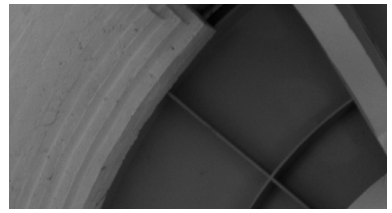
2013

Health care industry developments - 2013/14; Audit risk alerts

American Institute of Certified Public Accountants (AICPA)

Health Care Industry Developments



AUDIT RISK ALERT

Health Care Industry Developments

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Notice to Readers

This Audit Risk Alert (alert) replaces the Audit Risk Alert *Health Care Industry Developments—2012 / 13*.

This alert is intended to provide auditors of financial statements of health care entities with an overview of recent economic, industry, technical, regulatory, and professional developments that may affect the audits and other engagements they perform. This alert also can be used by an entity's internal management to address areas of audit concern.

This publication is an other auditing publication, as defined in AU-C section 200, *Overall Objectives of the Independent Auditor and the Conduct of an Audit in Accordance With Generally Accepted Auditing Standards* (AICPA, *Professional Standards*). Other auditing publications have no authoritative status; however, they may help the auditor understand and apply generally accepted auditing standards.

In applying the auditing guidance included in an other auditing publication, the auditor should, using professional judgment, assess the relevance and appropriateness of such guidance to the circumstances of the audit. The auditing guidance in this document has been reviewed by the AICPA Audit and Attest Standards staff and published by the AICPA and is presumed to be appropriate. This document has not been approved, disapproved, or otherwise acted on by a senior technical committee of the AICPA.

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The AICPA gratefully acknowledges those members of the AICPA Auditing Standards Board, the AICPA Technical Issues Committee, and the AICPA Health Care Expert Panel, who helped identify the interest areas for inclusion in this alert.

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Feedback

The Audit Risk Alert *Health Care Industry Developments* is published annually. As you encounter audit or industry issues that you believe warrant discussion in next year's alert, please feel free to share them with us. Any other comments you have about the alert also would be appreciated. You may e-mail these comments to A&APublications@aicpa.org.

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How This Alert Helps You

.01 This alert helps you plan and perform your health care entity audits and also can be used by an entity's internal management to identify issues significant to the industry. It also provides information to assist you in achieving a more robust understanding of the business, economic, and regulatory environments in which your clients operate. This alert is an important tool to help you identify the significant risks that may result in the material misstatement of financial statements and delivers information about current accounting, auditing, and regulatory developments. For developing issues that may have a significant impact on the health care industry in the near future, the "On the Horizon" section provides information on these topics, including guidance that either has been issued but is not yet effective or is in a development stage.

.02 This alert is intended to be used in conjunction with the Audit Risk Alert *General Accounting and Auditing Developments—2013 / 14* (product nos. ARAGEN13P, ARAGEN13E, or WGE-XX), which explains important issues that affect all entities in all industries in the current economic climate. You should refer to the full text of accounting and auditing pronouncements, as well as the full text of any rules or publications that are discussed in this alert.

.03 It is essential that the auditor understand the meaning of audit risk and the interaction of audit risk with the objective of obtaining sufficient appropriate audit evidence. Auditors obtain audit evidence to draw reasonable conclusions on which to base their opinion by performing the following:

- Risk assessment procedures
- Further audit procedures that comprise
  - — tests of controls, when required by generally accepted auditing standards (GAAS) or when the auditor has chosen to do so.
  - — substantive procedures that include tests of details and substantive analytical procedures.

.04 The auditor should develop an audit plan that includes, among other things, the nature and extent of planned risk assessment procedures, as determined under AU-C section 315, *Understanding the Entity and Its Environment and Assessing the Risks of Material Misstatement* (AICPA, *Professional Standards*). AU-C section 315 defines risk assessment procedures as the audit procedures performed to obtain an understanding of the entity and its environment, including the entity's internal control, to identify and assess the risks of material misstatement, whether due to fraud or error, at the financial statement and relevant assertion levels. As part of obtaining the required understanding of the entity and its environment, paragraph .12 of AU-C section 315 states that the auditor should obtain an understanding of the industry, regulatory, and other external factors, including the applicable financial reporting framework, relevant to the entity. This alert assists the auditor with this aspect of the risk assessment procedures and further expands the auditor's understanding of other important considerations relevant to the audit.

