority of fees for healthcare services are paid by third parties such as insurance companies, managed care companies, or government programs like Medicare and Medicaid. The amounts paid are typically not the 'rack rate' gross charge for the service, but rather they vary based on payer, site of care, and multiple other factors, and are often subject to regulatory review and retroactive adjustment.

Further, the transformational challenges being confronted by healthcare providers with respect to the continuing transition away from traditional fee-for-service reimbursement and toward alternative payment models, revenue sharing, and other forms of risk-based contracts create further complexities in implementing the new revenue recognition standard.

Various standard setting organizations continue to deliberate these issues and publish implementation guidance for specific industries, including healthcare entities. However, even with the ongoing dialogue, there are many things healthcare providers and related organizations can - and **must** - do to prepare themselves now. The first step is understanding the five-part framework of the standard.

STEP 1

Identify the contract with the customer

Most of us believe ***we*** are the customer when visiting the doctor (or other healthcare provider), and this standard doesn't change that. Patients are customers under the standard; third party payers are not (however, third party payer contracts are critical in determining the transaction price in Step 3).

Before revenue can be recognized, an enforceable contract must exist where a) both parties are committed to fulfill their obligations under the contract, and b) it is probable that the entity will collect substantially all of the consideration to which it is entitled under the contract. A contract does not have to be written – it can be implied based on customary business practices; however, a patient must have the intent and ability to uphold their obligation to pay. Otherwise, as in the case of many uninsured patients, the organization may be precluded from recognizing revenue. Until the organization determines it is probable the patient will pay, there is no contract and, thus, no revenue is recognized.

This is a new requirement established by the standard - under the old revenue recognition rules, providers were not required to determine if collectability was assured.

Practical Considerations – Self-Pay Patients

As discussed in Step 3, the consideration to which a provider is entitled does not refer to gross charges based on established rates. Instead, a contract with a patient is established based on the net realizable amount that is ultimately expected to be collected (i.e., variable consideration). In addition, an entity may elect to combine groups of contracts with similar characteristics into 'portfolios' by patient class as a practical expedient for purposes of applying the standard.

Thus, a portfolio of uninsured self-pay patients for which a provider only expects to receive pennies on the dollar can still meet the collectability threshold and satisfy Step 1 of the framework – but only for the 'pennies' portion of the charge, not for the full charge. Similarly, as discussed in Step 3, a portfolio approach may be utilized to estimate what percentage of self-pay patients may ultimately qualify for Medicaid.

STEP 2

Determine the performance obligation(s) in the contract

A performance obligation represents a promised good or service under a revenue contract, or a combined series of promised goods or services. Contracts for inpatient services may include numerous goods or services, such as room and board, nursing, drugs, surgeon, etc. Typically, inpatient acute care services represent a bundle of interrelated goods and services that may be accounted for as a single performance obligation that is satisfied when a patient is discharged. In this case, the overall 'promise' the provider makes to the patient is the delivery of inpatient care, with the series of individually distinct goods and services provided during the inpatient stay serving as 'inputs' to the combined 'output' which ultimately result in a discharge. As discussed in Step 4, inpatient revenue would generally be recognized 'over time' throughout the duration of the stay.

Similar to an acute care inpatient visit, an outpatient visit that includes multiple goods or services will in many cases be treated as one combined performance obligation with revenue recognized over time. However, some outpatient services may only provide one specific service, at varying intervals. For instance, a physical therapist who sees a patient several times a week may identify a separate performance obligation for each visit, with revenue recognized at a point in time, upon completion of each single session.

Many skilled nursing facilities will identify a separate performance obligation for each day of service; however, there are considerations that will need to be evaluated which could impact that conclusion (e.g., pricing discounts offered for additional days or other optional goods/services).

Continuing care retirement communities (CCRC) have very unique considerations that will need to be evaluated and which could potentially have a material impact on the identification of performance obligations and pattern of revenue recognition. The American Institute of Certified Public Accountants (AICPA) Health Care Revenue Recognition Task Force recently issued a Working Draft of Implementation Issue #8-3 *Application of FASB ASC 606, Revenue from Contracts with Customers, to Continuing Care Retirement Communities*, which provides preliminary interpretive guidance for CCRCs accounting for 'Type A' life contracts

STEP 3

Determine the transaction price

The 'transaction price' under the new standard does not refer to gross charges based on established rates per the charge description master; rather, it is the amount the provider expects to be entitled to under the contract. This 'variable consideration' is determined based on third party payer contractual rates and estimates of collectible amounts for uninsured self-pay patients and patient-responsible balances after insurance (e.g. deductibles and co-pays) using the probability weighted 'expected value' method or the 'most likely amount' method. All relevant information should be utilized in estimating variable consideration, including historical trends, current conditions, and expected future activity.

