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HFMA PRINCIPLES AND PRACTICES BOARD

Assessing reality in healthcare financial information

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Overview

Healthcare stakeholders, including management, regulators, investors, rating agencies, lenders, media and others seek information to **evaluate operating margins and profitability metrics** for hospitals and other healthcare organizations. Financial statements, tax/information returns and Medicare cost reports are key information sources for the healthcare industry, but many times they convey seemingly contradictory information, which creates confusion for both management and external stakeholders.

Understanding the purpose and use of distinct information sources is essential to **assessing reality in healthcare information**. Hospitals and other healthcare organizations, for instance, typically prepare their financial statements using generally accepted accounting principles (GAAP). GAAP-based financial statements are prepared following a set of accounting standards prescribed by the Financial Accounting Standards Board or the Governmental Accounting Standards Board.

GAAP aims to improve the clarity, consistency and comparability of financial statement information. The Medicare cost report is a regulatory filing for healthcare organizations based on regulations specified by the Centers for Medicare & Medicaid Services (CMS). The Internal Revenue Service (IRS) requires most hospitals to complete Schedule H of Form 990, which provides information on financial assistance and other community benefits.

There are many differences between regulatory reporting under CMS guidelines, GAAP, and Form 990 reporting. For example, CMS uses allowable cost principles for cost reporting whereas expenses reported under GAAP follow the accrual basis of accounting, which includes expenses accrued but not yet paid, for reporting in the financial statements. While GAAP reports charity care on a consolidated basis, Schedule H of Form 990 reporting is specific to the reporting 501(c)(3) hospital's Employer Identification Number (EIN), which oftentimes does not include other subsidiaries that also provide charity care.

Assessing financial information

It is important that conclusions reached from research and analysis consider the variations derived from financial statement and cost report information. Some of the key differences are reviewed below.

PHYSICIAN COSTS AND PROFESSIONAL REIMBURSEMENT

Hospital-based physician costs and related professional reimbursement are mostly excluded from cost report margins. Over the past two decades, hospitals have increasingly employed many physicians in their communities and much of this expense is not an ultimate component of allowable costs on the Medicare cost report. However, this level of physician expense for hospital organizations is often material to the hospital's overall financial performance as reflected in GAAP-based financial information.

In addition, step-down principles in the cost report allocate overhead costs away from hospital departments and into physician clinics. These direct physician costs and allocated overhead amounts are not a component of computed Medicare costs reflected in the cost report, which impacts the margin reported therein.

MEDICARE SERVICES REIMBURSED BY FEE SCHEDULE METHODOLOGY

Medicare pays for many outpatient services under a fee-schedule methodology, including certain lab, therapy, imaging and drug items. Services paid based on the Medicare fee schedule are not included in the computations of Medicare outpatient cost on the cost report. For Schedule H of Form 990 reporting costs, Medicare services are not included in the financial assistance disclosure, however Medicare shortfalls or surpluses, along with bad debt shortfalls or surpluses, are included in subsequent Schedule H disclosures.

COMMUNITY BENEFIT COSTS

The definition of patient care has advanced in the last decade to include promoting healthy communities. Many community benefit costs for prevention, health awareness and wellness are considered nonpatient care from a Medicare cost report standpoint. Therefore, they are treated as nonallowable costs under CMS's regulatory reporting and excluded from the cost report. However, they are included as expenses under GAAP.

Like the physician clinics discussed above, step-down principles in the cost report allocate overhead costs away from hospital departments and charge a portion of them to nonreimbursable cost centers.

For Form 990 Schedule H reporting purposes, many community benefit costs are able to be disclosed as part of the total financial assistance and other community benefit percentage. Other common community benefit categories reported are community health education, health professionals education and subsidized health services.

SYSTEM COST ALLOCATION

Multi-hospital health systems allocate corporate home office cost among multiple components of the organization on the cost report. Frequently hospitals may not receive the full allocation reflective of their actual total cost, skewing perceived profitability higher than actual profitability. For Form 990 reporting purposes, expenses allocated across a health system could affect the cost-to-charge ratio, which is often utilized in the financial assistance percentage.

