The New Healthcare World of Revenue Recognition, ASC 606 - DECODING CHALLENGES FOR GOVERNMENT REIMBURSEMENT

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With you today

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Revenue Recognition Workshop
Healthcare

Agenda

- ASC 606 Overview
- Third Party Settlements - Step 1
- Third Party Settlement Processes and Methodologies
- Third Party Settlements - Step 3
- Third Party Settlement Estimate Inputs
- Presentation and Disclosure
ASC 606 Overview
Overview of ASC 606

The new revenue standard aims to improve accounting for contracts with customers by:

- Providing a more robust framework for addressing revenue issues as they arise
- Increasing comparability across industries and markets
- Requiring better disclosure

Applies to:

- Contracts with customers
- Gain/loss recognition of some nonfinancial assets (intangibles and PP&E)
- All industries, with certain specific transactions excluded: leases, insurance contracts, financial instruments, guarantees, certain nonmonetary exchanges
Overview of ASC 606

Effective Dates:

- Public entities - First interim period within annual reporting periods beginning after December 15, 2017 (January 1, 2018 for December 31 year-end)
- Nonpublic entities - Annual reporting periods beginning after December 15, 2018 and interim periods within annual periods beginning after December 15, 2019 (January 1, 2019 for December 31 year-end)

ASC 606 is required to be applied retrospectively by one of the following methods:

- Retrospective application to each reporting period presented in accordance with ASC 250-10-45-5 through 45-10 (i.e., full restatement of comparative figures)
- Modified retrospective with one or more practical expedients (i.e., completed contracts, use of hindsight for variable consideration, etc.)
- Cumulative effect of change at adoption date (disclose effect of applying new standard)
Overview of the 5 Step Model

Core principle:

Recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.
Third Party Settlements - Step 1
Step 1 - Third Party Settlement Estimates

- Healthcare is unique in that there are multiple parties involved in the transaction
  - Patient, provider, and payer (maybe multiple payers)

- Contracts with customer under ASC 606 refers to the arrangement between the provider and patient

- Separate contractual arrangement exists between the provider and payer
  - Establishes amounts third party payer will pay on behalf of patient

- While the separate payer agreements are not “contracts with customers” these agreements still need to be considered under ASC 606 in determining the transaction price (Step 3)
Step 1 - Third Party Settlement Estimates

- When the third party payer is a government program (Medicare or Medicaid), the contract for reimbursement is made through a provider agreement
  - Specifies terms of payment, coverage, circumstances for which payment may be denied, etc.

- Payments under provider agreements subject to complex laws and regulations, including provisions for retrospective adjustments to rates paid

- Retrospective adjustments are based on cost reports filed with CMS and are referred to as third party settlements

- Third party settlements exist in any arrangement where there is a reconciliation process and potential for retrospective adjustment
Step 1 - Third Party Settlement Estimates

Reimbursement areas potentially affected include the following:

Non-PPS payments

Medicare and Medicaid Interim Payments

Medicare Settlement Estimates
  • Bad Debt Reimbursement
  • Disproportionate Share Reimbursement (DSH)
  • Uncompensated Care Reimbursement
  • Medical Education Reimbursement

Medicaid Settlement Estimates
  • Supplemental Pool Payments (Medicaid DSH, QAF)
  • Cost Report Settlements (vary by state)
  • DSH Audits
  • Upper Payment Limit (UPL)

Other Non-PPS payments, Add-on payments and Incentive Payments
  • Bundled Payments
  • Value Based Purchasing
    • Quality Incentives
  • Risk Sharing Agreements (Medicaid HMO)
  • Medical Necessity Audits (RAC)
  • Outlier Payments

Other Considerations
  • Payors with low volume
    • OOS HMO’s
  • Non-contracted payors
  • Out-of-network claims
Third Party Settlement Processes and Methodologies
Medicare Settlement Process

- Medicare Cost Report Acceptance and Settlement Process
  - “As-Filed” - Due 150 days after fiscal year end
  - Tentative issued
    - Prior years audit experience may be applied by accepting auditor

