Presented by:
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REVENUE RECOGNITION

CHANGES AFFECTING HEALTHCARE ORGANIZATIONS

BerryDunn

REVENUE RECOGNITION OVERVIEW

Eliminates industry-specific rules

Applies a core principle based approach

Achieves “convergence” between the FASB and IASB

Presents new challenges

THE REVENUE RECOGNITION CORE PRINCIPLE

"The core principle is that an entity should 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."

FASB ASC 606

FIVE STEPS TO ACHIEVE THE CORE PRINCIPLE

Step 1: Identify contract with customer

Step 2: Identify performance obligations in the contract

Step 3: Determine transaction price

Step 4: Allocate transaction price

Step 5: Recognize revenue as entity satisfies a performance obligation

ISSUES IDENTIFIED BY THE AICPA HEALTH CARE TASK FORCE

Issue #	Description of Implementation Issue
1	Consideration of the following regarding self-pay balances: • Application of step 1 in determining if there is a contract • Application of step 3 in determining the transaction price considering allowances/discounts and implicit price concessions • Application of the portfolio approach (including CCRC contracts)
2	CCRC Revenue Stream • Identifying the performance obligation(s) and recognizing the monthly/periodic fees and nonrefundable entrance fees under the different types of contracts for continuing care retirement communities • Identifying the performance obligation(s) and recognizing the performance obligation(s) to provide future services and use of facilities • Significant Financing Component - CCRC Contracts
3	Scope of prepaid health services as it relates to revenue recognition and the application of FASB ASC 954 vs. ASC 944
4	Disclosure requirements for health care entities
5	Contract acquisition costs for prepaid health services and CCRC entrance fees
6	Determination (estimation) of transaction price (expected value vs. most likely) as it relates to third party estimates

DETERMINING TRANSACTION PRICE

Constraining Estimates of Variable Consideration:

"Include in the transaction price some or all of an amount of variable consideration only to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the variable consideration is subsequently resolved."

- FASB ASC 606-10

IS THERE AN ENFORCEABLE CONTRACT?

IMPLEMENTATION DATE

Public Companies

- Delayed 1 year from initial target
- Reporting periods after December 15, 2017

Private Companies

- Delayed 1 year from initial target
- Granted an additional year
- Allowed to early adopt to coincide with public

Presented by:
Barbara McGuan

FINAL REGULATIONS ON 501(R)

AGENDA

- 501(r)(3) Community Health Needs Assessment (CHNA)
- 501(r)(4) Financial Assistance Policy (FAP) and Emergency Medical Care Policy
- 501(r)(5) Limitations on Charges
- 501(r)(6) Billings and Collections (handout)
- Revenue Procedure 2015-21 (effective 3/10/2015 – handout)

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

- Enacted section 501(r) of the IRC in March 2010
- Hospital will no longer be treated as a 501(c)(3) unless it meets 501(r)(3) through 501(r)(6) rules
- Final regs effective 12/29/2014, fully comply by start of 1st tax year beginning after 12/29/2015
- Failure to meet 501(r):
  - Rev Proc 2015-21
  - $50,000 CHNA failure

501(r)(3) CHNA

- Conduct at least once every 3 years
- Can build upon previous CHNA – 2 posted on website
- Collaboration encouraged
- Acquired Hospital: must meet the requirements by the last day of the second taxable year (including short years) beginning after the date on which the hospital was acquired

CHNA: SOLICIT INPUT

CHNA must take into account input from all the following:

1. At least one state, local, tribal, or regional governmental health department (or equivalent dept. or agency) or a State Office of Rural Health with knowledge, information, or expertise relevant to the health needs of the community

2. Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing their interests

3. Written comments received on the Hospital's most recent CHNA and adopted implementation strategy

CHNA: JOINT REPORTS

Joint CHNA reports allowed if:

1. All requirements met in joint report

2. Joint report clearly identified as applying to your Hospital

3. All collaborating hospitals included in the joint report define their community to be the same

If all 3 conditions not met, hospitals can still collaborate and use portions of another CHNA within their report, but they must have their own separate CHNA report.

CHNA: IMPLEMENTATION STRATEGY

Implementation strategy (IS) – attach most recent to 990 or add url

Describe how the hospital plans to address each significant health need identified in CHNA

Identify any significant health need the hospital does not intend to address and explain why

Must adopt an IS **by the 15th day of fifth month after the end of taxable year in which it completes the related CHNA**

Joint IS allowed if joint CHNA prepared – must meet certain requirements

FINANCIAL ASSISTANCE POLICY (FAP) 501(r)(4)(A)

Applies to all emergency and other medically necessary care (MNC) provided by the hospital or by a substantially-related entity.