DISPROPORTIONATE SHARE AND UNCOMPENSATED CARE POOL REIMBURSEMENT

Certain Medicare reimbursement mechanisms, e.g., disproportionate share and uncompensated care pool amounts, are included in the cost report as a component of Medicare payments, but they are intended to compensate hospitals for a portion of their non-Medicare uncompensated care costs and for treating a high proportion of Medicaid patients. The costs incurred for treating these Medicaid patients and the uncompensated care amounts are often not considered when computing the cost of Medicare services. Considering these Medicare payment programs without the related cost they

are intended to cover enhances the operating margin and financial performance reflected in the cost report, which can be misleading to those who lack this background and context. Direct offsetting revenue is a key component of the Form 990 Schedule H reporting, effectively reducing or offsetting the community benefit expense. Understanding the allocation of these payments (e.g., financial assistance, Medicare, Medicaid) has a direct and potentially significant impact on the reporting of financial assistance percentages on Schedule H.

RESIDENT TRAINING COSTS AND REIMBURSEMENT

Hospitals that train interns and residents receive specific funding from the Medicare program for indirect medical education (IME) and direct graduate medical education (DGME). When IME and DGME reimbursement are included in Medicare payments, but the teaching programs' full cost are not included in the Medicare costs on the cost report, it creates inconsistency in margin information.

UNPAID PATIENT RESPONSIBILITY AMOUNTS

Medicare rates are based on a portion being paid by the patient through deductible or coinsurance amounts. When a portion is unpaid by the patient, often referred to as bad debt, it reduces the overall Medicare reimbursement received. This is not reflected in the cost report data but is included in the financial statements. These unpaid patient responsibility amounts dilute the actual reimbursement received and should be considered when comparing financial margins between the Medicare cost report and hospital financial statements. Whether a payment is considered bad debt or Medicare revenue impacts the placement on the Form 990 Schedule H. Bad debt is not considered financial assistance for purposes of the Form 990 Schedule H reporting, unless specified within the Financial Assistance Policy.

OTHER OPERATING REVENUES AND EXPENSES

Many other vital operating revenues and expenses, e.g., CARES Act funding, retail pharmacy, corporate compliance, and recruiting and retention, are considered in a provider's overall GAAP operating margin but are not reflected in cost report data. For Form 990 reporting, Schedule H financial assistance is reduced by any direct offsetting revenue such as CARES Act funding, while operating expenses have a direct impact on cost-to-charge ratio.

Within the cost report, certain schedules are intended to present financial information in a manner similar to GAAP financial statements and IRS Form 990 Schedule H reporting. However, these cost report worksheets, commonly referred to as the G schedules, are often completed inconsistently and thus may not be a highly reliable source of cost information. For example, system corporate office costs on the G schedules likely represent amounts that have been internally allocated to a particular hospital within the organization's network, but other cost report schedules are ultimately adjusting these internal cost allocations to a CMS-approved methodology.

The Medicare cost report is an important document that is used to provide information to CMS on key metrics and cost trending throughout the industry using specific regulatory cost reporting principles. Data obtained from the cost report and Form 990 Schedule H is used for various purposes by regulators, including justification for 501(c)(3) status, setting wage index factors for geographic areas, evaluating cost inflation trends to assist in establishing prospective rates and reconciling earned reimbursement amounts to interim payments that have been received. However, it is important that internal and external users of the cost report information — particularly regulators that are evaluating rate information and considering future rate adjustments — understand the significant differences and key limitations in reporting that occur based on regulatory cost reporting principles compared to GAAP financial reporting. There is a reason that GAAP is considered the gold standard for financial accounting and reporting purposes and required for public companies in the United States. GAAP financial reporting encompasses an organization's entire operations and is a better reflection of overall financial operating performance, including those costs excluded from the Medicare cost report. ▮

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