The New World of Revenue Recognition, ASC 606 -

NAVIGATING THE CHALLENGES OF CAPITATION PAYMENTS AND RISK-SHARING AGREEMENTS

July 25, 2018
With you today

STEVEN SHILL, CPA
Assurance Partner and National Leader, Healthcare BDO USA, LLP
714-668-7370 sshill@bdo.com

JOHN BLAKEY, CPA
Assurance Partner, SoCal Healthcare Practice Leader BDO USA, LLP
310-557-7514 jblakey@bdo.com
The BDO Center for Healthcare Excellence & Innovation

DRIVING THE FUTURE OF HEALTHCARE

We help clients redefine their strategies, operations, and processes based on both patient-centric demands and rigorous best practices - responding to the industry’s new market disrupters, cost pressures, and outcome-based reimbursement models.

Our Team:

- Healthcare Executives
- Investment Bankers
- Forensic Technologists
- Clinical Practitioners
- Economists & Statisticians
- Regulatory Specialists
- Valuation Professionals
- Auditors
- Tax Accountants
- Turnaround / Restructuring Advisors
- IT Specialists / Data Analysts
- Real Estate Planners & Advisors
Who We Are: About BDO

BDO INTERNATIONAL

Accounting & Audit 57%
Tax 22%
Consulting Advisory 21%

$8.1 billion revenues

162 COUNTRIES  1,500* OFFICES  73,854+ TOTAL PERSONNEL

EXCEPTIONAL SERVICE. WORLDWIDE.

With a network spanning more than 160 countries worldwide, BDO is the 5th largest global network of public accounting firms. Our seamless global approach allows us to serve clients through a central point of contact, granting access to relevant experience across borders — where and when our clients need us.

*Including exclusive alliance of BDO Member Firms.
Statistics as of year ended 9/30/17.
Learning Objectives

- Understanding the key concepts of capitation and risk sharing arrangements
- Strategic imperatives for successfully navigating capitation arrangements and other risk arrangements
- Applying the provisions of ASC Topic 606 to these arrangements
Healthcare is chasing “The Triple Aim”

- Results
- Dissemination of best practices
- Enhanced data exchange

Data Sharing

- Performance relative to peers
- Episodes data
- Care pathway development
- CI metrics

Opportunity Identification

- Sites of care (hospital, outpatient, professional)
- Most efficient and high quality specialists
- Condition specific: chronic disease, elective care

Population Health

- Care pathway use
- Directing care to highest performing

Standardization and Optimization

- PCMH
- CQI
- Lean/TPS

Process Improvement

Care Experience  Cost per Capita

Observation and Learning

The New World of Revenue Recognition, ASC 606 - Navigating the Challenges of Capitation Payments and Risk-Sharing Agreements
Industry Pillars

- Value-Based Care (FKA P4P)
- Integration & Innovation
- Technology
- Patient/Consumerism
Migration to “Value Based Care”

The Movement to “Value-Based Care” (VBC) Via Payor Contracts and “Accountable Care” Models

Different metrics, initiatives and contract models in Medicaid, Medicare Advantage, Commercial products

Fee for Service  Pay for Performance  Medical Home Models  Accountable Care Organization (ACO)  Shared Risk  Global Payment or % Premium

Provider Accountability

The New World of Revenue Recognition, ASC 606 - Navigating the Challenges of Capitation Payments and Risk-Sharing Agreements
The New World of Revenue Recognition, ASC 606 - Navigating the Challenges of Capitation Payments and Risk-Sharing Agreements

**Reimbursement**

**Capitation - Revenue Flow Model**

- **Capitation revenue**
- **Net impact of capitation less claims and other expenses = surplus or deficit (contractual sharing arrangements)**
- **Out-of-network Claims/ IBNR estimates**
- **In network Claims/ IBNR estimates**
- **Other expenses/recoveries**

**Risk share Physicians**

- Complex accounting
- No AR
- High Risk
- Loss
- Contracts
- Disputes
- Litigation

Encounters

$
Reimbursement (cont’d.)

