



healthcare financial management association

April 24, 2026

Mr. Alan Skelton
Director of Research and Technical Activities
Governmental Accounting Standards Board
801 Main Avenue
P.O. Box 5116
Norwalk, CT 06856-5116
Via email: director@gasb.org

Re: **Project No. 3-25**, *Financial Reporting Model Improvements-Subsidies*

Dear Mr. Skelton:

The Healthcare Financial Management Association's (HFMA's) Principles and Practices (P&P) Board appreciates this opportunity to comment on the Governmental Accounting Standards Board's (GASB's) Proposed Implementation Guide, *Financial Reporting Model Improvements-Subsidies*.

HFMA is a professional organization of more than 145,000 individuals involved in various aspects of healthcare financial management. In 1975, HFMA founded the P&P Board, a group of experts who serve as the primary advisory group in the areas of accounting principles and financial reporting practices to meet the unique characteristics of health service organizations.

Summary

The GASB states that the objective of this Implementation Guide is to provide guidance that clarifies, explains, or elaborates on the requirements related to subsidies in Statement No. 103, *Financial Reporting Model Improvements*. The proposal primarily consists of a set of targeted questions and answers that address real-world application issues such as how to identify, classify, and present subsidies within proprietary fund financial statements, including the new required subtotal for noncapital subsidies. This builds on the broader stated objective of Statement 103 to improve transparency and comparability in financial reporting by clearly separating subsidies from operating revenues and expenses, helping users better assess whether operations are self-sustaining.

More broadly, the guidance reflects GASB's effort to move from high-level standards to practical implementation support, responding to stakeholder questions and inconsistencies observed in practice. By formalizing interpretations as authoritative "Category B GAAP," the guide aims to promote consistency across governments while reducing ambiguity in applying subsidy definitions and reporting requirements. Ultimately, the proposal is less about changing policy and more about tightening execution—ensuring that subsidy reporting under the updated

financial reporting model is applied consistently, decision-useful, and operationally clear for preparers, auditors, and financial statement users.

HFMA P&P Board's response

The P&P Board has specific comments to provide:

Effective Date and Implementation Concerns

We recommend that the Board consider delaying the effective date of Statement No. 103 by one year to align with the anticipated issuance of interpretive Q&A guidance.

As currently written, Statement 103 cannot be implemented effectively without additional clarification. Requiring business-type activities (BTAs) to adopt the standard before the related guidance is issued places preparers in an impractical and unreasonable position. Because many governmental entities have June 30 fiscal year-ends and the final Q&A guidance is not expected until summer or fall with proposed effective date for fiscal years beginning after June 15, 2026, a substantial number of BTAs are essentially required to implement Statement 103 without adequate interpretive support. As a result, there is a high risk that entities will:

- Apply the standard inconsistently in the initial year of adoption
- Need to revisit, reanalyze, or potentially restate transactions in later periods once additional guidance becomes available

Such an outcome would introduce unnecessary cost, complexity, and confusion—without improving financial reporting quality. A one-year deferral would allow for orderly, consistent, and decision-useful implementation.

Conceptual Concerns with the Q&A Interpretation

We are concerned that the proposed Q&A reflects a fundamental misunderstanding of the three-party relationship inherent in patient service revenue transactions.

1. Mischaracterization of Patient-Payer Relationship

Q&A 4.1 (the Q&A) asserts that supplemental payments are not addressed in the contract between the patient and the payer (e.g., Medicaid), implying relevance to the subsidy determination. However, this observation is not meaningful in the context of healthcare finance, where:

- The patient–payer relationship addresses coverage, not price

- Payment amounts—whether base or supplemental—are not defined in the patient contract in any circumstance

Instead, pricing is governed by a separate contractual or regulatory arrangement between the payer (i.e. Medicaid) and the provider, to which the patient is not a party. As such, the Q&A's reasoning does not appropriately reflect how healthcare payment systems function.

For example, the contract is between Medicaid and the provider requiring the provider to accept reimbursement for services as outlined in the respective state's Medicaid plan, which include both based payments paid on behalf of the payment and most forms of variable consideration supplemental payments. It might be helpful to provide some background context as described below.

Formal agreement with CMS. To be entitled to federal funding, each state executes a formal agreement with CMS (called the Medicaid State Plan) detailing how that state's Medicaid program is to be administered. In effect, the state plan represents a contract between that state and the federal government addressing (among other things) the health care services that will be covered (i.e. the benefits to be provided to Medicaid enrollees) and how providers will be paid for providing those services. If the state wishes to change its benefits or how it pays providers, the state Medicaid agency must submit and receive CMS approval of a "state plan amendment" (SPA). For example, enactment by a state of a Medicaid provider tax program typically requires a SPA, because it affects how providers will be compensated for their services.

Separate contractual agreement. The state Medicaid agency executes a separate contractual agreement with each healthcare provider who agrees to treat Medicaid enrollees (the "provider agreement"). Among other provisions, the provider agrees to accept compensation determined by the rules of that state's Medicaid program (which in turn are dictated by the terms of the Medicaid State Plan with CMS).

Therefore, all these payments are part of the compensation a provider receives for providing services under a single contract. Thus, most supplemental payments are not a separate transaction covered by a separate contract, but rather part of a single transaction with variable consideration usually based on a provider's underlying utilization metric (i.e. services provided to Medicaid patients).

