
March 13, 2012

Technical Director
Financial Accounting Standards Board
401 Merritt 7
P.O. Box 5116
Norwalk, Connecticut 06856-5116

File Reference No. 2011-230

Dear Technical Director:

The Healthcare Financial Management Association's (HFMA's) Principles and Practices (P&P) Board appreciates this opportunity to comment on the Financial Accounting Standards Board's (FASB's) exposure draft of the proposed Accounting Standards Update *Revenue Recognition (Topic 605), Revenue from Contract with Customers*, which would affect any entity that enters into contracts with customers unless those contracts are in the scope of other standards (for example, insurance contracts or lease contracts).

HFMA is a professional organization of more than 37,000 individuals involved in various aspects of healthcare financial management. In 1975, HFMA founded the P&P Board, a special group of experts to serve as the primary advisory group in the areas of accounting principles and financial reporting practices to meet the unique characteristics of health service organizations.

**General Comments**

In the exposure draft, FASB states that revenue is a crucial number to users of financial statements in assessing an entity's financial performance and position. However, revenue recognition requirements in U.S. generally accepted accounting principles (GAAP) differ from those in International Financial Reporting Standards (IFRSs), and both sets of requirements need improvement. U.S. GAAP comprises broad revenue recognition concepts and numerous requirements for particular industries or transactions that can result in different accounting for economically similar transactions. Although IFRSs have fewer requirements on revenue recognition, the two main revenue recognition standards, IAS 18, *Revenue*, and IAS 11, *Construction Contracts*, can be difficult to understand and apply. In addition, IAS 18 provides limited guidance on important topics such as revenue recognition for multiple-element

arrangements. Accordingly, the FASB and the International Accounting Standards Board (IASB) initiated a joint project to clarify the principles for recognizing revenue and to develop a common revenue standard for U.S. GAAP and IFRSs that would:

1. Remove inconsistencies and weaknesses in existing revenue requirements.
2. Provide a more robust framework for addressing revenue issues.
3. Improve comparability of revenue recognition practices across entities, industries, jurisdictions, and capital markets.
4. Provide more useful information to users of financial statements through improved disclosure requirements.
5. Simplify the preparation of financial statements by reducing the number of requirements to which an entity must refer.

To meet those objectives, the FASB and the IASB are proposing amendments to the *FASB Accounting Standards Codification* and to IFRSs, respectively.

**The Main Provisions**

The core principle of this proposed guidance is that an entity should recognize revenue to depict the transfer of promised 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. To achieve that core principle, an entity would apply all of the following steps:

Step 1: Identify the contract with a customer.
Step 2: Identify the separate performance obligations in the contract.
Step 3: Determine the transaction price.
Step 4: Allocate the transaction price to the separate performance obligations in the contract.
Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation.

FASB sought comments on whether the proposed guidance is clear and can be applied in a way that effectively communicates to users of financial statements the economic substance of an entity's contracts with customers, including a number of specific issues and questions. Our comments will reflect the P&P Board's longstanding efforts to balance two important goals:

1. Financial reporting should improve the level of understanding between those who provide financial information and those who seek and use this information, and

2. Reporting requirements should be feasible in the context of the unique characteristics of the healthcare field.

Below are the P&P Board's responses:

**Recognition of revenue for self-pay patients who have not yet been qualified for financial assistance or charity care**

The ED is not clear as to how healthcare entities should recognize revenue associated with services they provide to indigent self-pay patients. For instance:

a) Entity 1 may conclude that the contract criteria of paragraph 14 are met and that the amount of consideration to which the entity expects to be entitled would be based on its policy for pricing services to uninsured patients, with collectability concerns addressed by reflecting contra-revenue (bad debt). That view is consistent with the ASU 2011-07 model.
b) Entity 2 may conclude that the contract criteria of paragraph 14 have been met, but interprets the transaction price requirements differently. For example, it might conclude that the amount of consideration to which it expects to be entitled should be estimated in the aggregate for a portfolio of self-pay patients with similar characteristics using the provisions for estimating variable consideration (i.e. reflecting either the expected value of the portfolio or the most likely amount for the portfolio), since it typically does not know which specific patient will pay or how much they will pay.
c) Entity 3 may conclude that the contract criteria in paragraph 14 cannot be met with respect to this class of patient, because the significant doubt at contract inception about the collectability of consideration from the patient would indicate that the patient is not committed to perform his/her obligations to pay or that the contract does not have commercial substance. This entity presumably would report revenue from this class of patient on a cash basis

The FASB has provided guidance in ASU 2011-07, *Health Care Entities: Presentation and Disclosure of Patient Service Revenue, Provision for Bad Debts, and the Allowance for Doubtful Accounts for Certain Health Care Entities.* The ASU was intended to be an interim step in addressing revenue recognition for uninsured self-pay patients who do not qualify for charity care until the Board's joint project on revenue recognition could be completed (ASU 2011-07, BC4).