Bundled Payment Model

- Multiple models
- Untested/new
- Post-period reconciliations
- Potential for disputes
- Complex accounting

Gainsharing bonuses

Hospital services

Post-acute service

Physician services
# Definitions

<table>
<thead>
<tr>
<th>Capitation</th>
<th>PMPM</th>
<th>Division of Financial Responsibility (DOFR)</th>
<th>Full Risk Agreement</th>
<th>Shared Savings/Shared Risk Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue under these arrangements is earned as a result of agreeing to provide services to enrollees for a per member, per month fee without regard to the actual amount of services provided.</td>
<td>Per Member Per Month</td>
<td>DOFR is a tool used in the contracting process by health plans, physician organizations and hospitals in capitated or shared risk payment arrangements to define which party is financially responsible for services rendered.</td>
<td>Contracts in which providers assume financial risk for a defined population of patients not only for their own financial performance, but also for the performance of other providers in the network.</td>
<td>In a shared savings arrangement, the payer creates financial incentives for the provider to meet specific contract metrics such as controlling costs or improving quality of a predetermined patient population by sharing a percentage of the savings obtained for achieving or exceeding certain benchmarks.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utilization Review (UR)</th>
<th>Medical Loss Ratio (MLR)</th>
<th>BPCI</th>
<th>Fee-For-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The critical examination (as by a physician or nurse) of health-care services provided to patients especially for the purpose of controlling costs (as by identifying unnecessary medical procedures) and monitoring the quality of care.</td>
<td>Medical Loss Ratio is a common performance metric used by health plans to measure profitability.</td>
<td>Bundled Payment for Care Initiative</td>
<td>Under fee-for-service contracts, the provider earns revenue for providing patient services.</td>
</tr>
</tbody>
</table>
## Risk Contract Overview

<table>
<thead>
<tr>
<th>Pool Methodology (No Delegation)</th>
<th>Partial Risk (Some Delegation)</th>
<th>Global Risk (Full Delegation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums are allocated to Pools, and providers share in upside/downside of Pool Balances once claims are paid out of pools</td>
<td>Payor capitates a network for “Part B” services (physician, some OP Facility). Typical Revenue Components: Base Capitation, Utilization Fund, QI Fund, Pharmacy Fund</td>
<td>Network/IDS assumes “full risk” for a population (Premium Categories: Part A/Hospital, Part B/Physician, Part D/Pharmacy; often an “Exclusion” Pool/Fund that remains Plan Risk)</td>
</tr>
<tr>
<td>Pool Funding: Hospital 40%, Physician 35-40%, Health Plan 15-20% (dependent on which the plan retains)</td>
<td>Network serves as mini-HMO: Manages Eligibility, Provider Credentialing, Claims Payment, Medical Management, Customer Service, QI</td>
<td>Increasingly common in Medicare Advantage, Provider Sponsored Plans, Medicaid Plans</td>
</tr>
<tr>
<td>Members either enroll or are “Attributed” to your network/PCPs</td>
<td>Often includes incentives to provide services in non-hospital settings, and PHM metrics (i.e., HEDIS, HCAPS).</td>
<td>Ensure Premium Stewardship in Commercial Models, Risk Adjustment and Pharmacy Rebates in Governmental and Marketplace</td>
</tr>
<tr>
<td>Avoid Downside Risk in Attributed Models and/or where you can’t control claims and unit prices</td>
<td>Ensure that you and payor have a detailed Division of Financial Responsibility (DOFR) clearly and comprehensively detailing what services are paid from which pool</td>
<td>Need fully functional MSO, Finance and Risk Management Capabilities; 3rd party Reinsurance and IBNR calculation</td>
</tr>
<tr>
<td>Clear/concise DOFR</td>
<td>Broad network to provide as much care in network/under contract Medical Management geared toward Wellness, Transitions, Care Coordination (not on old school UR or UM)</td>
<td></td>
</tr>
</tbody>
</table>
Risk Contracting Foundational Principles

- That’s Why They Call it Risk:
- Know Your Numbers:
- Understand Delegation Requirements:
- Educate Your Members:
- Engage Your Clinicians:

- Must haves:
  - A payor partner who wants you to succeed
  - Engaged physicians (and hospitals if hospital in risk model)
  - Good “back office” or MSO partner
  - Understanding of how to maximize Contract Incentive Programs
Risk Contracts: Best Practices

Medical Management
Finance & Reimbursement
Operations
Commercial Payor ACO Models

Most commercial payors moving to:

- Additional reimbursements for “Quality” (Quality, Cost, Admin Compliance, Patient Satisfaction)
- Offering providers online access to data (claims data, patient registries)
- Future rate increases dependent upon provider performance (cost, quality, service metrics)
- Narrow networks
- Global Risk
- Expansion into Medicare, Medicaid, Individual/Marketplace products
Applying ASC 606 - Revenue from Contracts with Customer

Introduction and Transition

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.

