

## Reponse to Proposed Accounting Standards Update Health Care Entities

(Topic 954)

### Measuring Charity Care for Disclosure

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**Question 1:** Do you agree that an entity's disclosure of a measure of charity care should be based on the direct and indirect costs of providing the charity care? If not, why not? What alternative measure would you prefer and why?

**Response 1:** We do not agree that direct and indirect costs provide the best measurement of charity care as the total of direct and indirect costs do not represent the community value received for charity care services rendered to the discount pay patients. The value includes certain intangible costs including the opportunity cost of serving other fee for service, Medicare and Medicaid patients, plus the profit foregone on charity care patients. Furthermore, when explaining the communal value of charity care service to readers of financial statements, it is incumbent to provide them a framework to understand the value of those services provided to the community and patients served. The concept of discounted revenue and the resulting provision of charity care services is an easier concept to grasp than direct and indirect costs. It would bring clarity and consistency to the presentation of charity care.

The alternative measure should be the gross revenue less the average allowance for contractual adjustments for the service type as the provision of charity care services. This amount more clearly represents the communal value of services rendered to the underinsured and uninsured population within the community. Cost does not recognize the communal value.

**Question 2:** The Task Force considered requiring a measure of charity care based on the average rate collected from paying patients for similar services. Do you believe that this measure would be more meaningful for financial statement users than the cost to provide charity care and if so, why? If not, why do you believe cost is more meaningful?

**Response 2:** Measuring charity care based on the average rate collected from paying patients for similar services would be more meaningful for financial statement users as it more closely represents fair market value of the services rendered. The sum of direct and indirect costs is more subjective which will not lead to direct comparability. The following terms are not defined within the Accounting Standards Codification Glossary: direct, indirect, cost, direct costs, or indirect cost. Until there is universal clarity and use of these terms, to assume that amounts reported will be consistent and comparable is unreasonable.

**Question 3:** Do you agree that the amendments in this proposed Update should be applied retrospectively? If not, why not?

**Response 3:** See response 4.

**Question 4:** Do you anticipate that there would be significant changes in accounting systems or information gathering to implement the provisions of the proposed Update? If yes, please explain.

**Response 4:** This proposed standard is also Hospital centric in its view. The underlying assumption that “the proposed disclosure is based on information that already is being captured” is presumptuous. There are many organizations that do not capture cost information including many multi-specialty physician group practices of various sizes and sophistication. To capture cost information would require significant changes to accounting systems and applying it retroactively would be “nightmarish”.

Current systems do not capture cost information in either the Billing, Charge Entry or Accounting systems in our environment. To report accurately on costs and indirect costs would require an investment during a period where many healthcare organizations are scrambling to meet the requirements for “meaningful use” in implementing electronic medical records. Overlaying this requirement for direct and indirect cost data would be burdensome. It would require resources to analyze the impact, develop an appropriate approach,

design the applications, and implement a solution at a critical time for most organizations.

**Question 5:** How much time do you believe would be necessary for you to efficiently implement the provisions of this proposed Update?

**Response 5:** To effectively analyze the requirements, prepare a requirements definition, estimate a budget, submit for capital approval, go through an RFP process, evaluate alternatives, select, test and install an appropriate solution could range from one to two years. This assumes that the concepts of direct and indirect costs can be defined to the satisfaction of management and users of financial statements.

**General:** I would suggest that more needs to be done in structuring a solution oriented to the entire healthcare industry and consider the various constituents whom are being impacted by this proposal including hospitals, multi-specialty physician group practices, ambulatory surgery centers, skilled nursing facilities, and other healthcare providers which may or may not have the level of sophistication in costing and financial reporting that hospital systems will.

Also, the scope of this proposal is “any health care entity”. I would like clarification on what is meant by this broad and ambiguous term. What types of organizations are included? I check the ASC glossary and found no definition for this term or anything like it.

With respect to point BC4, I believe your assumption that health care entities do not have the average rate collected from paying patients is erroneous. It is more likely that this information is readily available since it has to be generated to perform collections from payors and patients.

With respect to point BC9, I disagree. It is my opinion that entities would incur significant costs as a result of the proposed amendment and that the information is not being captured by many health care entities.