Economic and Industry Developments

.05 When planning and performing audit engagements, an auditor should understand both the general and specific economic conditions facing the

industry in which the client operates. Economic factors, such as interest rates, availability of credit, consumer confidence, overall economic expansion or contraction, inflation, recession, real estate values, and labor market conditions, are likely to have an effect on an entity's business and, therefore, its financial statements.

.06 Appendix A, "Understanding the Entity and Its Environment," of AU-C section 315 includes examples of matters the auditor may consider in obtaining an understanding of the entity and its environment. The table at paragraph 2.44 in chapter 2, "General Auditing Considerations," of the 2013 edition of the Audit and Accounting Guide *Health Care Entities* identifies some unique characteristics of health care entities that the auditor may also consider when obtaining an understanding of a health care entity and its environment in order to assess the risks of material misstatement.

The Current Economy

.07 During 2012 and into 2013, the U.S. economy has continued to recover. The S&P 500 and the Dow Jones Industrial Average both reached all-time highs during 2013. The real gross domestic product (GDP) measures the output of goods and services by labor and property located within the United States. It increases as the economy grows or decreases as it slows. According to the Bureau of Economic Analysis, real GDP increased at an annual rate of 2.4 percent in the first quarter of 2013, based on the advance estimate (second estimate). Real GDP increased at an annual rate of 0.4 percent in the fourth quarter of 2012. The increase in real GDP in the first quarter of 2013 has been attributed to positive contributions from personal consumption expenditures and residential fixed investments, among other factors.

.08 According to the latest available information provided by the Bureau of Labor Statistics, although the total unemployment rate fluctuated between 8.4 percent and 7.8 percent, the unemployment rate for Education and Health Services industry fluctuated from 6.2 percent to 5.6 percent. Health care employment has actually grown by 264,000 employees from June 2012 to June 2013, with the majority of jobs (203,600) being added by the ambulatory health care sector.

.09 From September of 2007 to December of 2008, the Board of Governors of the Federal Reserve System (Federal Reserve) decreased the target for the federal funds rate more than 5.0 percentage points, from its high of 5.25 percent prior to the financial crisis to less than 0.25 percent, where it remains in early November 2013. The Federal Reserve indicates that the target range for federal funds rate of 0 to 0.25 percent is appropriate for as long as the unemployment rate stays above 6.5 percent, inflation over the next 2 years is projected to be less than 0.5 percent above the 2 percent longer-run goal, and longer-term inflation projections continue to be low.

Sequestration

.10 In the past several years, Congress and the president have worked together to lower the deficit. In 2011, Congress passed a law that required a $4 trillion reduction in the deficit including the $2.5 trillion that had already been accomplished. The required deficit reduction was not met and as a result there was an automatic and arbitrary across the board cut in government spending. The sequestration went into effect in March of 2013. The cuts will be spread over 9 years but will amount to approximately $85 million in 2013. About 50 percent

of the cuts will affect defense and national security. The other 50 percent will affect health care, education, law enforcement, disaster relief, unemployment benefits, nonprofit entities, and scientific research. For example, the health care industry was immediately affected by the sequestration's mandatory 2 percent cut to reimbursements effective April 1, 2013. This payment cut affects all Medicare physician claims with a date of service on or after April 1, as well as costs for physician-administered drugs included on the physician claim. Many Americans believe these cuts will have a negative effect on the recovering economy.

Health Care Reform Dominates the Agenda

.11 Coping with the changes associated with health care reform continues to dominate the agenda for most health care entities. The sweeping overhaul of the U.S. health care system that became law in March 2010 represents the most significant change for the health care industry since the passage of Medicare in the mid-1960s. Based on the legislation (discussed later in this alert), health care reform is achieved through three primary mechanisms: new coverage, new funding, and new regulations. The combination of these mechanisms is creating a profoundly different playing field for health care entities.