Steps to apply the core principle are:

- **STEP ONE:** Identify the contract
- **STEP TWO:** Identify separate performance obligations
- **STEP THREE:** Determine transaction price
- **STEP FOUR:** Allocate transaction price to performance obligations
- **STEP FIVE:** Recognise revenue when each performance obligation satisfied
Applying ASC 606 - Revenue from Contracts with Customer

Introduction and Transition

Effective dates:

- Public entities - 1st interim period within annual reporting periods beginning after Dec 15, 2017

- Nonpublic entities - Annual reporting periods beginning after Dec 15, 2018 and interim periods within annual periods beginning after Dec 15, 2019
Applying ASC 606 - Revenue from Contracts with Customer

Introduction and Transition

- Applies to contracts with customers, which may include in certain circumstances:
  - Collaborations arrangements
  - Gain/loss recognition on sale of some nonfinancial assets (intangibles and PP&E)
  - Applies to all industries, with certain specific transactions excluded: leases, insurance contracts, financial instruments, guarantees, certain nonmonetary exchanges
Applying ASC 606 - Revenue from Contracts with Customer

Introduction and Transition

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

- i. 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).
- ii. Modified retrospective with one or more practical expedients (i.e., completed contracts, use of hindsight for variable consideration, etc.), reflected as a cumulative effect in retained earnings at beginning of period of adoption.
Step 1- Identify the Contract

- Fee-for-Service arrangements - Contract is with the patient and not the payor:
  - For purposes of FASB ASC 606, “contract with the customer” refers to the arrangement between the health care provider and the patient.
  - Patient is receiving substantially all of the benefits of the contract. i.e. they are the recipient of the healthcare services.
  - Separate contractual agreements that exist between providers and payors which establish amounts to be paid on behalf of the patients are not considered separate contracts with customers.
  - Used to determine the transaction price.

- Capitation arrangements: For healthcare providers the contract is with the patient:
  - While the payor has transferred the financial risk for eligible contracted services to healthcare providers the services have to be provided by the providers to eligible beneficiaries.
Step 1- Identify the Contract

Five criteria under ASC 606-10-25-1 must be met in order for there to be a contract with a patient (customer):

1. Parties to the contract have approved the contract
   a. In writing or orally, or in accordance with other customary business practices
2. The party can identify each party’s rights regarding services to be transferred
3. The entity can identify the payment terms for the goods or services
4. The contract has commercial substance
5. Probable that the entity will collect substantially all of the consideration
Step 2- Identify Separate Performance Obligations

Definition of a ‘distinct’ good or service

Can the customer benefit from the good or service, either on its own, or with other readily available resources?  

(‘readily available resources’ are those that the customer possess or is able to obtain from the entity or another third party)

- No
- Yes

Is the promise to transfer a good or service separate from the other promised goods or services in the contract? Indictors may include:

- The entity does not provide a significant service of integrating the goods and services
- A good or service does not significantly modify or customize the other goods and services
- A good or service is not highly dependent or interrelated with the other goods and services

- No
- Yes

The good or service is distinct

The good or service is not ‘distinct’

(These are then grouped into ‘bundles’ of goods and services that are themselves ‘distinct’)

BDO
Step 2- Identify Separate Performance Obligations

Performance Obligation Considerations - Bundled payment scenario:

- Nature of the contract was for the provider to transfer the combined services.
- Patient’s expectation is to receive combined service.
- Provider provides a significant service of coordinating the care in the determination of the nature and extent of each of the individual services.
- Each of the services are highly dependent upon and integrated with the other services. Patient is not in a position to decide whether or not to purchase individual distinct services.

