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## Q&A Section 6400

### *Health Care Entities*

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#### **.63 Background to Sections 6400.64–.70 — CARES Act Provisions Specific to Health Care Entities**

The Coronavirus Aid, Relief, and Economic Security Act (the CARES Act) attempted to alleviate some of the financial strain on hospitals, physicians, and other health care entities through a series of new policies that temporarily boosted Medicare and Medicaid payments, allowed for added flexibility in treatment modalities, and expanded the availability of advance or accelerated payments from Medicare.

In addition, the CARES Act established a Provider Relief Fund to be used for economic support of health care entities in connection with health care–related expenses or lost revenues attributable to COVID-19 and treatment of uninsured COVID-19 patients. Initially, \$50 billion of the Provider Relief Fund was allocated for general distribution to a wide range of entities across the U.S. health system (hereinafter referred to as the *Phase 1 general distribution allocation*). Subsequently, additional amounts were allocated for targeted distributions to health care entities with specific characteristics, and an unspecified amount was allocated to pay health care entities for treating uninsured COVID-19 patients. At the time these sections were issued, the plan for distribution of the remainder of the Provider Relief Fund resources had not been determined.

Sections 6400.64–.66 pertain to accounting used by nongovernmental<sup>13</sup> health care entities for the Phase 1 general distribution allocation. When read in conjunction with the terms and conditions applicable to other distribution allocations from the Provider Relief Fund, the analysis provided in those sections may be helpful in evaluating the appropriate accounting.

[Issue Date: September 2020.]

#### **.64 Accounting for Provider Relief Fund Phase 1 General Distribution Payments**

*Inquiry* — A total of \$50 billion in payments from the Provider Relief Fund was allocated for general distribution to entities across the U.S. health system (the Phase 1 general distribution

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<sup>13</sup> References to *nongovernmental entities* include business entities and not-for-profit entities.



allocation). This allocation includes \$30 billion of funds distributed in early April 2020, plus an additional \$20 billion beginning in late April 2020.

According to the U.S. Department of Health and Human Services (HHS), the general distribution payments are subject to legal terms and conditions,<sup>14</sup> including the following, among others:

- The funds are to reimburse the recipient only for health care–related expenses or lost revenues that are attributable to COVID-19.
- The funds may be used only to prevent, prepare for, and respond to COVID-19.
- Noncompliance with the terms and conditions is grounds for the recoupment of some or all of the payments by HHS.
- The recipient will not use the funds to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse.

Recipients will be required to submit documentation to HHS demonstrating that these payments were used for health care–related expenses or lost revenue attributable to COVID-19, and HHS has stated that it will perform significant anti-fraud and auditing work. HHS has also stated that to avoid recoupment, recipients must be able to demonstrate that total payments from the Provider Relief Fund (including the general distribution payments) do not exceed their lost revenues and increased expenses attributable to COVID-19 that have not or will not be reimbursed from other sources.<sup>15</sup>

How should nongovernmental<sup>16</sup> health care entities account for these general distribution payments from the Provider Relief Fund?

*Reply —*

### *Not-for-Profit Health Care Entities*

Because the Phase 1 general distribution payments are for the purpose of providing relief to health care entities (rather than for the direct benefit of HHS), not-for-profit (NFP) health care entities would account for them as nonexchange transactions in accordance with the “contributions received” subsections of FASB *Accounting Standards Codification* (ASC) 958-605, *Not-for-Profit Entities—Revenue Recognition*. That model requires entities to first determine if a nonexchange transaction (hereafter referred to as a *contribution*) is conditional or unconditional. If a recipient is required to meet conditions imposed by the government to be entitled to receive or keep the funds, then the contribution is conditional, and recognition of contribution revenue is deferred until the conditions are substantially met. An NFP health care

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<sup>14</sup> See <https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/terms-conditions/index.html>.

<sup>15</sup> HHS FAQ 5/6/20.

<sup>16</sup> See footnote 13.

entity cannot factor in the likelihood that the condition will be met in determining whether a grant is conditional or unconditional.

Because entitlement to the general distribution payments is conditioned upon having incurred health care–related expenses or lost revenues that are attributable to COVID-19 (that is, a barrier to entitlement), and because noncompliance with the terms and conditions is grounds for recoupment by HHS of some or all of the payments (that is, a right of return), the general distribution payments would be considered conditional contributions under FASB ASC 958-605. Thus, contribution revenue would be recognized only to the extent that health care–related expenses or lost revenues have been incurred at that date, which will not be reimbursed from other sources.