- Settlement
  - Typically 6 to 24 months after cost report is filed
  - Incorporation of prior audit adjustments

- Appeals
  - Due 180 days after issuance of Notice of Program Reimbursement (NPR)
  - Often take significant time to resolve

- Re-openings
  - Due within 3 years after issuance of NPR
  - Often take significant time to resolve
Medicare Interim Payment Methodologies

- **Interim Payments**
  - Some providers receive interim payments for all or a portion of their cash flows from Medicare

- **Disproportionate Share (DSH)**
  - “Add-on” to DRG payment paid in interim based on prior statistic
  - Adjustments could be relatively minor or very substantial based on multiple payment criteria

- **Uncompensated Care**
  - “Add-on” to DRG payment paid in interim based on prior statistic
  - Adjustments typically approximate zero; however, could be material if hospital qualifies for DSH and was not projected to and/or if a hospital loses DSH eligibility during the year
Medicare Interim Payment Methodologies

- Medical Education
  - IME - “Add-on” to DRG payment paid in interim based on prior statistic
  - GME - Paid as a bi-weekly interim payment based on prior statistic
  - Settled in cost report settlement

- Bad Debts
  - Paid as a bi-weekly interim payment based on prior statistic

- Critical Access Hospitals (CAH)
  - Paid on an interim basis as they are cost reimbursed at final settlement
Third Party Settlements - Step 3
Step 3 - Third Party Settlement Estimates

- Amounts reimbursed under government programs (e.g. Medicare, Medicaid)
  - Subject to complex rules and regulations
  - Subject to retrospective adjustments
  - Can take several years to finalize

- Revenue from patients covered under government programs will typically have variable element

- Two methods available: Expected Value and Most Likely Amount
  - Should use best predictor
  - Not intended to be a “free choice” and should be applied consistently
Step 3 - Third Party Settlement Estimates

- **Expected Value**
  - The sum of the probability weighted amounts for a range of possible outcomes
  - Generally appropriate where there are a large number of contracts with similar characteristics

- **Most Likely Amount**
  - The single most likely amount of a possible range of outcomes
  - Generally appropriate when only two possible outcomes
  - However, ASC 606 does not limit the Most Likely Amount to only two possible outcomes
  - May be appropriate for third party settlements even though the outcome is not binary if it leads to a better predictive estimate
Step 3 - Third Party Settlement Estimates

- Estimate of variable consideration should consider the following:
  - Historical and current reimbursement information
  - Historical and current experience with the fiscal intermediary
  - Current charges, allowable costs, and patient statistics

- Method selected (expected value or most likely amount) needs to be applied consistently
Step 3 - Third Party Settlement Estimates

Step 3 - Determining Transaction Price - Constraint on Variable Consideration

- Again, in estimating third party settlements, it needs to be probable that there will not be a significant reversal of revenue based on final settlement.

- Factors to consider in applying the constraint:
  - Outside factors such as changes in regulations and reimbursement rates
  - Historical experience with similar contracts
  - Length of time to final settlement - Medicare and Medicaid settlements can take several years to resolve
  - Customary practice of offering concessions or negotiations - generally not applicable to Medicare and Medicaid as the government sets the prices and there is generally no negotiation with the government
  - Number of possible consideration amounts - often third party settlements vary widely period to period
Step 3 - Third Party Settlement Estimates

Step 3 - Determining Transaction Price - Constraint on Variable Consideration

- Given that many entities have a long history with government payors, the constraint may already be built into the estimation process, in which case a separate evaluation would not be necessary.

- If there is insufficient or limited historical experience the entity would be precluded from recognizing revenue until uncertainties are resolved.
Step 3 - Third Party Settlement Estimates

Step 3 - Determining Transaction Price - Reassessment of Variable Consideration

- Differences between original estimate and subsequent revisions are changes in the estimate of variable consideration
  - Accounted for as adjustments to revenue in the period of revision
  - Should disclose these differences in the financial statements
  - Differences not considered to be restatements unless they meet the definition of an error
Step 3 - Third Party Settlement Estimates

Step 3 - Determining Transaction Price - Significant Financing Component

- ASC 606 requires entities to consider the time value of money if the timing of payments provides the customer with a significant benefit of financing.