The P&P Board requests that the FASB clarify the principles or alternatively provide implementation guidance illustrating how the principles should be applied in this situation.

**Use of "most likely amount" in estimating variable consideration**

In the health care industry, the amount of revenue earned under arrangements with government programs (for example, Medicare or Medicaid) is determined under complex rules and regulations that subject the health care entity to the potential for retrospective adjustments in future years. Several years may elapse before all potential adjustments related to a particular fiscal year are known and before the amount of revenue to which the health care entity is entitled is known with certainty. As a result, revenue from contracts with government payers typically contains a variable element that requires providers to estimate the cash flows ultimately expected to be received for services provided during a contract period. Under current GAAP (ASC 954), management generally makes its best estimate of the third-party settlement adjustments required based on its knowledge and experience about past and current events.

Paragraph 55 of the ED indicates that when an element of consideration is variable, an entity's estimates shall either be based on the expected value (derived from a probability-weighted calculation) or the most likely amount (derived from the "best estimate"). An entity should select the method which it expects to provide the best prediction of the amount of variable consideration. Paragraph 55 goes on to state that "an expected value may be an appropriate estimate of the transaction price if an entity has a large number of contracts with similar characteristics," and that "the most likely amount may be an appropriate estimate of the transaction price if the contract has only two possible outcomes (for example, an entity either achieves a performance bonus or does not)."

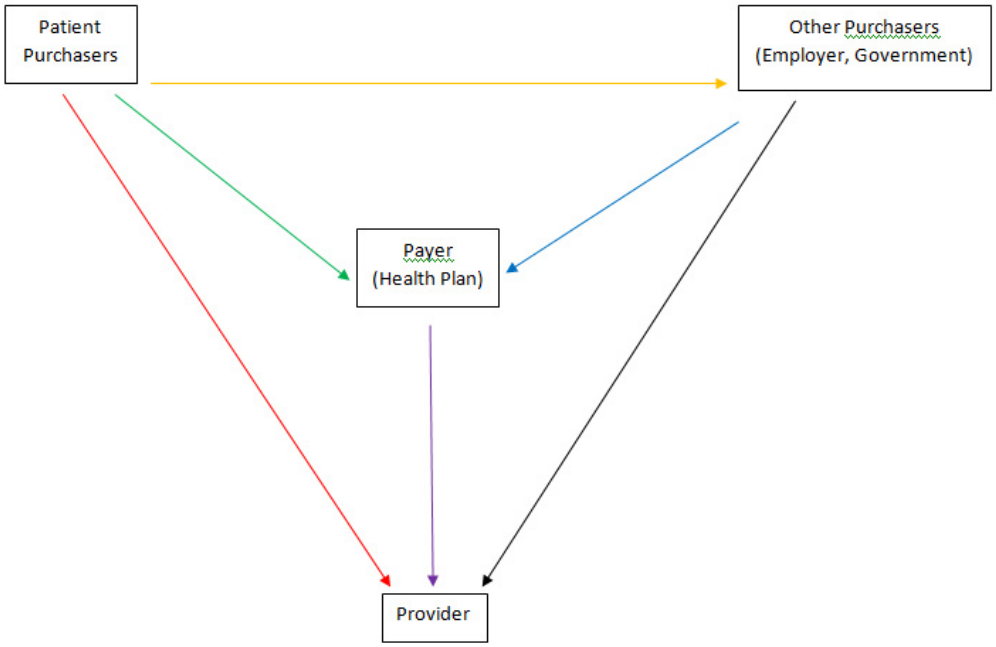
A healthcare entity's contracts with government programs such as Medicare or Medicaid do not have characteristics similar to either of the examples provided in paragraph 55. A healthcare entity initially signs an agreement with a government program which renews on a year to year basis unless the entity voluntarily withdraws or is disbarred from participating in the program. As a result, it represents a single contract with many years of renewals. In many cases, institutional providers' experience in estimating settlements associated with these contracts will extend back more than 40 years.