The difference between gross charges and net variable consideration represents a 'price concession.' Contractual adjustments for third party payers are typically considered explicit price concessions, whereas reductions for patient

Practical Considerations – Classification of Bad Debt

Step 3 is anticipated to be one of the more challenging implementation areas of the new standard for healthcare providers. In many cases, it is expected that there will not be significant changes in the pattern of revenue recognition. However, one potentially significant change relates to the presentation and classification of bad debt when a provider assesses the patient's ability to pay prior to providing the services (e.g., elective surgery). In those cases, when a provider takes on specific credit risk with patient accounts receivable that are subsequently determined to be uncollectible, it may be more appropriate to record an impairment charge (i.e. bad debt) which would be presented as an operating expense, rather than an implicit price concession and reduction of revenue.

In any event, the amount reported as bad debt in the statement of operations for most healthcare providers will generally 1) become much smaller (as it will be reflective of implicit price concessions) as compared with historical prior period reporting, and 2) will move out of the 'revenue' section and into the 'expense' section of the financial statements.

responsible balances are typically considered implicit price concessions. Under the new standard, such implicit price concessions are not presented separately as 'provision for uncollectible accounts' or 'bad debts,' but are direct reductions of revenue, similar to contractual adjustments. Such amounts are not part of the transaction price and thus are not recognized as revenue in the first place.

Under the new standard, the transaction price is subject to a 'constraint,' whereby revenue is only recognized if it is probable there will not be a 'significant reversal' of such revenue. Thus, while this may not change resulting estimates, it may change the estimation process and/or the timing or pattern of recognition to the extent there is potential for significant reversals.

Third party settlements under the new standard are part of the variable consideration for patient revenues and are estimated in a similar manner as patient accounts receivable using the 'expected value' method or the 'most likely amount' method, whichever better predicts the amounts to which the provider is entitled.

Changes to variable consideration (including third party settlement estimates) subsequent to initial recognition (e.g. based on a change in estimate or actual collections) are accounted for prospectively, similar to other changes in estimates.

STEPS 4 AND 5

Allocate the transaction price and recognize the revenue

The final steps of the new revenue recognition model require an entity to allocate the transaction price (including variable consideration) to the performance obligations and to recognize the revenue based on those allocations when (i.e., at a point in time) or as (i.e., over time) the entity satisfies the performance obligations. Thus, performance obligations (as described in Step 2) and related revenue recognition policies need to be determined based on the nature of the services provided. Inpatient service revenues, including unbilled amounts due, would typically

Practical Considerations – Portfolio Approach

As discussed in Step 1, providers may use a 'portfolio approach' in applying the standard, including estimating variable consideration for a particular patient class. Care should be taken in selecting the level of portfolio disaggregation (i.e. pure self-pay, co-pays and deductibles, high-deductible plans), as this could have a significant impact on timing and amount of revenue recognized. In addition, consideration should be given to anticipated changes in pay classifications in estimating revenues (subject to the 'significant reversal' constraint). For instance, the amount of variable consideration to be recognized for patient accounts identified as 'Medicaid pending' can be evaluated under a portfolio approach to estimate the amounts to recognize for this 'temporary' classification of patient accounts that will ultimately result in 'permanent' classification as Medicaid, self-pay, or other classifications.

Providers should evaluate their current system capabilities to generate sufficient historical information to support the desired level of portfolio disaggregation.

be recognized 'over time' because the patient simultaneously 'consumes' the benefits of the goods and services as they are provided/performed by the entity.

The pattern of revenue recognition 'over time' should correspond with the measurement of progress toward satisfaction of the performance obligation, with the ultimate objective being an accurate depiction of 'an entity's performance in transferring control of goods or serviced promised to the customer.' One approach that acute care providers may utilize to measure progress during an inpatient stay is a 'time-and-effort' input method (i.e. cost-based approach), using established charges as a proxy for the relative cost/effort expended. Many skilled nursing facilities, on the other hand, may utilize a 'time-elapsed' input method, based on days of service.

When performance obligations are satisfied over time, providers are required to disclose the methods used to recognize revenue and why the methods provide a reasonable depiction of the transfer of goods and services.