Care Coordination Services

- Some hospital may coordinate activities or provide case management services as these may be in the best interest of the hospital to manage costs.
- These types of care coordination activities do not transfer an additional good or service that are distinct.
Step 3 - Determine the Transaction Price

Key Consideration - Bundled Payment Scenario:

- **Portfolio Approach** - group individual contracts into portfolios consistent with CMS performance groups
- **Variable consideration**
  - Estimated transaction price is recognized to the extent it is probable that significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty is resolved.
- **Expected Value** or most likely amount methods
- **Transaction price variable component consists of:**
  - DRG payments for the patient contracts in the portfolio
  - Plus/Minus bonus or penalty amount
Retrospective Adjustment Estimation Consideration - Bundled Payment Scenario

• Estimate of the potential retrospective adjustment (payable or receivable) needs to be considered at each financial reporting date.
• Estimation process should consider:
  • Estimate calculated by patient contracts organized in a portfolio by CMS performance year
  • Consideration of actual episode spending compared to target episode prices
  • Adjustments to the target episode price for Hospital’s quality scores
  • Financial impact of overlaps with other CMS payment models i.e. shared savings.
**Step 3 - Determine the Transaction Price**

Probability of Significant Reversal - Factors to Consider

- **Lack of sufficient data**
  - Portion of consideration that is variable should be excluded from the transaction price until it becomes probable that there will NOT be a significant reversal.

- **Sufficient data**
  - If sufficient data such that it is probable that a significant revenue reversal would not occur upon resolution of the final amount, that amount should be estimated using one of the two methods is the better predictor:
    - Expected Value
    - Likely Amount
Step 3 - Determine the Transaction Price

- Probability Assessment
  - Providers should evaluate the uncertainties related to the variable considerations in order to assess the likelihood and magnitude of a revenue reversal including the following:

- Factors to consider include:
  - Availability of robust independent data related to claims filed across the spectrum of care
  - Availability of historical data may provide low predictive value
    - Whether the amount of the third party settlement is highly susceptible to factors outside the entity’s influence.
    - The entity’s experience with similar types of contracts.
    - How long the period is until the uncertainty is resolved.
Step 3-Determine the Transaction Price

Accounting considerations for uncertainties

- Probable reversal will not occur
  - At each reporting date, a hospital should adjust the transaction price based on its updated estimate of the amount payable to CMS under the stop-loss limits applicable to that performance year.

- Not probable reversal will not occur
  - At each financial reporting date, the reduction of the transaction price (due to the constraint) for the amount potentially repayable associated with the portfolio for that performance year should reflect the maximum amount potentially repayable to CMS under the stop-loss limits applicable to that performance year.
Step 3-Determine the Transaction Price

Interim Reporting

- Estimated bonus or penalty should be determined in each interim period on a pro-rata basis in proportion to the services rendered in the interim period, with each interim period bearing a reasonable portion of the anticipated annual amount. NG2

Significant Financing Component

- A significant financing component does not exist because the timing of the payment is at the discretion of CMS and does not involve the patient (that is, the customer).
I have edited out the last word

Nanda Gopal, 7/20/2018
Step 4 - Allocate the transaction price to the performance obligations

In this scenario, the entire transaction price is allocated to the single performance obligation.
Step 5- Recognize Revenue

Revenue is recognized as/when an entity satisfies each performance obligation.

Satisfaction occurs as/when the entity transfers control (the ability to direct the use of and obtain substantially all of the remaining benefits from an asset, or prevent others from doing so) of the goods or services to the customer.

Revenue is recognized either:

(i) Over time, when the following criteria are met:

- The customer simultaneously receives and consumes all of the benefits provided by the entity’s as the entity performs;
- The asset that is created or enhanced is controlled by the customer;
- The entity’s performance does not create an asset with an alternative use to the entity AND there is an enforceable right to payment for performance completed to date.

(ii) At a point in time:

- If the criteria for recognition over time under ASC 606 are not met.
Case Study - Bundled Payment

Facts available as of June 30, 2018:

- Fiscal year ended June 30, 2018
- CMS (PY1) performance period ended December 31, 2018
  For the six month period ended June 30, 2018 70 patients have episodes ending in the CMS PY1.
- For the six month period ended December 30, 2018 an additional 30 patients have episodes ending in CMS PY1.
- DRG payment is $12,500 per discharge
- Initial target episode price $25,000
- Target episode price based on Hospital’s actual quality score earned for the PY $25,425
  Stop gain/loss percentage 10%
- As of June 30, 2018, Hospital determines that the amount of variable consideration included in the transaction price related to CMS PY1 should be constrained
- As of March 31, 2019, Hospital determines that it has sufficient data to make a reasonable initial estimate of the PY1 penalty or bonus estimate that was previously constrained
Case Study - Bundled Payment

