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Revenue Recognition: Impact on Hospice/LTC

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Today’s Speaker

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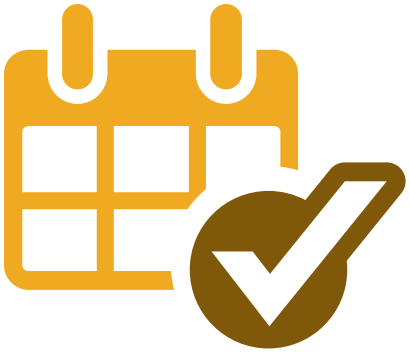
Agenda

- Healthcare Example: New Five-Step Model for Revenue Recognition



- Implications for Hospice/LTC
  - Portfolio Approach
  - Bad Debt Expense
  - Third Party Settlements
  - Footnote Disclosure Requirements

- Continuing Care Retirement Communities: Specific issues being discussed by RRWG and FinREC

Objectives

As a result of participating in this session, you should be able to:

- Discuss how the portfolio model can be used as a practical expedient for like contracts
- Describe how bad debt expense presentation is changing
- Implement changes to footnote disclosure requirements
- Discuss the new requirements for assessment of a significant financing component
- Describe the ways in which CCRCs may account for contract costs

Implications for Hospice/LTC

HC Example: Five-Step Model for Revenue Recognition

ASC 606:

> > > **Example 3—Implicit Price Concession**

606-10-55-102 An entity, a hospital, provides medical services to an uninsured patient in the emergency room. The entity has not previously provided medical services to this patient but is required by law to provide medical services to all emergency room patients. Because of the patient's condition upon arrival at the hospital, the entity provides the services immediately and, therefore, before the entity can determine whether the patient is committed to perform its obligations under the contract in exchange for the medical services provided. Consequently, the contract does not meet the criteria in paragraph 606-10-25-1, and in accordance with paragraph 606-10-25-6, the entity will continue to assess its conclusion based on updated facts and circumstances.

- Paragraph 606-10-25-1 = Step 1 = a contract does not exist under the standard since the parties are not able to determine if the patient is committed to perform its obligations under the contract until it obtains certain information about the patient.

- Paragraph 606-10-25-6 = An entity shall continue to assess the contract to determine whether the criteria in Step 1 are subsequently met (and the entity is able to recognize revenue).

HC Example: Five-Step Model for Revenue Recognition

- Credit risk evaluation
- Payor class assessment

- Transaction price:
  - Customary business practices
  - Variable consideration constraints

- Credit risk evaluation
- Revenue recognition

606-10-55-103 After providing services, the entity obtains additional information about the patient including a review of the services provided, standard rates for such services, and the patient's ability and intention to pay the entity for the services provided. During the review, the entity notes its standard rate for the services provided in the emergency room is $10,000. The entity also reviews the patient's information and to be consistent with its policies designates the patient to a customer class based on the entity's assessment of the patient's ability and intention to pay. The entity determines that the services provided are not charity care based on the entity's internal policy and the patient's income level. In addition, the patient does not qualify for governmental subsidies.

606-10-55-104 Before reassessing whether the criteria in paragraph 606-10-25-1 have been met, the entity considers paragraphs 606-10-32-2 and 606-10-32-7(b). Although the standard rate for the services is $10,000 (which may be the amount invoiced to the patient), the entity expects to accept a lower amount of consideration in exchange for the services. Accordingly, the entity concludes that the transaction price is not $10,000 and, therefore, the promised consideration is variable. The entity reviews its historical cash collections from this customer class and other relevant information about the patient. The entity estimates the variable consideration and determines that it expects to be entitled to $1,000.

606-10-55-105 In accordance with paragraph 606-10-25-1(e), the entity evaluates the patient's ability and intention to pay (that is, the credit risk of the patient). On the basis of its collection history from patients in this customer class, the entity concludes it is probable that the entity will collect $1,000 (which is the estimate of variable consideration). In addition, on the basis of an assessment of the contract terms and other facts and circumstances, the entity concludes that the other criteria in paragraph 606-10-25-1 also are met. Consequently, the entity accounts for the contract with the patient in accordance with the guidance in this Topic.