2. Overgeneralization of Supplemental Payment Programs

The Q&A focuses narrowly on Medicaid and does not reflect the diversity and variability of payment mechanisms across:

- Medicaid programs (including state-by-state variation)
- Medicare

- Private payers

Supplemental payments arise through a wide range of structures (e.g., state-directed payments, provider tax programs), each with distinct mechanics. The Q&A does not analyze any specific program in sufficient detail to support a generalized conclusion that such payments meet the definition of a subsidy.

3. Misinterpretation of Variable Payment Structures

Many payer-provider arrangements include variable payment mechanisms tied to performance, quality, or outcomes.

Variability in price:

- Is common across healthcare contracts
- Reflects incentives for higher-quality or more efficient care

The existence of variable consideration does not indicate that a payer is subsidizing a provider. Rather, it reflects a willingness to pay for enhanced value. Concluding that variability implies subsidy is inconsistent with both economic substance and industry practice.

4. Supplemental Payments Represent Consideration for Services

In the vast majority of cases, supplemental payments are directly tied to the provision of healthcare services to patients. Accordingly:

- These payments represent variable consideration for goods or services
- Therefore, do not meet the definition of a subsidy

While limited exceptions may exist (e.g., payments for infrastructure or IT investments), these are not representative of the broader population of supplemental payment programs.

5. Unsupported Assertion Regarding Pricing Behavior

The Q&A suggests that supplemental payments enable providers to lower their fees and charges. This conclusion is unsupported and inconsistent with the following aspects of industry reality:

- Providers have minimal-to-no discretion in pricing for Medicare and Medicaid services as rates are administratively set by regulatory authorities.
- Medicaid reimbursement levels are typically below the cost of care, even after supplemental payments.

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As a result, providers are not lowering prices due to supplemental payments; rather, such payments are intended by regulators to partially offset systemic underpayment as part of the performance obligation of providing care.

Interaction with Revenue Recognition Principles

The Q&A does not address the significant overlap with revenue recognition concepts, particularly those reflected in FASB Topic 606. Under Topic 606, supplemental payments:

- Are generally treated as variable consideration (i.e., an adjustment of transaction price)
- Represent adjustments to transaction price for goods and services provided.

This approach is applied consistently across:

- Not-for-profit healthcare organizations
- Private entities
- Public registrants

The proposed GASB interpretation would create misalignment between public and private sector accounting despite no substantive difference in the underlying payment mechanisms of these transactions. Given that the GASB's revenue and expense recognition (RER) project is rooted in similar conceptual principles, divergence in conclusions is difficult to justify and may introduce unnecessary complexity and confusion for stakeholders.

This Q&A represents a significant change in industry practice and would essentially require providers to shift the accounting model used for these payments. Providers have always viewed these payments as part of the exchange transaction with the patient, but since an exchange transaction cannot meet the subsidy definition, calling these payments subsidies would mean providers would instead need to account for these payments under GASB 33, Accounting and Financial Reporting for Nonexchange Transactions. It is unclear how providers would apply GASB 33 to this form of reimbursement since providers do not view these as separate nonexchange transactions. It would also have the potential to significantly alter the timing of revenue recognition because of GASB 33's guidance on eligibility requirements.

Inconsistencies in Financial Statement Presentation

The proposed application of the subsidy definition may also create internal inconsistencies within financial statements. Paragraph 13 of Statement 103 provides that transactions otherwise classified as nonoperating should be reported as operating if they relate to the entity's principal ongoing operations. However, in practice:

- Foundations (reported as discretely presented component units) classify contributions as operating revenues, as these are central to their mission.

- When those same resources are transferred to the primary government (e.g., hospitals or universities), they may be classified as subsidies in the primary enterprise column.

This results in the same economic transaction being reported differently within the same financial report, reducing clarity and potentially confusing users.

Additional Considerations on Market Dynamics

It is important to clarify that payer negotiations and supplemental payment programs operate independently:

- Commercial payer contracts (e.g., with private insurers) are negotiated separately from Medicaid supplemental payment arrangements.
- Hospitals do not accept lower commercial rates due to the existence of supplemental payments.

Rather, supplemental payments are designed to:

- Address systemic underpayment in Medicaid
- Move reimbursement closer to the cost—or market value—of services provided

The assertion that these payments indirectly suppress pricing across payer classes is not supported by observed market behavior.

Conclusion

In summary, we urge the Board to:

- Consider the broader implications for consistency, comparability, and interaction with revenue recognition frameworks
- Remove question 4.1 from the implementation guide
- Delay the effective date of Statement 103—if question 4.1 is not removed—to allow for the release and proper consideration of interpretive guidance

Absent these refinements, the current approach risks introducing operational burden, interpretive inconsistency, and reduced decision-usefulness in governmental financial reporting. Further, creating different recognition, measurement, and presentation guidance for these transactions in the public sector when there are no differences from the private sector creates challenges for public sector entities in educating rating agencies, bondholders, and other stakeholders and makes their operations look worse than their private sector counterparts, making it more difficult for these governments to obtain necessary capital.

Thank you for the opportunity to comment. We are always ready to provide additional comments or meet with you or members of your board to discuss this matter further. If we can provide

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additional material or perspective on this issue, please contact me at (708) 880-7510, or
rgundling@hfma.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard L. Gundling".

Richard L. Gundling
Senior Vice President Professional Practice
Chief Mission Officer