The P&P Board believes that many healthcare entities are likely to conclude that the best predictor of the variable consideration is continued use of their best estimate. However, it's not clear whether paragraph 55 is intended to create a rebuttable presumption that the best estimate method should only be used when outcomes are binary. The P&P Board believes that without clarification of whether this is intended to be a rebuttable presumption, it will create tension between an entity and its auditor related to judgments in this area.

**Revenue transactions involving multiple contractual relationships**

A unique aspect of healthcare operations is that revenue transactions primarily involve more parties than the traditional "buyer" and "seller." As many as four parties may be associated with a revenue transaction involving an institutional health care entity such as a hospital. These include: (1) the individual who receives the medical care; (2) the physician who orders the required services on behalf of the patient; (3) the hospital that provides the setting or administers the treatment; and (4) a third-party payer that pays the hospital on behalf of the patient (for example, Medicare, Medicaid, or a managed care plan).

As a result, the provision of services to the patient may involve a network of contractual relationships.




Key:

Red = Patient self-pay, co-pay, deductible
Green = Premium for individual policy
Orange = Employee premium contribution for employer-based policy
Blue = Employer payment of employee premiums (includes employee and employer contributions)
Purple = Payment as negotiated between payer and provider
Black = Government payments per government-established rates

A hospital admits a Medicare patient. The hospital will have an overall contract with Medicare (the primary payer) setting forth the terms and conditions of payment for services provided to any Medicare beneficiaries treated by the hospital, and will also execute a contract with the patient related to his or her specific admission. The contract with Medicare will indicate the services which are covered or not covered, the amount that can be charged for the services and the amount of the patient's responsibility for the services provided. Historically, the contract with the primary payer has driven the timing and amount of revenue recognized. Other contractual relationships will affect the hospital's ability to collect the agreed-upon sales price from among the various parties. These include the portion payable by Medicare (as the primary payer), the portion due from one or more secondary payers (for example, a Medicare supplement policy that pays certain costs that otherwise would be the responsibility of the patient, based on a contract between the patient and commercial payer), and the remaining patient responsibility. Each contract referenced above would have been entered into at different times and on different terms. Furthermore, the contract between the provider and the payer may include payment dependent on the performance (e.g. ones based on quality and/or efficiency goals) of the provider relative to a group of patients as compared to other providers, in addition to the payments for the services provided. The contract terms can include settle up or reconciling mechanisms long after the performance period.

Paragraphs 13–15 of the proposed ASU would indicate that all of these arrangements are "contracts," as they are in writing, have commercial substance, and identify each party's rights and payment terms. However, guidance in ASC 954-280-45-1 states that third-party payers are not "customers" of a healthcare organization for purposes of providing disclosures by segment. Paragraph 17 of the proposed ASU also requires contracts to be entered into at the same time in order to combine such contracts.

As a result of the guidance in ASC 954-280, different conclusions could be reached regarding whether third-party payer contracts can be considered "contracts with customers" for purposes of applying the ED as well as whether the contracts with the patient and payer could be combined for application of the ED. Differences in interpretation would result in differences in applying the revenue recognition process described in ED as well as in applying the onerous contract provisions.

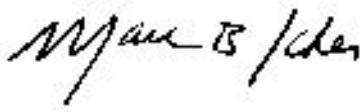
The P&P Board requests that FASB give consideration to the unique characteristics of healthcare revenue transactions in developing the final guidance.

**Elimination of "prepaid health care plan" definition in Master Glossary**

The P&P Board is concerned that the definition of "prepaid health care plan" is being eliminated from the Master Glossary and would no longer be referenced in ASC 954. Without a clear indication that prepaid health care plans are healthcare entities (within the scope of ASC 954), health care entities may incorrectly apply the guidance in Topic 944, *Insurance Entities*, to these arrangements, instead of the intended guidance in Subtopic 605-10. This is a risk with respect to both general revenue recognition for premiums received by prepaid health care plans, and also the guidance for onerous performance obligations. The EP believes that the Codification should continue to explicitly indicate that such entities/activities are within the scope of ASC 954, and that the guidance they apply with respect to general revenue recognition (e.g., premiums received) and onerous performance obligations is the guidance in Subtopic 605-10, not Topic 944.

Thank you for the opportunity to comment. We are always ready to provide additional comments, or meet with you or members of your board to discuss this matter further. If we can provide additional material or perspective on this issue, please contact Richard Gundling, Vice President of HFMA's Washington, DC office, at (202) 296-2920.

Sincerely,



Marc B. Scher, CPA
P&P Board Chair