Polling Question #1

Gross patient service revenue under ASC 606 will likely:

A. Increase

B. Decrease

C. Stay the same

Implications for Hospice and Long-term Care/CCRCs

- Re-assessment of revenue recognition accounting policies and procedures; consider impacts on policies arising from your customary business practices
- Greater analysis and documentation of contract types and their performance obligations
- Estimation of transaction price, including constraints on variable consideration (e.g., price concessions, discounts, charity care), and assessment of patient's intent and ability to pay
- Assessing current portfolio models for size and composition; it is possible organizations may need to disaggregate their current grouping levels and / or classifications.
- Potential for revenue recognition delays ("outside the model")
- Increased disclosure

Application of the Portfolio Approach

- Requires significant judgments
- Can be useful to predict outcomes (estimate a transaction price)
- Monitor and periodically update for changes in collection patterns / reimbursements
- Assess the effectiveness of the overall portfolio composition; maintain documentation to support that it does not materially differ from applying an individual contract approach.
- Characteristics for grouping individual contracts (performance obligations) can include:
  - Type of service - inpatient, outpatient, emergency room, elective procedures, non-elective procedures, physician practice, skilled nursing, home health, etc.
  - Type of payor - 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. May also consider the size of co-pay or deductible (for example, high deductible)
  - Whether contracts are entered into at or near the same time (same quarter)

Bad Debt Expense

- **Current guidance:** the collectability assessment does not affect revenue recognition; it only affects the presentation of bad debt expense on the income statement.

- **New standard:** bad debt expense will be classified as an operating expense for all entities; a reduction in the amount of bad debt expense recognized is anticipated. Note: Charity care is not impacted by this new standard.

- **Reminder:** the amount of revenue recognized will be based on the estimated transaction price.

- **Effect:** This could significantly decrease gross revenue and change the presentation of revenue and bad debt expense in an organization's financial reporting.

Polling Question #2

Bad debt expense is expected to be impacted in the following way under ASC 606:

A. No real change from current practices

B. All healthcare entities will present bad debt expense as an operating expense

C. Bad debt expense will likely decrease

D. Both B and C

Third Party Settlements

- Hospice and LTC are not under retrospective rate-setting systems.
- In Hospice, third party settlements typically arise from compliance audits that vary in reviewed claims, scope, and auditor.
- Variable consideration: Ways to estimate
  - Expected value method
  - Most likely amount method
  - The method chosen should be based on which will be more accurate, not which will be easier.
- Factors to consider:
  - Historical and current reimbursement information
  - Historical and current experience with the fiscal intermediary
  - Current charges, allowable costs, and relevant patient statistics
- In summary:
  - Third party settlements not expected to materially change for hospice and LTC providers unless history becomes more representative of the future.
  - See Issue 8-8 for more details about the above approaches.

Footnote Disclosure Requirements

It is anticipated health care organizations will experience a significant increase in their footnote disclosures from current practices!

606-10-50-1 The objective of the disclosure requirements is for an entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers. To achieve that objective, an entity shall disclose qualitative and quantitative information about all of the following:

a) Its contracts with customers (see paragraphs 606-10-50-4 through 50-16)

b) The significant judgments, and changes in the judgments, made in applying the guidance in this Topic to those contracts (see paragraphs 606-105-50-17 through 50-21)

c) Any assets recognized from the costs to obtain or fulfill a contract with a customer in accordance with paragraph 340-40-25-1 or 340-40-25-5.

Footnote Disclosure Requirements (continued)

New qualitative and quantitative disclosure requirements:

- Disaggregation of revenue
  - How do economic factors, such as the following, impact the nature, amount, timing and uncertainty of revenue and cash flows from contracts with customers: payor type, geographic considerations, types of contracts (fee-for-service, per diem, per case, episodic, etc.), segments and / or lines of service (routine home care, inpatient care for Hospice, independent living, assisted living, skilled nursing for CCRCs, etc.).
  - Nonpublic entities may elect to provide alternate disclosures to comply
- Information about contract balances
  - Opening and closing balances of receivables, contract assets, and contract liabilities
  - Revenue recognized in the reporting period that was included in the contract liability balance at the beginning of the period
  - Nonpublic entities may elect to provide alternate disclosure to comply
- Enhanced information about performance obligations