Must be widely publicized, and must include:

1. Eligibility criteria for financial assistance, including free or discounted care,
2. Basis for calculating amounts charged to patients,
3. Method for applying for financial assistance,
4. If no separate billing and collections policy, actions taken for non-payment,
5. Information obtained from sources other than patient,
6. List of providers, other than the hospital facility itself, delivering emergency or other MNC that specifies which providers are covered (or not) by the FAP

FINANCIAL ASSISTANCE POLICY (FAP) 501(r)(4)(A)

Medically Necessary Care:

- As defined under state law
- Medicaid definition
- Generally accepted standards of medicine in the community, or
- Examining physician’s determination

FAP: BASIS FOR AMOUNTS CHARGED

- State that FAP-eligible patients will not be charged more for emergency or other MNC than the amounts generally billed (AGB) to patients who have insurance

- Describe method used to determine AGB

- If look-back method used for AGB, state either:
  (1) hospital's AGB %'s and describe how calculated, or
  (2) how public may readily obtain this info in writing

FAP: METHOD FOR APPLYING

- Describe how an individual may apply for financial assistance under the FAP
- FAP application form, including instructions, must describe the information and documentation required as part of the application
- Provide contact information to obtain assistance

FAP: ACTIONS RE NONPAYMENT

FAP/separate billing & collections policy must describe:

- Actions that may be taken to obtain payment, including extraordinary collection actions (ECA)
- Process and time frames used in taking actions, including reasonable efforts to be made to determine if FAP-eligible before engaging in any ECAs
- Office, department, committee or other body with the final authority to determine if reasonable efforts were made to determine eligibility under the FAP

WIDELY PUBLICIZING THE FAP

- FAP, FAP application, and plain language summary on website
- Paper copies of above available, both by mail and in public locations in hospital (must be in emergency room and admissions)
- Notify and inform members of the community about the FAP in a manner reasonably calculated to reach those who are most likely to require financial assistance from the hospital (examples included in regs)

WIDELY PUBLICIZING THE FAP

Notify those who receive care from the hospital about the FAP:

- Offer a paper copy of plain language summary during intake or discharge

- Include conspicuous written notice on billing statements that informs the availability of financial assistance, including:
  - department telephone number to obtain information
  - url for FAP, FAP application & plain language summary

- Conspicuous public displays that attract attention to notify about FAP, in public areas of the hospital including, at a minimum, the emergency room and admissions areas

TRANSLATIONS OF THE FAP

Must accommodate all significant populations with limited English proficiency (LEP) by translating the FAP, FAP application, and plain language summary into the primary language(s) spoken

Each LEP language group constituting the lesser of 1,000 individuals or 5% of the community served or the population likely to be encountered by the hospital

Reasonable methods to determine LEP populations include data from:

- US Census Bureau (latest decennial census or American Community Survey data)
- State and local governments
- School systems
- Community organizations

PLAIN LANGUAGE SUMMARY

Clear, concise, easy-to-understand written statement that notifies an individual that the hospital offers financial assistance under a FAP including:

- Brief description of eligibility requirements and assistance offered
- Brief summary of how to apply for assistance under the FAP
- URL & physical locations with FAP and FAP application
- Instructions on how FAP and FAP application can be obtained by mail
- Phone number & physical location of hospital office for assistance with the FAP application process as well as any nonprofit and/or government agencies that the hospital identifies as available sources of assistance with FAP applications
- Availability of any translations of the FAP, application and summary
- Statement that no FAP-eligible person will be charged more for emergency or medically necessary care than AGB

ESTABLISHING JOINT POLICIES

Establishing for more than one hospital:

- Joint policy allowed as long as each hospital facility clearly identified
- However, different AGB %'s or methods of determining AGB require different FAP information regarding AGB

EMERGENCY MEDICAL CARE POLICY

501(r)(4)(B): A written policy requiring the organization to:

- Provide, without discrimination
- Care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 USC 1395dd))
- To individuals regardless of their eligibility under the financial assistance policy described in 501(r)(4)(A)

LIMITATION ON CHARGES

501(r)(5): An organization meets the requirements of this paragraph if the organization—

A. limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy to not more than the amounts generally billed to individuals who have insurance covering such care, and

B. in the case of all other medical care covered under the FAP, prohibits the use of gross charges.

AMOUNTS GENERALLY BILLED (AGB)

Two methods available (many examples in regs):

1. Look-back method: based on actual past claims allowed by either (a) Medicare fee-for-service only, (b) Medicare fee-for-service with all private insurers, or (c) Medicaid either alone or with (a) or (b).

2. Prospective method: estimate amount that would be paid by Medicare or Medicaid and the amount the beneficiary would be personally responsible for paying as co-pay, co-ins or deductible (excludes Medicare Advantage). If both Medicare and Medicaid used, FAP must describe circumstances where each used to determine AGB.

- Hospital may only use one method to determine AGB at any one time, but may change the method at any time.

- Critical Access Hospital: Net patient service revenue versus Gross revenue

LOOK-BACK METHOD

- AGB % = **Sum** of all claims allowed by insurers chosen (see previous slide) **divided** by gross charges for those claims
- Multiply AGB % by gross charges for the care
- AGB % must be calculated at least annually
- “All claims allowed” = claims to be reimbursed by Medicare, Medicaid or private insurer plus amounts expected to be paid by patient in form of co-insurance, copayment or deductibles during previous 12 months (claims processed not dates of service).