For performance obligations satisfied at a point in time (e.g., a physical therapy visit), disclosures should include a discussion of the significant judgments in determining when there is a transfer of control of promised goods and services to the patient. Example disclosures are included in AICPA Implementation Issue #8-6 *Revenue Recognition Presentation and Disclosure Practice Aid.*

If there are multiple performance obligations (e.g., separate and distinct care coordination activities post-discharge, such as in a 'bundled' payment situation), then the transaction price is allocated across the performance obligations based on relative stand-alone values and then recognized as or when the obligations are satisfied.

RECENT DEVELOPMENTS

The AICPA continues to issue interpretive guidance on the application of the new revenue recognition standard to healthcare providers. Among other issue papers, the exposure document on risk sharing arrangements (applicable, for example, to Medicare's Comprehensive Care for Joint Replacement model), was recently exposed for public comment, which discusses the uncertainties in estimating variable consideration and the complexity associated with application of the CMS performance years with performance years of participating hospitals. In addition, the AICPA recently exposed its draft guidance on CCRC reporting issues, including the accounting for monthly and refundable and nonrefundable entrance fees for 'Type A' life contracts, significant financing components, and contract acquisition costs.

IN CLOSING…

The new revenue recognition rules have the potential to affect not only the timing, amount, and classification of revenue reported in the financial statements, but also the processes by which revenue estimates are developed. Additionally (and importantly), the new standard requires expanded qualitative and quantitative disclosure, including disaggregation of revenue, determination of performance obligations, and significant judgments involved in the revenue recognition process. In many instances, in addition to the core accounting changes, the expanded disclosure requirements under the new revenue recognition rules will have a significant impact on the effort required by preparers of healthcare financial statements.

In short, the time is **now** to take action - to re-evaluate the characteristics of your organization's revenue streams and define specific portfolio attributes for each of the 5 steps in the model; to identify new information needs; to update systems and processes; to revise policies and procedures; and to determine the nature and extent of documentation that will be needed to evidence compliance with the standard in the initial year of implementation.

For additional information, contact Norman Mosrie, DHG Healthcare partner, chair of the AICPA Expert Panel, and member of the HFMA Principles and Practices Board (norman.mosrie@dhg.com); Daron Tarlton, DHG Healthcare National Professional Standards Group (daron.tarlton@dhg.com) or any member of your DHG Healthcare service team.

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APPENDIX A - ASC 606 EFFECTIVE DATES

Public Entities (including certain NFP conduit bond obligors)		Nonpublic Entities
Annual Fiscal years ending	*Interim Fiscal quarters ending*	*Annual Fiscal years ending*
12/31/18	3/31/18	12/31/19
3/31/19	6/30/18	3/31/20
6/30/19	9/30/18	6/30/20
9/30/19	12/31/18	9/30/20

APPENDIX B - SIDE BY SIDE COMPARISON - ASC 605 VS. ASC 606

Existing Requirements under ASC 605	New Requirements under ASC 606
Wide variety of industry and transaction-specific rules that result in diversity in practice and lack of comparability	Single 5-step principles-based model consistently applied to substantially all contracts with customers, regardless of industry or transaction type
Revenue is recognized when earned and realizable	Revenue is recognized when, or as, performance obligations in a customer contract are satisfied
Gross patient charges are recognized for services provided, regardless of collectability, and reduced by estimated contractual adjustments, discounts, and bad debts to determine net patient revenue	Net patient revenue is recognized based on estimated variable consideration, measured at the 'expected value' or "most likely amount" to be collected, subject to the 'significant reversal' constraint (i.e. that it is probable there will not be a significant reversal of the revenue)
Provision for uncollectible accounts / bad debts is presented separately as a component of net patient service revenue	Price concessions (explicit and implicit) are not presented separately, while provision for uncollectible accounts / bad debts that meet certain criteria is presented as operating expense
Provision for uncollectible accounts / bad debts is reported as an operating expense only if related patient revenue is recognized to the extent that collection is expected; otherwise presented as a component of net patient revenue	Provision for uncollectible accounts / bad debts is reported as an operating expense if related patient revenue is determined not to be variable consideration and there is credit impairment of the patient receivable
Third-party settlements are measured based on a 'best estimate' approach	Third-party settlements are recognized and measured as variable consideration using either the 'expected value' or 'most likely amount' approach, subject to the "significant reversal" constraint
Limited disclosure requirements about revenue contracts and related accounting policies for revenue recognition and measurement	Robust qualitative and quantative disclosure requirements for revenue contracts and related recognition and measurement policies, for instance, disclosure of disaggregated revenues by category (for entities with public debt)

DHG

healthcare

191 Peachtree Street NE, Suite 2700
Atlanta, GA 30303

www.dhg.com/healthcare

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DIXON HUGHES GOODMAN LLP