Footnote Disclosure Requirements (continued)

New qualitative and quantitative disclosure requirements:

- Enhanced information about remaining performance obligations with an original expected duration of more than one year
  - Nonpublic entities may elect not to provide these disclosures
- Significant judgments and changes in judgments
  - Nonpublic entities may elect not to provide certain of these disclosures
- Assets recognized for contract costs
  - Nonpublic entities may elect not to provide these disclosures

Polling Question #3

My entity currently includes the minimal amount of required revenue disclosure information in our financial statements. Our finance department frequently prepares other more detailed revenue analysis for internal use and for owner and investor presentations. What is the appropriate level at which to disclose disaggregated revenues under the new revenue standard?

A. No real changes from current practices

B. Disaggregated revenue information is only needed for different geographies or major lines of service

C. The lowest level of revenue reporting available that is utilized by our organization for decision making purposes

D. Disaggregated revenue information into categories that depict how the nature, amount, timing, and uncertainty of revenue are affected by economic factors

Implications for Continuing Care Retirement Communities

Continuing Care Retirement Communities

- Various types of contracts
  - Promises of care –Type A
  - Use of facilities –Type C
  - Blend – Type B

- Components of a typical contract:
  - Nonrefundable: Generally recognized as income based on resident life expectancy
  - Refundable: Generally not amortized and now narrow exception is eliminated
  - Monthly fees

- Revenue recognition for the nonrefundable portion of contracts that include healthcare services will have the most impact under the new standard
  - Care under this model could be back loaded when the resident needs nursing care
  - Revenue may also be recognized more at the end of the contract to match the expected level of services provided but various options are being discussed

Continuing Care Retirement Communities (continued)

- The following CCRC issues are being considered by the RRWG as they relate to the transaction price of contracts:
  - Aggregation of fees and recognition of revenue for Type A contracts
  - Recognizing performance obligations for future service and use of facilities
  - Determining if a significant financing component exist as part of the entrance fee contract
  - Contract costs: Already issued

Continuing Care Retirement Communities (continued)

Financing component - general

- CCRCs required to evaluate each contractual arrangement with residents to determine if contract provides a significant benefit of financing to either party.
  - Financing component either explicitly identified or implied via payment terms of contract.
- Assessment as to whether a significant financing component exists is done at the contract level.
- Entity does not need to account for a financing component if the effects of the financing component are considered immaterial to the individual contract.
- The assessment of *significance* requires the CCRC to apply judgment. CCRC may not need to adjust the promised amount of customer consideration if the effects of the financing component will not materially change the revenue recognized.

Continuing Care Retirement Communities (continued)

Financing component – determining whether the transaction price contains a significant financing component

- Refundable entrance fees received by a CCRC from residents are not part of the transaction price and therefore do NOT need to be considered as part of a CCRC's significant financing component.

- Non-refundable entrance fee contracts must be evaluated to determine if a significant financing component exists. Evaluations should be made based on the provisions of each resident contract.

- CCRCs need to consider all facts and circumstances in assessing nonrefundable advance (entrance) fee payments in determining if a significant financing component exists.

- CCRCs need to consider the combined effects of the following:
  - (1) expected length of time between entity transfers goods or services to customer and when the customer pays for the goods or services
  - (2) Prevailing interest rates in the relevant market place.

Continuing Care Retirement Communities (continued)

Financing component – determining whether the transaction price contains a significant financing component (continued)

- Combined effect of timing and the prevailing interest rates may provide a strong indication that a significant benefit of financing is provided.

- Entities should consider whether the advance fee provides the resident with the assurance that promised services will be provided when assessing whether a significant financing component exists.

- If a nonrefundable advance (entrance) fee arrangement contains a significant financing component, the CCRC would need to determine whether the financing component materially changes the amount of revenue recognized in relation to the contract.

- Situations in which a CCRC would not have a significant financing component:
  - Customer paid for the goods or services in advance and the timing of the transfer of those goods or services is at the discretion of the customer.