Physician Practice Acquisitions

.12 Health care systems continue to increase the frequency with which they are acquiring physician practices. This movement to integration is driven by several factors. From the physicians' perspective, many are no longer willing or able to continue to manage the administrative burden of complying with the changing regulatory environment. Changes in Medicare and Medicaid are driving down the profitability of physician practices. In addition, the uncertainty of the effects of health care reform has created anticipated reductions in the profitability of most practices. When these trends, as well as others, lead a physician practice to consider a sale transaction, practice management may consider preparation steps discussed in the "Private Equity Health Care M&A Transactions—Preparer and Auditor Considerations" section of this alert, which includes broader implications for other merger and acquisition (M&A) transactions beyond private equity.

.13 Hospitals are also inclined to complete these acquisitions, given the increase in demand for primary care physicians to coordinate care and participate in other integrated payor arrangements. Accountable care entities, which are discussed in more detail within the "Risk-based Payment Arrangements, Including ACOs" section of this alert, are a good example of this trend towards coordinated care and integrated payor arrangements. Additionally, health care entities are using physician practices to increase market share.

.14 These economic pressures on physicians and hospitals have increased attention on integration and collaboration between providers. Health care reform has also spurred providers to explore new integrated models of care delivery. Many experts agree that hospital-physician integration is a growing trend that has the potential for significant improvements in efficiency, quality, and cost savings.

Private Equity Participation in Health Care

.15 Over the last few years, the health care industry has attracted considerable interest from private equity funds eager to invest in an industry that

represents 17 percent of the U.S. GDP. As the private equity sector grew over the last 30 years, investors were first hesitant to invest in health care, given the risky regulatory and reimbursement environment. Now, however, these risks are outweighed by the potential to achieve attractive returns in both up and down economic cycles. Investors are also drawn to the industry, in part, because the existing health care environment has not addressed the growing concerns regarding costs, physician shortages, and demand for quality and consumer preferences. Opportunities to address these deficiencies could provide a market advantage and greater profitability for private equity portfolio companies. The number and value of private equity buyouts in health care accounted for roughly 11 percent of all deals consummated worldwide in 2012. Practice management may consider preparation steps and audit considerations discussed in the "Private Equity Health Care M&A Transactions—Preparer and Auditor Considerations" section of this alert.

Cost Containment Issues for Health Care Entities

.16 As the U.S. economy moves toward recovery, hospitals are still seeing the effects of recession on their business. Additionally, the level of underinsured and uninsured patients continued to rise over the last decade. Underinsured and uninsured patients represented 44 percent of U.S. adults ages 19–64 in 2010, up from 36 percent in 2003. Between 2010 and 2013 however, there has been no significant change, likely due to gains in coverage among young adults and declined coverage for adults in older age groups. Because the majority of nonelderly Americans receive health insurance through their employers, declining employer-sponsored health coverage and the weak economy have increased the number of uninsured who seek medical care but are unable to pay for it. Thus, the amount of uncompensated care that health care entities are being called on to provide is increasing. The implementation of health insurance exchanges brought on by the Patient Protection and Affordable Care Act (ACA) is expected to remediate this. Beginning in 2014, these exchanges will serve as marketplaces that will allow individuals and businesses to shop for comprehensive and affordable health plans. By allowing states to develop and run their own exchanges (or elect to implement a federally operated exchange), user-friendly, transparent, and stable options will be available in hopes of better meeting the unique needs of their consumers.

.17 In addition, payments to health care entities from government programs such as Medicare and Medicaid are scheduled for significant cutbacks due to payment cuts required by the ACA and the Budget Control Act of 2011 (discussed in the "ACA Developments" section of this alert). On top of those looming cuts, health care entities are experiencing reimbursement pressures from payors, such as commercial health insurance and managed care plans, and employers.

.18 To counteract these downward pressures on revenues, cost containment activities have taken on increased importance. In recent years, hospitals resorted to payroll cuts and frozen wages, including freezing benefit plans. These avenues for cost control are not effective in the long run and as a result, health care executives are shifting their focus to process reengineering for more substantial year-over-year savings. As a result of payment changes from Medicare and private payers, hospitals are not only seeking ways to reduce expenses, but also ways to increase the value and quality in their processes. Such process improvement tactics require collaborative decision making across

clinical and nonclinical leadership, setting priorities, tracking improvement, and creating widespread systems of accountability.