NFP health care entities will need to evaluate their individual facts and circumstances in determining the extent to which conditions have been substantially met at a given reporting date (see section 6400.65). Payment amounts received that exceed recognizable contribution revenue (for example, because entitlement is conditioned on health care–related expenses or lost revenues that are expected to be incurred in the subsequent accounting period) are reported as a refundable advance (that is, a liability).

To the extent that conditions have been met (and, thus, contribution revenue is recognizable), FASB ASC 958-605 also requires a recipient to consider whether the government has imposed restrictions on the use of the funds. Because the general distribution payments can only be used to prevent, prepare for, or respond to COVID-19, they would be considered donor-restricted. Due to the linkage of the conditions with the restrictions, restrictions will likely be satisfied simultaneously with meeting the conditions (but each entity’s specific facts and circumstances would need to be considered). Thus, in an NFP health care entity’s statement of operations and statement of changes in net assets, any contribution revenue recognized would be reported as an increase in donor-restricted net assets, along with a reclassification to net assets without donor restrictions to reflect the satisfaction of the restriction. However, an NFP health care entity that has elected one of the “simultaneous release” accounting policy options described in paragraph 4A–B of FASB ASC 958-605-45 (for donor-restricted contributions whose restrictions are met within the same reporting period) would be permitted to report the contribution revenue directly in net assets without donor restrictions.

#### *For-Profit Health Care Business Entities*

Because the Phase 1 general distribution payments are for the purpose of providing relief to health care entities (rather than for the direct benefit of HHS), health care business entities would account for them as nonexchange transactions.

FASB Accounting Standards Update (ASU) No. 2018-08, *Not-for-Profit Entities (Topic 958): Clarifying the Scope and the Accounting Guidance for Contributions Received and Contributions Made*, established accounting guidance within U.S. GAAP for nonexchange transactions that are contributions. The ASU was codified in FASB ASC 958-605. However, because the scope of FASB ASC 958-605 excludes transfers of assets from governments to business entities, there is no explicit guidance within U.S. GAAP on the accounting for government grants to business entities (hereafter referred to as *government grants*). When

selecting the appropriate accounting model to apply to a government grant, a health care business entity should consider

- a. U.S. GAAP guidance on selecting accounting principles for transactions or events for which no guidance exists (FASB ASC 105, *Generally Accepted Accounting Principles*);
- b. the specific characteristics and facts and circumstances associated with the grant; and
- c. any preexisting accounting policies the entity may have established for government grants.

FASB ASC 105 describes the decision-making framework for determining the guidance to apply when guidance for a transaction or event is not specified within U.S. GAAP.<sup>17</sup> The AICPA staff has observed that guidance in International Accounting Standard (IAS) 20, *Accounting for Government Grants and Disclosure of Government Assistance*, FASB ASC 958-605<sup>18</sup> (discussed in the reply for NFP health care entities), or FASB ASC 450-30, *Contingencies—Gain Contingencies*, might be considered for application by analogy.

Under the IAS 20 framework, government grants cannot be recognized in income until there is reasonable assurance that a recipient

- a. will comply with the conditions associated with the grant and
- b. will receive the grant.

Thus, before recognition can occur, a health care business entity should have received the grant payments (or have reasonable assurance that it will receive grant payments in an amount that can be reliably estimated) and must be reasonably assured of meeting any compliance requirements associated with receiving or retaining the funds. As used in IAS 20, “reasonably assured” is a threshold generally considered analogous to “probable” as defined in FASB ASC 450-20, *Contingencies—Loss Contingencies*.<sup>19</sup>

Under the IAS 20 framework, once there is reasonable assurance that the conditions will be met, the earnings impact is recorded “on a systematic basis over the periods in which the entity recognizes as expenses the related costs for which the grants are intended to compensate.”<sup>20</sup> Thus, with respect to the general distribution payments, grant income would be recognizable

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<sup>17</sup> FASB *Accounting Standards Codification* (ASC) 105-10-05-2 explains that, in the absence of explicit guidance, entities should first analogize to other areas of authoritative generally accepted accounting principles before considering other nonauthoritative sources.

<sup>18</sup> The issue of business entities analogizing to the guidance in FASB ASC 958-605, *Not-for-Profit Entities—Revenue Recognition*, was discussed by FASB staff at the Private Company Council meeting on [April 17, 2020](#), as well as by the FASB Not-for-Profit Advisory Committee during its meetings on [September 13–14, 2018](#), and [April 7, 2020](#).

<sup>19</sup> The FASB ASC Master Glossary defines *probable* as “[t]he future event or events are likely to occur.”

