MEDICAL CENTERS: ACCOUNTING FOR CAPITATED CONTRACTS

Contents

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I. INTRODUCTION

This chapter summarizes a number of accounting and reporting issues related to capitation agreements at the University's medical centers, including the treatment of health care revenues and expenses, contract losses, stop-loss insurance, and contract acquisition costs of providers of prepaid health services.

The rapidly rising cost of health care services has led to an increase in the number of prepaid health care plans. These plans serve as an alternative system for the delivery and financing of health care services and have largely replaced the traditional cost-based and charge-based (fee-for-service) reimbursement systems. Under a capitation arrangement, a medical center agrees to treat the members of a health plan for a fixed-rate-per-member-per-month. The medical center, thus, is at risk and is liable for any expenses incurred beyond the monthly capitation payments. Consequently, the focus of the medical center has changed from revenue maximization to reducing costs.

Because of the market pressures to reduce costs, insurance companies, health maintenance organizations (HMOs), physicians, medical centers, and other health care providers and managers have organized into integrated delivery systems and networks that combine inpatient, outpatient, and physician services into single contracting organizations. These systems and networks may be formed through mergers, joint ventures, affiliation agreements, or contractual risk sharing arrangements to provide services on a predetermined, fixed-fee capitation basis, rather than the customary fee-for-service arrangements.

It is essential, therefore, for effective case management that the terms and conditions of capitated contracts be understood by the medical center contract manager and the appropriate finance department staff.

II. DEFINITIONS

- **Admitting Medical Center** - The medical center that admits a member for 24-hour inpatient care. This may be the contracting medical center or another medical center from which purchased inpatient services are obtained by the contracting medical center.

- **Acquisition Costs** - Marketing costs directly related to the acquisition of specific subscriber contracts and member enrollment and incremental to general marketing activities.

- **Capitation Fee (Medical Center)** - A fixed amount (usually per member) that is paid periodically (usually monthly) to the contracting medical center as compensation for providing comprehensive health care services (usually excluding physician-covered services) for the period. The fee is set by contract between the HMO and the contracting medical center.

- **Contracting Medical Center** - The medical center that has contracted with an HMO to provide inpatient services and/or medical center outpatient services for HMO members on a risk-based capitation fee basis.

- **Contract Period** - The period for which premium rates are fixed by contract, typically one year.

- **Co-payment** - A payment required to be made by a member to the contracting medical center when specific health care services are rendered. Typical co-payments include fixed charges for each prescription or certain elective medical center procedures.

II. DEFINITIONS (Cont.)

- **Health Maintenance Organization (HMO)**- A generic set of medical care organizations organized to deliver and finance health care services. An HMO provides comprehensive health care services to enrolled members for a fixed, prepaid fee (premium).

- **Incurred But Not Reported (IBNR) Costs** - Costs associated with health care services incurred during a financial reporting period but not reported to the prepaid health care provider (see below) until after the financial reporting date.

- **Individual Practice Association (IPA)** - A partnership, association, corporation, or other legal entity organized to provide or arrange for the delivery of health care services to a member of a prepaid health care plan and non-member patients. In return, the IPA receives either a capitation fee or a specified fee based on the type of service rendered.

- **Member** - An individual who is enrolled as a subscriber, or an eligible dependent of a subscriber, in a prepaid health care plan.

- **Preferred Provider Organization (PPO)** - An organization that contracts with providers to deliver health care services for a negotiated fee based on the level of utilization. There are financial incentives to subscribers to use the contracting providers. PPOs normally do not accept the transfer of financial risks.

- **Premium (also known as Subscriber Fee)** - The consideration paid to a prepaid health care provider for providing contract coverage. Typically, premiums are established on an individual, two-party, or family basis and paid monthly.

- **Prepaid Health Care Provider** - An entity that provides or arranges for the delivery of health care services in accordance with the terms and provisions of a prepaid health care plan. The provider assumes the financial risk of the cost of delivering health care services in excess of pre-established fixed premiums. However, some or all of this financial risk may be contractually transferred to other providers or by purchasing stop-loss insurance.

- **Purchased Inpatient Services** - Services purchased by a contracting medical center from another medical center when a member is admitted to the other medical center with the approval of the contracting medical center. Such services usually do not include ancillary services purchased from another medical center or organization for inpatients of the contracting medical center.

- **Purchased Services** - Services, other than purchased inpatient services, purchased by the contracting medical center from another medical center or organization (vendor).