- ASC 606 indicates that there would not be a significant financing component if certain factors exist:
  - Customer paid in advance but deliver is at discretion of customer
    - Generally not applicable to healthcare
  - A substantial amount of the consideration is variable
    - Applicable to third party payors and settlements
  - Difference between promised consideration and cash selling price arises for reasons other than the provision of finance
    - Applicable to third party settlements as the timing aspect is unrelated to financing, rather it is related to the normal course of business.

- A significant financing component likely does not exist as the timing of the payment is at the discretion of a third party payor and not the customer.
Third Party Settlement Estimate Inputs
Medicare Settlements - Drivers of Reimbursement

Areas of potential application of the constraint in variable consideration for Medicare settlements include:

- **DSH - Medicaid days to total days and SSI**
  - Two thresholds achieving different reimbursement levels (15% and 20.2%), if below 15% do not qualify (all or none)
  - Need to be comfortable with statistical data utilized (paid and eligible days, SSI percentages)

- **Uncompensated Care**
  - Change in Distribution Methodology
  - Worksheet S-10 - not historically audited
    - Are totals included “auditable” and can variances be explained in detail?
Medicare Settlements - Drivers of Reimbursement

- Medical Education
  - Weighting of FTE’s
  - Out-rotations
  - Affiliation Agreements

- Bad Debts
  - Crossovers should have relatively low expected impact
  - Agency Bad Debts
  - Non-Title XVIII/Title XIX

- CAH
  - Current and prior year charges, cost structure, payor mix and volumes
Medicaid Settlements - Drivers of Reimbursement

Areas of potential application of the constraint in variable consideration for Medicaid settlements include:

- Prior years audit experience
  - Medicaid cost report settlements vary by state and entity type

- Upper Payment Limits (UPL)
  - Cost report
  - DSH
  - Other

- Medicaid DSH Audits
  - A lot of UPL not settled individually but ultimately settled through DSH audit limits

- Other Supplemental Payments
  - Initial Distribution
  - Re-distribution
Medicaid Settlements - Drivers of Reimbursement

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- Medicaid DSH Audits
  - A lot of UPL not settled individually but ultimately settled through DSH audit limits

- Other Supplemental Payments
  - Initial Distribution
  - Re-distribution
Non Hospital Provider Considerations

- **Home Health Agencies**
  - Episodic payments
    - 60 day episode of care
    - Paid as case-mix adjusted HH PPS
    - 60% paid at Request for Anticipated Payment (RAP)
    - 40% paid at billing of final claim
    - Likely not substantial exposure on a claim by claim basis

- **Skilled Nursing Facilities**
  - Episodic payments
    - Paid as case-mix adjusted PPS - Resource Utilization Groupings (RUG)
      - Initial RUG determination at billing
      - Final RUG determination at discharge
    - Likely not substantial exposure on a claim by claim basis
Presentation and Disclosure
Presentation

Balance sheet
An entity is required to present the following items separately:
- Receivables
- Contract assets*
- Contract liabilities*

* Alternative descriptions can be used, however if so an entity must provide sufficient information to distinguish ‘receivable’ from the name given to contract assets. This is because receivables represent an unconditional right to receive consideration, whereas contract assets represent a right to consideration in exchange for providing additional goods or services.

Income statement and other comprehensive income
- An entity presents revenue from contracts with customers separately from other revenue streams.
- Impairment on both receivables and contract assets is presented separately.
Disclosure

Qualitative and quantitative disclosures include:

i. The entity’s contracts with customers
   ▶ Disaggregation of revenue
   ▶ Information about an entity’s contract assets and contract liabilities (including reconciliations)
   ▶ Information about the entity’s performance obligations
   ▶ The entity’s remaining performance obligations at the end of the reporting period.

ii. Significant judgments in the application of the guidance
   ▶ Determining the timing of satisfaction of performance obligations
   ▶ Determining the transaction price and amounts allocated to performance obligations

iii. Assets recognized from the costs to obtain or fulfill a contract with a customer

iv. Use of practical expedients.