<sup>20</sup> Paragraph 12 of International Accounting Standard (IAS) 20, *Accounting for Government Grants and Disclosure of Government Assistance*.

only to the extent that the health care business entity is reasonably assured that health care–related expenses or lost revenues attributable to COVID-19 that will not be reimbursed from other sources have been incurred at a reporting date. Companies will need to evaluate their individual facts and circumstances in evaluating the extent to which compliance with grant conditions is reasonably assured at a given reporting date (see section 6400.65). If the amount of general distribution payments received or receivable at a reporting date exceeds the amount of grant for which the reasonable assurance threshold has been met, the difference is reported as a refundable advance (that is, a liability).

Under the IAS 20 framework, the grant may be reported either as income or as a reduction in the related expense that the grant is intended to defray. To the extent that a general distribution grant represents compensation for lost revenues (and, thus, there are no “related expenses” against which it would be offset), it would be presented as grant income.

FASB ASC 450-30 outlines a model for gain contingency recognition. Under this model, the earnings impact of a gain contingency is recognized when all the contingencies related to receipt of the assistance have been met and the gain is realized or realizable. A health care business entity would record the general distribution payments received from the Provider Relief Fund as a refundable advance (that is, a liability). Those amounts would continue to be reported as a liability until the grant proceeds are realized or realizable, at which time the earnings impact would be recognized.

A health care business entity with material grants should disclose its accounting policy for such grants and the related impact to the financial statements.

[Issue Date: September 2020.]

### **.65 Recognition Uncertainties Associated With Provider Relief Fund General Distribution Payments**

*Inquiry* — What uncertainties associated with aspects of the general distribution payment terms and conditions would need to be considered when evaluating the extent to which conditions have been substantially met (for nongovernmental<sup>21</sup> health care entities that apply the FASB ASC 958-605 model) or that compliance with conditions is reasonably assured (for nongovernmental health care entities that apply the IAS 20 model)?

*Reply* — The uncertainties are similar, irrespective of the recognition model applied. Prior to issuance by HHS of proposed regulations or other guidance clarifying either the precise nature of allowable health care–related expenses or a specific approach to be used for determining the amount of lost revenues, uncertainty will exist with respect to evaluating the amount of contribution or grant income that is recognizable at a given reporting date. Additionally, to avoid recoupment, recipients must be able to demonstrate that total payments from the Provider Relief Fund (for example, the general distribution payments, targeted distribution payments, and claims payments received for treating uninsured patients) do not exceed lost revenues and increased

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<sup>21</sup> See footnote 13.

health care–related expenses attributable to COVID-19 (excluding losses or expenses that have been or will be reimbursed from other sources). Even for health care entities with a large amount of cushion between what they believe to be reimbursable health care–related expenses or lost revenues and the amount of general distribution payments received, any payments to be received from other allocations within the Provider Relief Fund, as well as potential reimbursements from other sources (for example, the Federal Emergency Management Agency (FEMA), business interruption insurance, and other CARES Act programs), would need to be considered when making this assessment at a reporting date.

If a nongovernmental health care entity expects that, ultimately, its total payments from the Provider Relief Fund will exceed its lost revenues and increased health care–related expenses attributable to COVID-19 (excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse), it will be important to consider the appropriate financial statement presentation and disclosure for the liability related to the funds received that may need to be returned to HHS.

[Issue Date: September 2020.]

#### **.66 Period of Accounting for Provider Relief Fund General Distribution Payments**

*Inquiry* — Should nongovernmental<sup>22</sup> health care entities begin to account for income arising from the general distribution payments in the reporting period the CARES Act was signed into law (March 27, 2020) or when information regarding the recipients and payment amounts became available from HHS?

*Reply* — Although the funding was appropriated in March 2020, subsequent government action was necessary in order to determine which entities would receive general distribution payments and in what amounts. Those subsequent government actions did not take place until after March 31, 2020. Therefore, in quarterly or annual financial statements issued by nongovernmental health care entities for the period ended March 31, 2020, the contribution or grant associated with the general distribution payments would be considered a non-recognized (Type II) subsequent event in accordance with FASB ASC 855, *Subsequent Events*, with consideration given to the need to provide the non-recognized subsequent event disclosures in FASB ASC 855-10-50-2.

[Issue Date: September 2020.]

