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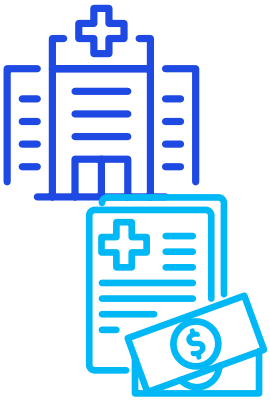
Healthcare accounting hot topics:
Risk-based contracting



The healthcare industry is adapting as business needs and directives in the market change. For instance, the Centers for Medicare and Medicaid Services (CMS) has set a strategic direction to convert all Medicare and the majority of Medicaid beneficiaries to accountable care models.[1] With these changes, healthcare organizations are assuming more financial risk and the responsibility to manage the medical services through managed care organizations (MCOs) or accountable care organizations (ACOs) (together "providers") through risk-based contracting.

Risk-based contracting is a type of arrangement between healthcare providers and health plans or government programs (together "plans") whereby financial responsibilities for the cost of care shifts between the plan to the provider. Entities have used a variety of structures to shift the profit or loss to the provider, which includes but is not limited to bundled payments, capitation or prepaid healthcare, pay-for-performance, shared savings, and risk pools.[2] The economics of risk-based contracting have resulted in an increase in its popularity in recent years; however, this form of contracting introduces several accounting complexities that are not present in traditional fee-for-service arrangements. Providers have recognized revenue related to the risk-based contracts under different accounting models based on judgment and differences in the contractual arrangements, including how services are provided.

Risk-based contracts can vary in form and can display economics of derivatives, guarantees, and revenue contracts. Considering this, providers should perform an accounting analysis under Financial Accounting Standards Board (FASB) Accounting Standards Codification Topic No. (ASC) 815, *Derivatives and Hedging* (ASC 815); ASC 606, *Revenue from Contracts with Customers* (ASC 606); and ASC 460, *Guarantees* (ASC 460). The majority of risk-based contracts fall within ASC 606 or ASC 460 (or both) as they are typically either revenue-generating contracts or revenue-generating contracts with financial guarantees; whereas providers generally do not account for these arrangements under the scope of ASC 815 since it provides a scope exception for "insurable events." The remainder of this document details certain accounting considerations under ASC 460 and ASC 606, as well as a few additional considerations that providers should be aware of.

1 See Centers for Medicare and Medicaid website for more details (CMS Announces Increase in 2023 in Organizations and Beneficiaries Benefiting from Coordinated Care in Accountable Care Relationship | CMS).

2 See AICPA Audit and Accounting Guide: Health Care Entities, Chapter 13 – Financial Accounting and Reporting for Managed Care Services for a description of each structure.

ASC 460 guarantees

When a risk-based contract is not within the scope of ASC 815, providers assess whether the risk-based contract (or a portion thereof) is within the scope of ASC 460 or whether a scope exception applies.

One of the scope exceptions in ASC 460 that providers consider, is whether a risk-based contract is a guarantee for the "entity's own performance." The own-performance scope exception requires a provider to analyze whether the services provided are a performance obligation under ASC 606. If all promises in the contract are scoped out of ASC 460, then the contract should be analyzed under ASC 606 (discussed below). Alternatively, a provider may determine that the contract should be analyzed under both ASC 460, for promises that are a guarantee, and under ASC 606, for services that are a performance obligation. Only if all promises are subject to ASC 460 is the risk-based contract analyzed entirely under ASC 460.

Contracts where an entity is financially responsible for covering the costs of care for a specific patient population, but not providing any other services, explicitly or implicitly, may constitute a financial guarantee in the scope of ASC 460. For these contracts, a practical expedient exists that allows entities to measure the guarantee using the stated value of the premium receivable under the guarantee. In limited practice for risk-based contracts, using this expedient resulted in recognizing the gross per member per month amount due (or similar payment) as revenue, which effectively results in presenting the premiums earned on a gross basis.

However, the practical expedient cannot be used if a portion of the contract is within the scope of ASC 606, which may be the case if a service is promised or implied in the contract. For these contracts, the guarantee subject to ASC 460 (not related to a service element) must be measured at the fair value.

ASC 606 Revenue from Contracts with Customers

For a risk-based contract or a portion of a risk-based contract that is not subject to ASC 460, providers should analyze the contract or portion of the contract under ASC 606.