- **Stop-loss Insurance** - A contract in which an insurance company agrees to indemnify a contracting medical center for certain health care costs in excess of a predetermined amount (limit) incurred by the contracting medical center in providing care to members. The limit usually covers an annual period and is applied against accumulated charges, a percentage of charges, or patient days for all episodes of care, rather than being applied to each episode of care.

- **Subscriber** - The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in the HMO.

III. CAPITATED CONTRACTS

There are two types of capitated contracts:

A. RISK SHARING CONTRACTS

In this type of contract, the medical center agrees to absorb a portion of the cost of treating a particular HMO's patients if the expenses incurred during the year exceed the previously agreed upon budgetary limits. At the same time, the medical center will share in the profit if the expenses are under the previously agreed upon budgetary limits. This creates an incentive for the medical center to treat each patient as efficiently as possible.

At year-end, there will be a liability to or a receivable from the HMO for the difference between the actual cost and the budgeted cost. On the medical center's balance sheet, the entry will be recorded in either "Third-Party Settlements-Receivable" or in "Third-Party Settlements- Payable." The other side of the entry to create this asset/liability must be recorded in the "Contractual Adjustment HMO/PPO and Other Contracts."

B. FULL RISK CONTRACTS

Under this type of contract, the medical center agrees to treat the members of a health plan for a fixed rate-per member-per-month. The medical center is at risk and is liable for any expenses incurred beyond the monthly capitation payments.

Under certain circumstances, an HMO may remit payments in advance to medical centers for services not yet identified. Such situations should be accounted for similarly to the accounting for capitated contracts. A medical center may purchase stop-loss insurance, which will indemnify the medical center for any patient whose charges exceed a flat amount.

IV. ACCOUNTING FOR INPATIENT SERVICES

For inpatient services provided by the contracting medical center within its own facilities, the accounting of revenue

and expenses for capitation patients is no different than that for any other patient. Revenue (recorded at full-established rates) and all direct expenses must be accounted for in the functional centers related to the services provided.

However, for inpatient services (other than just ancillary services) that must be obtained from another medical center that has admitted the member, the accounting for the related revenue and expenses must be accommodated in a different manner. Because the capitation fees are not related to specific patients, all earned capitation fees must be recorded as a credit to "Contractual Adjustments - Other."

Sections A, B, and C below contain accounting entries for various situations in which inpatient services are provided to members.

A. GROSS REVENUE

Gross revenue for inpatient and outpatient services rendered by the contracting provider is recorded at established rates in the cost centers that provide the patient care.

Revenue Recognition - Since capitation revenue is earned as a result of agreeing to provide services to members without regard to the actual amount of services provided, revenue should be recorded in the period that beneficiaries are entitled to health care services.

Services provided by a contracting provider are recorded as follows:

IV. ACCOUNTING FOR INPATIENT SERVICES (Cont.)
A. GROSS REVENUE (Cont.)

Dr. Inpatient Receivable - Other (Capitated)
Cr. Various Revenue Accounts

Gross revenue for ancillary services purchased from another provider by a contracting provider is recorded in the appropriate cost center. Gross charges should be based on the same rates as those applied to other payor categories.

Ancillary services purchased from another provider are recorded as follows:

Dr. Patient Accounts Receivable
Cr. Ancillary Revenue

Note: No revenue is recorded for capitated patients admitted to another facility.

B. NET REVENUE

1. Capitation Payments Earned in the Period Received

These payments are recorded as a credit to contractual allowances and should be recorded net of risk pool withholds. In addition, if the capitation payment has been reduced to pay for items such as stop-loss insurance provided by the insurer, the capitated amount should be grossed up to include these items. Any reductions for expenses netted against capitation payments should be recorded in the appropriate expense account.

Capitation payments earned in the same period they are received are recorded as follows:

Dr. Cash
Cr. Contractual Allowances - Capitated

2. Capitation Payments Received Before Being Earned

Capitation payments received before they are earned may be recorded as deferred income. A credit to contractual allowances is recorded when the payments are earned, as follows:

When payment is received:

Dr. Cash
Cr. Deferred Income - Capitation Fee

When payment is earned:

Dr. Deferred Income - Capitation Fee
Cr. Contractual Allowances - Capitated

Note: Use of the Deferred Income account is not necessary if the amounts received are earned within the same accounting period.