Health Care Worker Shortages

.19 A U.S. Department of Health & Human Services (HHS) report projects that an additional 1 million nurses and 200,000 physicians will be needed in the United States by 2020. With 34 million newly insured Americans coming into the health care system following health care reform, accompanied by an additional 66 million retiring baby boomers, the strain on the nation's health care system will be unprecedented. In addition, a considerable portion of the health care workforce is expected to retire in the next 10–15 years, 40 percent of physicians are 55 years old or older, and approximately 33 percent of nurses are 50 years old or older. Although some of the provisions of the ACA attempt to encourage individuals to pursue health care careers, immediate needs for physicians will be addressed through increased salaries, more attractive benefit packages, and the use of staffing firms.

Exempt Organizations Issuing Taxable Bonds

.20 For many health care entities, the recent economic downturn necessitated debt restructuring or refinancing. Although there are numerous advantages to tax-exempt financing, this type of financing leaves health care facilities with limited options when they experience such financial distress. Winding down from a flurry of refinancing activity in the tax-exempt market, some providers are now considering taxable financing as an alternative to tax-exempt bonds. The increased private equity participation in the marketplace has increased the availability of willing investors, and interest rates on taxable debt are comparable to those of tax-exempt bonds.

Legal and Regulatory Developments

.21 Auditors of health care entities are interested in knowing about changes in government regulations for various reasons. Because the federal and state governments are the largest purchasers of health care services, changes in government regulations involving payments to providers often raise issues about whether requirements for recognizing revenue have been met, in what period the revenues should be recognized, and whether reserves should be established related to the government's ability to recoup amounts previously paid. In addition, changes to government regulations are frequently used from a public policy standpoint to change how health care services are delivered. Also, health care entities that provide or arrange services for Medicare and Medicaid patients have potential exposure to fines and penalties as a result of laws and regulations governing billing or cost-reporting processes. Reporting to regulators such as the IRS and the Securities and Exchange Commission (SEC) is also important.

ACA Developments

Overview

.22 On June 28, 2012, the U.S. Supreme Court upheld the ACA, ruling that the law's individual mandate is a constitutional exercise of Congress's power to impose taxes. Originally signed into law in March 2010, this sweeping overhaul of the U.S. health care system represents the most significant change for the

health care industry since the passage of Medicare in the mid-1960s. Under the new law, health care reform is achieved through three primary mechanisms: new coverage, new funding, and new regulations. The combination of these mechanisms is creating a profoundly different playing field for health care entities. Based on the Congressional Budget Office and Centers for Medicare & Medicaid Services (CMS) estimates made prior to enactment of the ACA, by 2019, the law will expand coverage to 32–34 million additional individuals (resulting in coverage of an estimated 94 percent of the legal U.S. population).

.23 Some of the provisions of the ACA took effect immediately, but others will take effect or be phased in over time, ranging from a few months to 10 years following approval. Many of the compliance and implementation efforts that had slowed to a halt until the Supreme Court could rule on the law have once again picked up speed.

.24 Because of the complexity of the ACA, generally, additional legislation is likely to be considered and enacted over time. The law will also require the promulgation of substantial regulations with significant effects on the health care industry and third-party payors. In response, third-party payors and suppliers and vendors of goods and services to health care providers are expected to impose new and additional contractual terms and conditions. Thus, the health care industry will be subjected to significant new statutory and regulatory requirements, contractual terms and conditions and, consequently, structural and operational changes and challenges for a substantial period of time. Some changes and requirements of the ACA that are expected to have a significant impact on the health care industry are discussed in the following paragraphs.

.25 *Medicare and Medicaid payments*. The law expands access to care and pays for expansion through the reduction of payments to physicians and hospitals. Although the ACA includes a mandate that significantly expands the number of U.S. citizens that have health insurance coverage, it pays for that expansion through a reduction of Medicare and Medicaid payments to health care providers. The legislation contains nearly $500 billion in Medicare cuts, including more than $156.6 billion in payment reductions to hospitals, long-term care facilities, inpatient rehabilitation facilities, and hospice care entities. For example, hospitals' annual Medicare market basket updates will be reduced through 2019. Beginning in 2013, Medicare and Medicaid disproportionate share payments will be significantly reduced. These adjustments may result in payment rates for a given year being less than the payment rates for the preceding year. (See also the related discussion "Disproportionate Share Hospital Payments" in this alert.)

