May 17, 2010

Technical Director
Financial Accounting Standards Board
401 Merritt 7
PO Box 5116
Norwalk, CT 06856-5116

RE: Proposed Accounting Standards Update—Health Care Entities (Topic 954): Measuring Charity for Disclosure (A consensus of the FASB Emerging Issues Task Force) (EITF090L)

Dear FASB Technical Director,

On behalf of Verité Healthcare Consulting, LLC, I am pleased to provide the Financial Accounting Standards Board with comments on the Proposed Accounting Standards Update for Measuring Charity for Health Care Entities.

For background, I have extensive experience in community benefit accounting and reporting, including measurement of uncompensated care. I was a co-author of the Catholic health Association (CHA) *Social Accountability Budget* published in 1989, and as part of that effort, I helped CHA develop the first accounting framework for community benefit, including charity care. That was one of the first publications to suggest that charity care should be valued based on cost (using a ratio of cost to charges) rather than on the basis of gross charges.

In recent years, I have updated the CHA community benefit accounting framework by drafting the accounting chapters and accounting worksheets in the *Guide to Planning and Reporting Community Benefit* published by CHA in May 2006 and December 2008. With a few notable modifications, the worksheets were used by the IRS and incorporated into Form 990, Schedule H. In 2008, I worked with IRS officials to help develop the instructions to Schedule H, and also interacted with members of the HFMA Principles & Practices Board to review the accounting and operational implications of HFMA Statement 15 – which provides guidelines for accounting and policies governing charity care and bad debt.

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 measures would you prefer and why?

Answer: Enhancing the comparability of health care entities by specifying the method by which they measure charity care is important. Valuing charity care at cost (instead of charges) is an excellent step in achieving comparability and in establishing the true impact of charity care on financial statements as evidenced by its use in the Catholic

Health Associations Social Accountability Budget in 1989 and on IRS Form 990, Schedule H.

The generally accepted methodology for valuing charity care at cost is to apply an entity's "ratio of cost to charges" to the amount of charity care charges forgiven pursuant to the entity's charity care policy. The ratio of cost to charges (total expense excluding bad debt divided by total gross charges) by definition includes both direct and indirect costs.

However, there are two issues with valuing charity care using this methodology. An alternative valuation measure would provider greater comparability than valuing charity only on the basis of direct and indirect cost.

- The **first** issue is that an entity can receive credit for providing charity care even though it is making (or reporting) what can be a substantial profit on accounts where the patients have received partial charity discounts, and

- The **second** issue is that entities with comparatively high charges can receive more credit for providing charity care than entities with comparatively low charges – even though patients receive lower (or comparable) bills at the lower-charge provider.

These two problems are corrected if charity care is valued not based on the following formula:

Charges Forgiven Pursuant to Charity Care Policy

Times

Ratio of Cost to Charges

But instead on this formula:

(Total Charges for Accounts Receiving any Charity *Times* Ratio of Cost to Charges)

Minus

Any Revenue from Patients or Third-Party Payers Accrued in those Accounts

The second formula accounts for the fact that patients receiving a partial charity discount (including "underinsured" patients receiving charitable discounts for their co-payments or deductibles) contribute revenue towards the cost of their care. Under the second formula, only if the entity's revenues for a given patient are below the cost of care for that patient would the entity report charity care.

The following examples illustrate these issues.

For example, take a patient account where the gross charges are $10,000 for services provided. The entity's "ratio of cost to charges" is 0.40. The total cost of the patient's care would be $4,000 (total charges for the account x 0.40).

If this entity provides a 50% charity care discount, the patient would be granted a $5,000 charity care discount at charges and would have medical debt (patient bills) for the $5,000 balance.

If valued at only at cost, the $5,000 charity discount at charges would be multiplied by the ratio of cost to charges (in this example is 0.4) yielding $2,000 in charity care valued at cost (see table below).

Total Charge	$	10,000
Charity Discount		**50%**
Charity Discount at Charges	**$**	**(5,000)**
Patient Bill	$	5,000
Ratio of Cost to Charges (RCC)		0.40
Cost of the Care	$	4,000
Charity Care at Cost	**$**	**2,000**

However, in this example the patient is being asked to pay $5,000 for care received. The entity may have established a payment plan for this amount, recognized revenue of $5,000, and added the $5,000 to its accounts receivable. The $5,000 in revenue is above the $4,000 cost of the patient's care. As a result, the healthcare entity is recording a $1,000 (or 25 percent) profit on the account.

If charity care were valued using the "second formula" on the prior page, the entity in this example would not report charity care for this account, because patient revenue is greater than cost. Since the ratio of cost to charges is 0.40, only if the discount provided by the entity is 60 percent or greater would charity be reported.