3. Patient Deductibles and Co-payments

Patient deductibles and co-payments are recorded as a reduction of patient accounts receivable:

Dr. Cash
Cr. Patient Accounts Receivable

4. Stop-loss Proceeds

Stop-loss proceeds for patients treated by the contracting provider are recorded as a reduction of patient accounts receivable:

Dr. Cash
Cr. Patient Accounts Receivable

Stop-loss proceeds for patients not treated by the contracting provider are recorded as a reduction of contractual allowances:

IV. ACCOUNTING FOR INPATIENT SERVICES (Cont.)
B. NET REVENUE (Cont.)

Dr. Cash
Cr. Contractual Allowances - Capitated

Note: Stop-loss proceeds may be recognized as a receivable. Stop-loss proceeds for patients not treated by the contracting provider are recorded at the time they are recognized as a receivable. The receivable is reduced when payment is received.

When recognized as a receivable stop-loss proceeds are recorded as follows:

Dr. Other Accounts Receivable - Capitated
Cr. Contractual Allowances – Capitated

Stop-loss proceeds are recorded when they are received as follows:

Dr. Cash
Cr. Other Accounts Receivable- Capitated

Note: Monthly net revenue estimates should include all anticipated stop-loss proceeds, regardless of where the patient is treated.

5. Risk Pool Distributions

Risk pool distributions to a provider are recorded as a credit to contractual allowances. To the extent they can be estimated on an interim basis, contractual allowances should be adjusted to reflect anticipated risk pool distributions. Risk pool distributions should be prepared monthly and an extensive review done quarterly. These estimates are corrected when the risk pool distribution is received.

Dr. Cash
Cr. Contractual Allowances - Risk Pool

C. EXPENSES

Health care expenses should be accrued as services are rendered, including estimates of the cost of services rendered but not yet reported. Furthermore, if a provider of prepaid health care services is obligated to render services to specific members beyond the premium period due to provisions in the contract or regulatory requirements, the costs of such services to be incurred, net of any related anticipated revenues, should be accrued currently.

Expenses that will be incurred after a contract is terminated, such as guaranteed salaries, rent, and depreciation, net of any anticipated revenues, should be accrued when it is determined that a contract with a sponsoring employer or other group will be terminated.

Amounts payable to medical centers, physicians, or other health care providers under risk-retention, bonus, or similar programs should be accrued during the contract period based on relevant factors, such as experience-to-date.

1. Purchased Medical Services

Purchased medical services occur when a member is not admitted to the contracting medical center but is admitted to another medical center with the approval of the contracting medical center. Since the contracting medical center is responsible for all of the cost of the services provided by the admitting medical center, the admitting medical center will bill the contracting medical center for the care provided. Because the member was not admitted to the contracting medical center, it is

IV. ACCOUNTING FOR INPATIENT SERVICES (Cont.)
C. EXPENSES (Cont.)
1. Purchased Medical Services (Cont.)

inappropriate to record the expenses and related units of service (e.g., patient days, surgery minutes, etc.) in the functional cost centers for the contracting medical center. It is also inappropriate to gross up the revenue of the contracting medical center related to the services provided by the admitting medical center. However, since the contracting medical center is responsible for the cost of the services provided and has received capitation fees to provide all inpatient services, such costs must be recorded as inpatient service expense.

Inpatient Services Purchased From Another Medical Center are recorded as follows:

Dr. Purchased Inpatient Services
Cr. Accounts Payable

Note: No revenue is recorded for capitated patients admitted to another facility.

The anticipated cost of patient care services furnished by other providers should be estimated monthly and recorded on the balance sheet as an "Incurred But Not Reported" (IBNR) expense. Payments for purchased medical services are offset against IBNR.

The costs for patients admitted to another facility for services are recorded as purchased service expense in a separate cost center for each capitated contract. The cost of ancillary services purchased from another provider is recorded as purchased service expense in the appropriate ancillary cost center.
Record the estimated cost of purchased medical services:

Dr. Purchased Services
Cr. IBNR (Liability)

Receipt of bills for purchased medical services is recorded as follows:

Dr. IBNR (Liability)
Cr. Accounts Payable

If IBNR costs are not recorded, the following entry should be made:

Dr. Purchased Services
Cr. Accounts Payable

2. Cost of Stop-loss Insurance

By purchasing stop-loss insurance, prepaid health care providers or associated entities transfer portions of their financial risks to insurance companies. Under a stop-loss arrangement, a provider typically contracts with an insurance company to recover health care costs in excess of stated amounts during the contract periods.