#### **.67 Accounting for Uninsured Pool Portion of Provider Relief Funds**

*Inquiry* — A portion of the Provider Relief Fund was used to establish a program that will pay health care entities for treatment of uninsured COVID-19 patients. This program is administered by the Health Resources and Services Administration (HRSA), a division of HHS. Health care

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<sup>22</sup> See footnote 13.

entities that enroll in the HRSA COVID-19 Uninsured Program and agree to the conditions of participation are paid for the services at Medicare program rates. Participation rules are similar to the Medicare fee-for-service program, with health care entities agreeing to accept the program payment amount as payment in full (that is, they cannot bill patients for a remaining balance).

For nongovernmental<sup>23</sup> health care entities, are payments for services provided to uninsured COVID-19 patients that are billed to the federal government under the HRSA COVID-19 Uninsured Program accounted for as patient service revenue, or are such payments accounted for as nonexchange transactions?

*Reply* — According to HRSA, payments received by health care entities under the program are claims reimbursements and should be treated in the same manner as reimbursements received from commercial insurance, Medicare, or Medicaid. Consequently, the federal government is acting as a third-party payer and, accordingly, the payments would be considered patient service revenue. In light of the no-balance-billing requirement, differences between an uninsured patient's gross service revenue and the amount payable by the program would be considered contractual allowances (explicit price concessions), rather than changes in the estimate of implicit price concessions (if the entity has adopted FASB ASC 606, *Revenue from Contracts with Customers*) or changes in the estimate of the provision for uncollectible accounts (if the entity has not yet adopted FASB ASC 606).

[Issue Date: September 2020.]

## **.68 Accounting for Payments Received Under the Medicare Accelerated and Advance Payment Program**

*Inquiry* — Under Medicare program rules, the federal agency that administers Medicare and Medicaid programs (the Centers for Medicare and Medicaid Services, or CMS) can make accelerated or advance payments to eligible health care entities during periods of claims payment disruption or unusual operating circumstances (for example, national emergencies or natural disasters). The CARES Act provided for a temporary expansion of this program<sup>24</sup> during the public health emergency.

Under this program, qualifying health care entities can request advances against payments for future claims that they are expected to submit to Medicare. With the exception of hospitals paid under the Period Interim Payment (PIP) program (for whom modified requirements apply), recoupment of the advances begins 120 days after an advance payment is issued. Prior to the beginning of the recoupment period, the health care entity continues to bill for services provided to Medicare patients and is paid by CMS as usual. Once the recoupment period begins, amounts billed to CMS for services provided will be offset against the advance payment until the advance is fully recouped. The majority of hospitals will have one year to offset future claims against the advance; other providers and suppliers will have 210 days. If the advance has not been entirely

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<sup>23</sup> See footnote 13.

<sup>24</sup> See [www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf](https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf).

offset by claims at the end of this period, the health care entity will be required to repay the remaining amount.

How should nongovernmental<sup>25</sup> health care entities account for payments received under the Medicare Accelerated and Advance Payment Program?

*Reply* — The funds provided under this program represent advances on payments for future goods or services to be provided to Medicare patients. Therefore, nongovernmental health care entities that have not yet adopted FASB ASC 606 would reflect the advance payments received as a liability (refundable advance) that will be reduced over time as revenue is recognized for claims submitted for services provided after the recoupment period begins.

Nongovernmental health care entities that have adopted FASB ASC 606 will generally reflect the advances received as a contract liability under FASB ASC 606-10-45-2. The contract liability will be reduced over time as revenue is recognized for claims submitted for services provided after the recoupment period begins. However, an assessment should be made to determine whether the health care entity expects to fully settle the liability through providing future services to Medicare patients. If an entity does not expect to have sufficient Medicare volume to be able to settle the liability by providing services, it may be appropriate to reclassify any amounts expected to be repaid to CMS from contract liability to a refund liability. Similarly, if an entity expects to settle the liability through repayment of the funds prior to the start of the recoupment period, the advances received would be reflected as a refund liability, not a contract liability.

[Issue Date: September 2020.]

## **.69 Accounting for Temporary Increases in Medicare and Medicaid Payments**

*Inquiry* — The CARES Act attempts to alleviate some of the financial strain on hospitals, physicians, and other health care entities through a series of new policies that temporarily boost Medicare and Medicaid payments and allow for added flexibility. For example, it increases the Medicare in-patient payment rate by 20 percent for treating COVID-19 patients, delays the annual 2 percent cut (sequester) in Medicare payments to health care providers, and reduces or delays cuts in Medicaid Disproportionate Share Hospital (DSH) funding.

How will these changes to Medicare and Medicaid payment rules affect recognition of patient service revenue by nongovernmental<sup>26</sup> health care entities?