.26 *Accountable care organizations*. The law also calls for the creation of new delivery models aimed at increasing quality and efficiency while lowering costs. Starting in 2012, the law provided for the establishment of accountable care organizations (ACOs) that are collectives of different types of providers that will align their services to treat specific geographic regions of Medicare beneficiaries. (See also the related discussion "Risk-based Payment Arrangements, Including ACOs" in this alert.) In addition, Medicaid's medical home program is designed to better coordinate care for people with multiple chronic conditions. Under this model, the offices of primary care physicians will become the "home" in which care is coordinated and centralized for patients with chronic illnesses. Beginning in 2013, for approved pilot projects or approved ACOs, Medicare bundles payments for hospitals, nursing homes, physician

services, and other providers into one payment over a period of time called an *episode of care*.

.27 *Value-based purchasing program*. In October 2012, the Medicare value-based purchasing (VBP) program implemented a pay-for-performance component to select clinical processes of short-term acute care hospitals other than critical access hospitals. The CMS now measures hospital performance using the clinical process of care; the patient experience of care; and, starting in fiscal year 2014, outcome measures.

.28 Beginning October 1, 2012, hospital diagnosis-related group (DRG) payments were reduced by 1 percent to create a VBP payment pool. The reduction will increase to a full reduction of 2 percent in fiscal year 2017. This reduction is supposed to be reallocated to hospitals in a budget-neutral manner based on each hospital's total performance score under the VBP measurement criteria. For each measure, the CMS sets an achievement threshold and a benchmark threshold for which relative scores related to performance are computed. Hospitals that receive higher performance scores receive higher incentive payments than those that receive lower total performance scores.

.29 *Readmission penalties*. Beginning October 1, 2012, prospective payment system (PPS) hospitals became subject to the Hospital Readmissions Reduction Program. For certain applicable conditions, hospitals with readmission rates higher than the threshold are now penalized up to 1 percent of the DRG rate. The penalty increases to a maximum of 3 percent in fiscal year 2015. The CMS has begun to publish hospital readmission rates on the hospital compare site. In 2015, Medicare will reduce payment by 1 percent for select hospital-acquired conditions (HACs), such as infections, falls, or blood incompatibility. In addition, the federal government no longer reimburses states for Medicaid services related to HACs.

Conclusion

.30 Health care reform, as it continues to be phased in, is having a significant effect on the operational performance and strategic direction of hospitals, health systems, physician groups, and payors. The introduction of ACOs, bundled payments, regulatory requirements to implement health IT, reductions in Medicare rates, and quality-based payments are forcing hospitals and physicians to collaborate more closely. The transition to ACOs will fundamentally transform hospitals' current business models. Physicians will become the hub of the ACO, directing patients to inpatient care, when necessary. Hospitals will become cost centers as opposed to revenue centers, and their objective will be to proactively manage health care. Those switching to the ACO model will need to slowly transition from a fee-for-service model to a capitation or at-risk model. In addition, hospitals will need the technological infrastructure, such as electronic health records (EHRs), in order to develop a strong ACO. Implications of changes such as these are discussed in other sections of this alert.

Risk-based Payment Arrangements, Including ACOs

.31 Providers are increasingly entering into contracts with payors (or, in the case of governmental payors, assuming new payment models) that incentivize them to contain or reduce the total cost of care and improve quality performance. These contracts and payment models may take the place of or complement a standard fee-for-service payment. The most familiar of these

arrangements are the ACOs under the Medicare Shared Savings Program, established by the ACA and discussed in more detail subsequently.

.32 Implementing ACOs and other similar risk-sharing arrangements will be a challenge. Because revenue comes from potential savings that are shared back with the entity, inherent risk exists in the overall operation. From IT systems that capture transactions for compliance reports, setting up complex legal structures, and establishing and maintaining required clinical operations and systems management, these entities can take a variety of forms, but most include primary care physicians and other types of providers that provide care in a way that is intended to control costs. Depending on the arrangement and payor, providers may be subject to increased financial risk, often with no guarantee of receiving shared savings.