LOOK-BACK METHOD

- Must apply AGB % by 120th day after the end of the 12-month period used to calculate the AGB %
- AGB may be one average % of gross charges for all emergency or other medically necessary care, or
- May calculate multiple AGB %'s for separate categories of care or for separate items or services as long as AGB %'s have been calculated for all emergency or other medically necessary care provided by hospital
- May use claims allowed for **all medical care** during the 12-month period rather than just those allowed for emergency or other medically necessary care

PROSPECTIVE METHOD

- Uses the billing and coding process the hospital would use if the FAP-eligible individual were a Medicare or Medicaid beneficiary
- AGB is set for the care at the amount the hospital determines would be the amount Medicare or Medicaid and the beneficiary together would be expected to pay for the care
- If both Medicare and Medicaid used, FAP must describe circumstances where each used to determine AGB.

BILLING & COLLECTION

501(r)(6): An organization meets the requirements of this paragraph only if the organization—does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy

BILLING & COLLECTION

ECAs are actions taken by the hospital against a patient related to obtaining payment for care covered under the FAP that:

- Require a legal or judicial process
- Involve selling the patient's debt to another party (except under certain circumstances)
- Report adverse information about the patient to consumer credit reporting agencies or credit bureaus
- Defer, deny or require prepayment before providing MNC because of a patient's nonpayment of one or more bills for previously provided care under the FAP

BILLING & COLLECTION

Actions of legal or judicial process include, but not limited to:

- Place a lien on an individual's property
- Foreclose on an individual's real property
- Attach or seize a bank account or any other personal property
- Commence a civil action against an individual
- Cause an individual's arrest
- Cause an individual to be subject to a writ of body attachment
- Garnish wages

BILLING & COLLECTION

What is not an ECA:

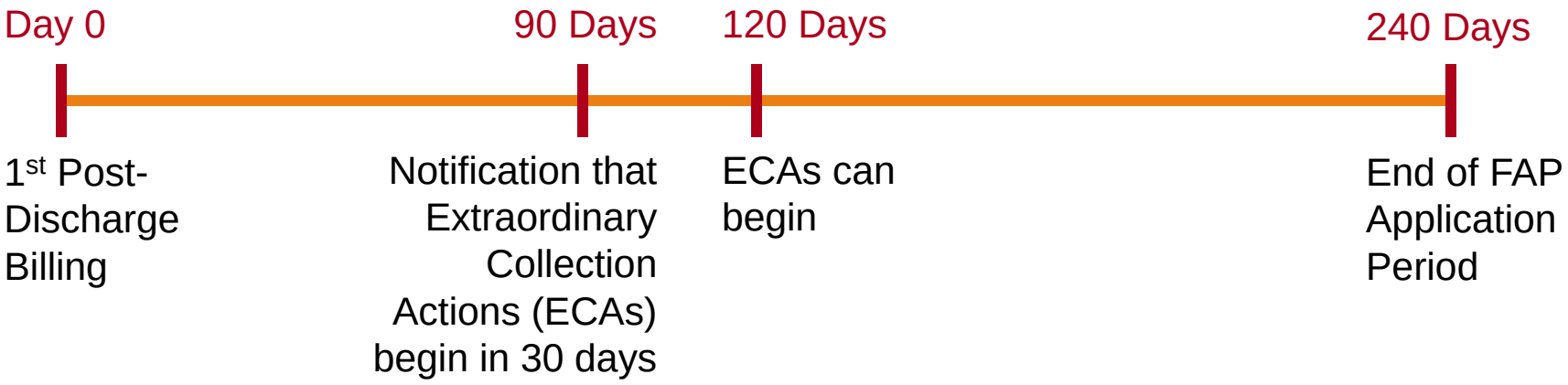
- Asserting a lien on personal injury judgment
- Filing claim in bankruptcy
- Selling debt to third party – see next slide

BILLING & COLLECTION

Debt sales not ECAs if prior to sale enter into legal binding agreement where:

- Purchaser prohibited from engaging in ECAs
- Purchaser prohibited from charging excessive interest
- Debt is returnable or recallable upon determination that individual is FAP-eligible, and
- If debt not returned or recalled, purchaser required to adhere to procedures specified in agreement that ensure individual does not pay more than he or she is personally responsible for paying as a FAP-eligible patient

BILLING & COLLECTION



APPLICATION PERIOD DEFINED

Period during which the hospital must accept and process a FAP application in order to determine FAP-eligibility

Period begins – date care is provided to individual

Period ends – on the **later of** the 240th day after hospital provides individual with first post-discharge billing statement for the care, **or** either the deadline specified in a written notice or the end of a reasonable period of time for individuals deemed to be eligible for less than the most generous assistance available under the FAP

INTERESTED IN MORE?

We are always available for your questions

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