Determination of Transaction Price as of June 30, 2018

Patient service revenue $875,000
Less:
Minimum potential compensation per patient $10,000
Number of patients 70
Total minimum potential compensation $700,000

Total reduction of the transaction price (constraint) for amounts potentially repayable $175,000
Case Study - Bundled Payment

Facts available as of March 31, 2019:

- Target episode price based on Hospital’s actual quality score earned for the PY $25,425.
- Hospital estimates that the CMS total spending for episodes in this portfolio, including the MS-DRG payments made to Hospital and the amounts billed for services provided by all other post-acute providers associated with the episodes, will be $2,600,000.
- As of March 31, 2019, Hospital determines that it has sufficient data to make a reasonable initial estimate of the PY1 penalty or bonus estimate that was previously constrained.
Case Study - Bundled Payment

Determination of Transaction Price as of March 31, 2019

Total estimated CMS spend $2,600,000

Less:
- Minimum potential compensation per patient $25,425
- Number of patients $100
- Estimated quality-adjusted target episode payments 2,542,500

Total PY1 estimated CMS liability $57,500
Case Study - Bundled Payment

Determination of Transaction Price as of March 31, 2019 (continued)

Apportionment between FY 2018 and FY 2019 is based on a proration based on the number of episodes in each period

<table>
<thead>
<tr>
<th></th>
<th>FY 2018</th>
<th>FY 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CMS PY1 estimated CMS liability</td>
<td>$40,250</td>
<td>$17,250</td>
</tr>
<tr>
<td>Allocation (70/100)</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>$57,500</td>
<td>$57,500</td>
</tr>
</tbody>
</table>
Case Study - Bundled Payment

Facts available as of June 30, 2019:

- Final reconciliation report for CMS PY1 shows total CMS spending is $2,300,000.
- Hospital’s audit quality score is “good” resulting in a total quality-adjusted target price of $2,550,000.
- Hospital evaluates the impact of this information on its estimate of variable consideration for the year ended June 30, 2018. Hospital attributes the spending difference to PY1 claims that have not yet been processed by CMS and determines that its original spending estimate of $2,600,000 should not be revised.
Case Study - Bundled Payment

Determination of Transaction Price as of June 30, 2019 (continued)

Revised estimate of the penalty for CMS PY1

Total estimated CMS spend $2,600,000

Less:
Total quality-adjusted target price of $(2,550,000)

Total CMS PY1 estimated CMS liability $50,000
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.
Healthcare industry leadership

INDUSTRY ASSOCIATION & EVENT PARTICIPATION

- Healthcare Financial Management Association (HFMA) HFMA is the nation’s premier membership organization for healthcare finance leaders. BDO has membership and involvement with regional and local chapters throughout the U.S;
- National Investment Center, The National Investment Center for the Seniors Housing & Care Industry (NIC) is a 501(c)(3) organization whose mission is to facilitate informed investment in the long-term care space. Members of national Healthcare group are active members of NIC, and BDO is the only accounting firm sponsor of NIC’s national conference (held in October) and regional conference (held in March);
- American Hospital Association
- American Health Lawyers Association
- California Hospital Association
- Columbia Business School Healthcare Conference
- Harvard Business School Healthcare Conference
- HealthLeaders Media
- J.P. Morgan Annual Healthcare Conference
- LeadingAge
- McDermott, Will & Emery Litigation, Compliance & Investigations Healthcare Conference
- Medical Group Management Association
- New England Journal of Medicine Catalyst Research Program
- Pediatric SuperGroup Conference
- Polsinelli Dealmakers Conference
- Wharton Healthcare Conference
- Women in Bio
- Healthcare Business Women’s Association

BDO KNOWS HEALTHCARE: THE BLOG OF THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

The BDO Knows Healthcare blog (http://healthcareblog.bdo.com) is a resource and discussion platform focused on critical issues impacting the industry and re-defining the future of care. Our posts explore how reimbursement and regulatory changes re-shaping provider and payer business models, covering both the financial and clinical implications and drawing on our depth of experience in healthcare finance, operations and clinical practice. We will also touch on the myriad compliance and risk management challenges healthcare organizations face, as well as M&A and capital strategies.