.33 Accounting for revenue from these payment models will present similar challenges. Depending on the specific terms, a risk-based contract may resemble a risk pool, a performance-based incentive fee, an insurance contract or other arrangement. Understanding the structure of the contract may help providers to determine when the revenue recognition criteria have been met. Readers should be aware that industry associations are currently developing an issue analysis or white paper that should help assist entities with this determination.

Medicare Shared Savings Program

.34 The ACA required the CMS to establish the Medicare Shared Savings Program, which allows Medicare to contract with ACOs to share in a portion of the potential savings if targeted quality-of-care benchmarks and per-capita expenditure targets are met. Generally, a Medicare ACO is formed by a group of health care providers, which becomes accountable for the care of a group of Medicare beneficiaries assigned based on their use of primary care services. The providers are collectively accountable for quality performance and per-capita costs in that shared savings payments are contingent upon reducing costs on a variety of quality metrics. Adopting an ACO model will have pervasive business effects on entities in the health care industry. Some of the requirements for a Medicare ACO include the following:

- Accepting accountability for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it
- Agreeing to participate for no fewer than 3 years
- Establishing a formal legal structure allowing the organization to receive and distribute payments for shared savings to participating providers of services and suppliers
- Providing a sufficient number of primary care professionals to provide care to the assigned beneficiary population (minimum of 5,000)
- Maintaining a leadership and management structure that includes clinical and administrative systems
- Complying with reporting requirements regarding the professionals in the ACO, the determination of payments, and other reporting requirements as may be determined
- Maintaining processes to promote evidence-based medicine and patient engagement, reporting on quality and cost measurement, and coordinating care

- Meeting patient-centeredness criteria, such as the use of patient caregiver assessments or individualized care plans
- Responsibly distributing savings to participating entities
- Establishing and maintaining a process for evaluating the population that it serves

.35 Although a Medicare ACO must adhere to these and other requirements, there is no specific legal organizational structure required. Currently, there is no established best practice ACO organizational structure identified within the industry—each ACO's structure can be dictated by a myriad of factors, including: the existing structure of the forming organization(s); the needs, preferences, and demographic characteristics of the covered population; and, the supply and practices of the health care providers. Existing provider organizations, including integrated health systems,[1] multispecialty groups,[2] practitioner-hospital organizations[3] and independent practice associations,[4] already operate under varying degrees of integration. These existing organizations are independently or collaboratively forming ACOs under a variety of complex legal structures. As an example, when forming an ACO, an existing health system often creates a subsidiary entity, with the health system as the sole corporate member. Member providers (including individuals, groups, and associations of physicians) then sign separate legal agreements with the subsidiary to participate in the ACO. The newly formed subsidiary becomes the legal entity that bears the risk for the patient population covered by the ACO and its providers.

.36 The collaboration, cost, and time involved in the transition to an ACO will vary depending on the existing type of organization, or organizations, making the transition. For example, an existing independent practice association would likely require more collaboration with other health care organizations and would need to develop more infrastructure than an existing integrated health system.

.37 Auditors of entities involved in Medicare shared savings programs will need to be aware of the regulatory compliance and legal requirements surrounding the establishment of ACOs. On October 20, 2011, the CMS issued final regulations governing Medicare's authority to contract with ACOs under shared savings or other payment arrangements. These regulations cover a range of issues critical to the development of ACOs, including their organizational structure and governance, internal operations, contracting obligations with the CMS, reimbursement systems under the shared savings program, and quality reporting and monitoring. Additionally, the following federal agencies issued related guidance addressing legal and regulatory matters pertaining to ACO formation:

- The HHS Office of Inspector General (OIG) issued an interim final fraud and abuse rule establishing waivers of the application of the

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[1] An integrated health system generally includes one or more hospitals and one or more multispecialty groups.

[2] Multispecialty groups include physician practices that provide a variety of specialty medical services, which may include primary care practices, and operate under one combined organizational structure.