Note that not recording charity in this example is consistent with HFMA Statement 15, which states in point 6.3 (emphasis added):

> "Cost of charity care should be estimated using the most accurate method available to the facility <u>less any related revenue on those accounts</u>."

In the above example, the entity has recorded revenue that more than offsets the cost of care, so charity is not reported. If the patient fails to pay the $5,000 bill, then any uncollected balance would be classified as bad debt expense.

The second main issue with valuing charity care at cost is that it can reward high charge entities compared to lower-charge entities. Gross charges for healthcare entities generally are at the discretion of each entity and can vary widely.

In the following example, a higher charge entity has gross charges of $20,000 while a lower charge entity has gross charges of $10,000. The higher charge entity has a ratio of cost to charges of 0.20; the lower charge has a ratio of 0.40. The higher charge entity grants a charity discount of 50 percent. The lower charge entity grants no charity discount. Both entities have billed the example patient the same amount and have incurred the same amount of total costs for patient services provided. When charity care is valued at based on charity care discount valued at charges x the ratio of cost to charges, the high charge entity reports charity care cost of $2,000 while the lower charge entity reports no charity care.

		High Charge		**Lower Charge**
Total Charge	$	20,000	$	10,000
Charity Discount		50%		0%
Charity Discount at Charges	**$**	**(10,000)**	**$**	**-**
Patient Bill	$	10,000	$	10,000
Ratio of Cost to Charges		0.20		0.40
Cost	$	4,000	$	4,000
Charity Care at Cost	**$**	**2,000**	**$**	**-**

Under the second formula, neither entity would report charity care, because the example patient bills are greater than the total cost of the patients' accounts. Only if the high charge entity provides a discount that is 80 percent or greater would it report charity care.

We recommend valuing charity care as described by HFMA Statement 15: "Cost of charity care should be estimated using the most accurate method available to the facility less any related revenue on those accounts." Formulaically this means subtracting revenue from the cost of care for patients being granted financial assistance, and only reporting charity for those accounts where the entity has patient or third-party revenue lower than the estimated cost of care. If patients are granted a 100 percent charity care discount (free care), then there is no revenue offset.

We also recommend including as charity care cost – any provider taxes or assessments levied on hospitals or other entities that provide resources to offset the cost of care for uninsured patients. For example, several states require hospitals to pay funds to the state Medicaid program. Those funds are matched with federal resources and then distributed back to hospitals as disproportionate share hospital revenue. If those resources are targeted to hospitals providing the most care for patients qualifying for charity, then the cost of the taxes or assessments should be considered charity care cost and the revenue received should be considered an offsetting charity care revenue.

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?

The same issues described in the answer to Question 1 apply to valuing charity care based on average rates collected from paying patients. Payment rates received from third-party payers vary from state to state, market to market, and entity to entity. For example, entities located in states would low payment rates for Medicaid would report lower charity care values. Entities with lower payment rates would be penalized when it comes to reporting charity care; entities with higher payment rates (and perhaps greater ability to provide charity) would be able to report greater amounts of charity – even though the underlying cost of charitable services provided is the same for the entities.

Cost (net of revenue from patients or third-party payers for patients qualifying for financial assistance) is the most meaningful and direct measure of the actual loss associated with providing charity care.

It is worth noting, however, that recently-passed federal health reform legislation requires tax-exempt hospitals to offer discounts to patients qualifying for charity that are no lower than amounts "generally billed" to insured patients. This requirement takes effect before the beginning of each hospital's next tax year. Accordingly, tax-exempt hospitals are likely to adjust the discounts offered to patients qualifying for financial assistance.

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

It would be helpful to apply the amendments retrospectively.

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.

Many hospitals have been valuing charity care at cost (using the first formula) for years. The proposed valuation method has not be as prevalent in non-hospital entities. Physician groups, health maintenance organizations, home health agencies, and others may have more difficulty in establishing the cost of care for patients receiving financial assistance.

If FASB indicates that charity care should be valued using the "second formula," then there would be significant changes in accounting system and information gathering. Charity care would need to be valued either account-by-account, or by arraying charity care write-offs at different levels of the "sliding fee scale" that typically is established. Only the net cost for accounts where revenue in accounts for patients qualifying for financial assistance is lower than the estimated cost of care would be reported as charity.

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

Most hospitals collect the required data currently. The Update would require new procedures for non-hospital entities, in particular if the "second formula" is used as the basis for valuing charity care.

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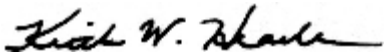
Thank you for the opportunity to provide comments on the proposed FASB Accounting Standards Update regarding charity care.

Sincerely,



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