Stop-loss insurance premiums should be included in reported health care costs. Stop-loss insurance recoveries should be reported as reductions of related health care costs. Receivables representing amounts recoverable from insurers should be reported as assets, reduced by appropriate valuation allowances. In addition, the nature, amounts, and effects of significant stop-loss insurance contracts should be disclosed in the notes to the financial statements.

IV. ACCOUNTING FOR INPATIENT SERVICES (Cont.)

C. EXPENSES (Cont.)

2. Cost of Stop-loss Insurance (Cont.)

The cost of stop-loss insurance is recorded as insurance expense. As noted earlier, capitation payments are sometimes reduced to pay for stop-loss insurance provided by the insurer. If the amount of this reduction can be determined, it is recorded as insurance expense.

Dr. Insurance Expense
Cr. Cash/Accounts Payable

3. Risk Pool

Some risk contracts may provide for the medical center to maintain and distribute a risk pool. Risk pools create an incentive to manage care and hold down costs. Payments into a risk pool are recorded as a liability, which is reduced as distributions are made from the risk pool.

Dr. Cash
Cr. Risk Pool Liability

Risk pool distributions should be prepared regularly and an extensive review done quarterly.

V. ACCOUNTING FOR LOSS CONTRACTS

A prepaid health care provider enters into contracts to provide members with specified health care services for specified periods in return for fixed periodic premiums. The premium revenue is expected to cover health care costs and other costs over the terms of the contracts. Only in unusual circumstances would the provider be able to increase premiums on contracts in force to cover expected losses. A

provider may be able to control or reduce future health care delivery costs to avoid anticipated losses, but the ability to avoid losses under existing contracts may be difficult to measure or to demonstrate.

Associated entities such as medical centers, medical groups, and IPAs may enter into similar contracts with prepaid health care providers in which they agree to deliver identified health care services to the providers' members for specified periods in return for fixed fees.

Financial Accounting Standards Board Statement No. 5, *Accounting for Contingencies,* states that a loss should be accrued in financial statements when it is probable that a loss has been incurred and the amount of the loss can be reasonably estimated. Accordingly, losses should be recognized when it is probable that expected future health care costs and maintenance costs under a group of existing contracts will exceed anticipated future premiums and stop-loss insurance recoveries on those contracts.

For purposes of determining whether a loss exits, the expected future health care costs include all costs other than general and administrative, selling, maintenance, marketing and interest costs. The term "maintenance costs" refers to costs associated with maintaining enrollment records and processing premium collections and payments. The estimated future health care costs and maintenance costs to be considered in determining whether a loss has been incurred should include fixed and variable, direct, and allocable indirect costs. Contracts should be grouped in a manner consistent with the provider's method of establishing premium rates, for example, by community rating practices, geographical area, or statutory requirements, to determine whether a loss has been incurred. Contracts should be reviewed quarterly.

VI. ACCOUNTING FOR CONTRACT ACQUISITION MARKETING COSTS

Many prepaid health care providers incur costs that vary with, and are primarily related to, the marketing of subscriber contracts and member enrollment. These costs, which are sometimes referred to as acquisition costs, consist mainly of commissions paid to agents or brokers and incentive compensation based on new enrollments. Commissions and incentive compensation may be paid when the contracts are written, at later dates, or over the term of the contracts as premiums are received.

Some providers incur additional costs directly related to the acquisition of specific contracts, such as the costs of specialized brochures, marketing, and advertising.

Providers also incur costs that are related to the acquisition of new members but that do not relate to specific contracts and are not considered acquisition costs. These costs include the salaries of the marketing director and staff, general marketing brochures, and general advertising and promotion expenses. Incremental direct acquisition costs, e.g., brokers commissions or bonuses, should be capitalized and charged to expense over the contract period to which the costs relate. For purposes of capitalizing and amortizing such costs, they should be grouped consistent with the medical center’s manner of acquiring, servicing, and measuring the profitability of its managed care arrangements. Network and product development costs (i.e., start-up costs) should not be capitalized as deferred acquisition costs.

Although there is theoretical support for deferring certain acquisition costs, the acquisition costs of providers of prepaid health care services, other than the cost of advertising, should be expenses as incurred. Advertising costs should be accounted for in conformity with the guidance in Standard Operating Procedure 93-7, *Reporting on Advertising Costs.*

VII. REFERENCES

American Institute of Certified Public Accountants Audit and Accounting Guide for Health Care Organizations

Financial Accounting Standards Board Statement No. 5, Accounting for Contingencies

Standard Operating Procedure 93-7, Reporting on Advertising Costs

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