This analysis should include identifying the contract and the customer, identifying the performance obligations, determining the transaction price, allocating the transaction price to the performance obligations, and recognizing revenue as control transfers. Additionally, providers should consider, for each of the performance obligations identified, whether they are the principal or the agent, which is critical to the presentation of revenue. When a provider is determined to be the principal, the consideration received is presented on a gross basis and the medical claims are recognized as an expense. On the other hand, when a provider is not the principal then the consideration received (or paid) is presented on a net basis reduced by (increase of) medical claims. In this case, the contingent payment to the provider represents variable consideration.

Identifying the performance obligations considers the nature of the promise and the services provided. Providers should determine whether they are contracted to provide healthcare services, to coordinate or manage integrated healthcare services, to provide a cost mitigation service, or something else, and to what patient population or subpopulation the services may be provided. The nature of the promise and identified performance obligations will have a direct impact on the principal versus agent analysis.

As ASC 606 is industry agnostic, there are no specialized criteria for providers to consider when determining whether a provider is the principal or agent. Therefore, in conjunction with the criteria in ASC 606, providers may consider the following areas that are related to risk-based contracts: assumption of risk up to a benchmark percentage and which costs are assumed, active care

ASC 606 Revenue from Contracts with Customers continued

management, and control over the medical referral process. Questions that may help providers assess these include, but are not limited to, the following:

- What percentage (up to a benchmark, if stated) of risk does the provider assume for the population?
- Does the provider receive payment directly from the plans?
- Is the provider directly responsible for patient care for the services?
- Do patients view the company as providing care directly or indirectly?
- Does the company employ (directly or through consolidation) the medical professionals performing the services?
- If the company does not employ the medical professionals performing the in-scope services, are such medical professionals independent contractors of the company and are they directly compensated by company?
- How are medical professionals performing the services compensated? Are there incentives in place that align their performance to the company's incentives?
- Do shared savings provisions exist and to what degree do shared savings provisions compensate the professionals performing the services to align incentives?
- Does the provider actively manage the medical services for the patient population?
- Does the provider determine the patient's care journey (physical space, technology, intake, information share, etc.)?
- Does the provider directly or indirectly control referrals from the primary care physicians?
- Does the provider direct and develop the plan of care for the patient, either directly or through a network of referrals?

Depending on the principal versus agent analysis, a provider may determine they are principal for some, all, or none of the performance obligations. If a provider determines that they are a principal for certain services, the consideration received related to those services is presented on a gross basis. Determining the amount to recognize in this scenario can be complex as most risk-based contracts have elements that could reduce the consideration received including, but not limited to, risk corridors, stop-loss insurance, and other risk-sharing provisions.

When a provider is determined to be the principal, the consideration received is presented on a gross basis and the medical claims are recognized as an expense.

Additional considerations

As a result of the growing complexity in risk-based contracting as well as the accounting for such contracts, more diversity in the application of the accounting guidance has occurred.

For instance, situations where companies may be both within the scope of ASC 460 for a financial guarantee and within the scope of ASC 606 for services it provides to the customer have become more common. An example of this situation is a provider that is a principal for medical treatment for a specific subset of medical conditions (e.g., oncology) but otherwise entering into a financial guarantee for the total cost of care for other medical conditions.

Regardless of the accounting model applied, providers disclose the information required by ASC 460 and/or ASC 606 in the financial statements. Disclosures include the accounting models applied, the resulting presentation, and management's significant judgments and assumptions used, among other requirements. The disclosures allow providers the ability to communicate the risks and opportunities associated with these risk-based contracts and provides stakeholders with a clear understanding of how these contracts impact the financial performance of the business.

Given the degree of judgment, the accounting for risk-based contracts continues to be a challenge for companies entering into these arrangements, resulting in discussions among regulators, standards setters, the AICPA and accounting firms. As such, providers should consult with their accounting advisors and auditors to understand the latest developments as they enter risk-based arrangements.

Contact us

To discuss your risk-based contracts or for more information on KPMG's healthcare accounting advisory services contact one of our healthcare specialists below.

Alex Neil
Partner, HCLS Deal Advisory Service Leader,
KPMG LLP
917-375-5029
alexneil@kpmg.com

Hillary Cimock
Partner, Account Advisory Services Leader for HCLS,
KPMG LLP
415-926-0419
hfender@kpmg.com

Christopher Dickson
Director
KPMG LLP
661-645-6264
christopherdickson@kpmg.com

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