*Reply* — If a nongovernmental health care entity has adopted FASB ASC 606, such changes will affect its estimates of variable consideration when determining the transaction price for services provided to patients. Health care entities generally estimate the transaction price, including the related explicit price concessions (contractual adjustments) and implicit price concessions, by using historical portfolios of data (for example, by patient type, payor). In view of the changes to

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<sup>25</sup> See footnote 13.

<sup>26</sup> See footnote 13.

Medicare and Medicaid payment rules, health care entities should also consider that their historical models used to estimate contractual adjustments with third-party payers might not be indicative of future cash flows and will likely need to be adjusted for changes to expected payments.

If a nongovernmental health care entity has not yet adopted FASB ASC 606, such changes will affect its estimates of contractual adjustments that are deducted from gross service revenue when determining net patient service revenue. These entities should consider that their historical models used to estimate contractual adjustments with all third-party payers (not just Medicare and Medicaid) might not be indicative of future cash flows and will likely need to be adjusted for changes to expected payments.

Payment changes that are applied retroactively often result in lump-sum payments. Nongovernmental health care entities should ensure that retroactive lump-sum amounts received in connection with changes in payments for services to Medicare or Medicaid patients are appropriately distinguished from lump-sum payments received in connection with nonexchange transactions (for example, the general distribution payments discussed in sections 6400.64–.66). Retroactive lump-sum payments received in connection with payments for services to patients should be considered in the determination of patient service revenue, not accounted for as contributions or grants.

[Issue Date: September 2020.]

### **.70 FEMA Public Assistance Payments to NFP Health Care Entities for Emergency Protective Measures During the COVID-19 Pandemic**

*Inquiry* — Through its public assistance (PA) program, FEMA provides assistance to governments and certain NFPs in responding to major disasters or emergencies. Certain NFP health care entities may be eligible for reimbursement of “extraordinary” costs associated with operating emergency rooms and providing temporary facilities for emergency medical care or expanding existing medical care capacity during the declared COVID-19 public health emergency under Category B (Emergency Protective Measures) of FEMA’s PA program. How should eligible NFP health care entities account for reimbursement received from FEMA for costs associated with eligible emergency medical care activities?

*Reply* — Because grants made to NFP health care entities under Category B of FEMA’s PA program are for the purpose of reimbursing certain specific costs incurred in connection with the public health emergency (rather than for the direct benefit of FEMA), they would be accounted for as nonexchange transactions in accordance with the “contributions received” subsections of FASB ASC 958-605.

Generally, FEMA provides public assistance awards on the basis of actual costs incurred (that is, through cost-reimbursement grants that are subject to the Office of Management and Budget [OMB] Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards). Because the NFP health care entity must incur qualifying expenses in accordance with OMB rules and regulations, the terms of the award limit the entity’s discretion

about how to use the assets; in addition, any disallowed costs that may be drawn down are required to be refunded (and, thus, a right of return exists). Although individual facts and circumstances would need to be considered, the assistance provided by FEMA for issues related to the COVID-19 pandemic would generally be accounted for as conditional contributions. Once FEMA has obligated the funds (that is, has approved the grant award for release), contribution revenue would be recognized as the conditions are met. An NFP health care entity cannot factor in the likelihood that the condition will be met in determining whether a grant is conditional or unconditional.

Because the funding is provided to defray certain specific costs, it would be classified as donor-restricted. Due to the linkage of the conditions with the restrictions, restrictions will likely be satisfied simultaneously with meeting the conditions. Thus, in an NFP health care entity's statement of operations and statement of changes in net assets, any contribution revenue recognized upon meeting the conditions would be reported as an increase in donor-restricted net assets, along with a reclassification to net assets without donor restrictions to reflect the satisfaction of the restriction. However, an NFP health care entity that has elected one of the "simultaneous release" accounting policy options described in paragraph 4A-B of FASB ASC 958-605-45 (for donor-restricted contributions whose restrictions are met within the same reporting period) would be permitted to report the contribution revenue directly in net assets without donor restrictions.

The revenue recognition model used for grants made under Category B of the PA program will differ from the revenue recognition model used for FEMA awards in connection with damage to facilities and equipment arising from natural disasters. Because losses associated with damage to facilities and equipment normally result in filing insurance claims, revenue from those FEMA awards typically is recognized using a "loss recovery" model that applies when long-lived assets such as property, plant, and equipment are involuntarily converted to monetary assets via insurance recoveries. The reimbursement provided for the COVID-19 pandemic will pertain to costs incurred in eligible emergency medical care activities, rather than to cover property losses potentially covered by insurance; therefore, the loss recovery revenue recognition model would not apply to COVID-19 awards.

[Issue Date: September 2020.]