Continuing Care Retirement Communities (continued)

Discount rate

- Upon contract inception, an entity cannot update the discount rate for changes in interest rates or other circumstances (e.g. change in assessment of the customer's credit risk).

- Once a CCRC determines that a significant financing component is present and adjusts the promised consideration accordingly, the entity would continue to use the same assumed discount rate for the specific contract assessed unless there is a contract modification that results in the original contract being effectively terminated.

Continuing Care Retirement Communities (continued)

Practical expedient

- Adjusting the promised amount of consideration for the effects of a significant financing component
  - Entity does not need to adjust promised amount of consideration for the effects of a significant financing component if, at contract inception, the period between the entity transferring the goods or services and the customer paying for the goods and services is less than one year.
  - Most CCRCs provide for good or services beyond one year and this practical expedient will not apply.
  - Other healthcare entities will need to consider expected timing of payments to determine if it can elect the practical expedient.

Continuing Care Retirement Communities (continued)

Future service obligations

- CCRCs will need to determine if its calculation of the future service obligation (FSO) will be affected upon the adoption of ASC 606.

- Determination of 2 components of the FSO calculation may change:
  - Unamortized deferred revenue (Issue 8-3)
  - Unamortized costs of acquiring initial contracts (Issue 8-7)

- Methodology used to calculate a CCRC's obligation to provide future services does not change with revenue recognition updates.

Continuing Care Retirement Communities (continued)

Future service obligations (continued)

- Unamortized deferred revenue (contract liability)
  - Several acceptable approaches for recognizing the material right resulting from the nonrefundable upfront fees.
  - CCRCs should determine if the unamortized deferred revenue (contract liability) recorded on a CCRC's balance sheet under ASC 606 may be calculated differently than under current guidance, when preparing the FSO calculation.

- Unamortized costs of acquiring initial contracts
  - CCRCs should determine if the capitalization of certain types of costs (e.g. sales commissions) related to acquiring a CCRC resident contract will change as a result of adopting ASC 606.

- CCRCs are recommended to review all other applicable guidance related to FASB ASC 606 to become aware of the potential changes to the two components of the FSO calculation.

Polling Question #4

The methodology for determining future service obligations is changing under ASC 606.

A. True

B. False

Continuing Care Retirement Communities (continued)

Contract Costs

- The new standard includes specific guidance for accounting for certain costs related to obtaining or fulfilling a contract with a customer
- Incremental costs that are expected to be recovered under a prepaid healthcare services contract may be recognized as an asset going forward
- Costs which have been expensed in the past may need to be capitalized
- Capitalized costs will be amortized in a manner consistent with the pattern of the transfer of goods or services to which the asset relates
  - Practical expedient to expense cost if the period of amortization is less than one year
- Any recorded asset will be subject to an ongoing impairment assessment

Continuing Care Retirement Communities (continued)

Contract Costs (continued)

- Example situation:
  - A CCRC incurs the following costs to obtain an entrance fee contract that will provide for future services over the life of the resident
  - The CCRC has determined that the costs incurred would be recoverable from the fees generated from the contract
  - Incremental costs to obtain a contract:

• Sales commission to employees directly related to the contract	$10,000
• External legal fees for due diligence	5,000
• Actuarial report	1,000
• Total costs incurred	$16,000

  - How are these costs treated?
    - Sales commission is capitalized
    - Actuarial report and legal fees are expensed

Continuing Care Retirement Communities (continued)

Contract Costs (continued)

- Example – Amortization and Impairment
  - CCRC has capitalized $10,000 of contract acquisition costs
  - What is the amortization period?
    - Need to consider the pattern of transfer of services:
    - Option 1:
      - Allocate the costs based on transaction price of multiple performance obligations
      - Performance Obligation / Transaction Price Allocation / Expected years

Performance Obligation	Transaction Price Allocation	Expected years
Independent Living	50%	2
Assisted Living	20%	2
Skilled Nursing	30%	2

    - Option 2:
      - Amortize the single contract cost asset using the ratio of total costs incurred to date to total costs.
      - May result in similar pattern of amortization as above but with no specific allocation to individual performance obligations
    - Impairment: Contract termination would result in immediate expense recognition of remaining unamortized contract costs

Thank you

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