[3] A practitioner-hospital organization generally relates to a joint venture between a health system and its physicians and medical staffs.

[4] Independent provider associations are alliances between physicians, who independently own their own practices, to contract as a group to provide services.

Physician Self-Referral Law, the Federal anti-kickback statute, and certain civil monetary penalties law provisions to specified arrangements involving ACOs.

- The Federal Trade Commission and Department of Justice issued a joint statement outlining how antitrust laws will be applied to ACOs.
- IRS clarified its guidance concerning tax-exempt ACOs and tax-exempt organizations (for further discussion, see IRS Fact Sheet 2011-11 "Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations").

.38 The final CMS regulations are available at www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf. The Federal Trade Commission and U.S. Department of Justice (DOJ) "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program" can be accessed at www.ftc.gov/bc/healthcare/aco/ or www.justice.gov/atr/public/health_care/aco.html.

GAO Studies on the Coordination of Medicare Audits

.39 In June 2012, members of Congress requested that the Government Accountability Office (GAO) conduct a study on the coordination of audit initiatives under the Medicare program. Currently, there are a variety of contract auditors tasked with the broad responsibility to ensure Medicare program payments are accurate and associated with valid claims. These contract auditors include the following:

- Recovery audit contractors (RACs)
- Medicare administrative contractors
- Zone program integrity contractors, which are replacing the CMS's program safeguard contractors
- Comprehensive error rate testing review contractors
- Payment error rate measurement contractors

.40 Congress' request to GAO seeks to identify ways to streamline the Medicare program audit processes, determine what additional levels of oversight are needed, and improve detection of improper payments while avoiding unnecessary burden on providers. This request stems from a variety of complaints and frustrations expressed by hospital organizations and related industry groups, including the following:

- *Inefficient, uncoordinated, duplicative, and poorly monitored audits*. Industry groups have observed a lack of coordination between the previously mentioned audit contractors and the CMS. This often results in duplicative audit procedures and uncoordinated requests by the various contract auditors. Further, organizations have complained that certain RAC audit methodologies being employed are invalid or inherently flawed, and the Medicare physician payment rules are often misapplied by the contract auditors.
- *RAC auditor compensation*. Industry studies and surveys have indicated that the number of medical records reviewed by RAC auditors continues to increase. A corresponding increase in the

number of denied claims and overpayment recoveries has also been identified. However, when hospital providers appeal RAC audit decisions, approximately three of every four denied claims or overpayment recoveries are reversed in the favor of the provider. This trend of increased claim denials and overpayment recoveries may be caused by incentives implicit in the RAC auditor's compensation structure, whereby RAC auditors are paid based on the value of the overpayments they recover.

.41 The GAO is conducting two related studies that have the collective and ultimate goals of addressing Congress's request and informing the CMS and the HHS as they decide what Medicare audit reforms need to be implemented.

.42 The first study report, GAO-13-522 "Medicare Program Integrity—Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency," was issued in July 2013 and can be found at www.gao.gov. It describes the various types of contractors and contains related statistics pertaining to their current audit processes (types of audits, current methodologies, the CMS's audit requirements and audit oversight, overpayment statistics, the appeals process, contractor compensation structures, and so on). The study conducted investigations and determined that the CMS's requirements and methodologies for postpayment claims reviews are inconsistent across the various contractors. The GAO study suggests that these inconsistencies and differences impede effective and efficient claims reviews. The GAO report recommends that the CMS

- examine all contractor postpayment review requirements to determine those that could be made more consistent;
- communicate its findings and time frame for taking action; and,
- reduce differences where it can be done without impeding efforts to reduce improper payments.

.43 HHS officials have concurred with the GAO's recommendations and agreed to reduce differences in postpayment review requirements where appropriate. HHS also indicated that the CMS has already begun examining its processes for postpayment claims review and requirements related to ADRs. This examination indicates that the CMS may attempt to standardize audit requirements across the various types of contractors and audits. Such policy and requirement changes would likely affect hospital organizations in the future. Therefore, hospital organizations should remain alert for further developments as the HHS and the CMS examine and respond to the recommendations contained in the GAO's first study report.

.44 The second study, which is expected before the end of 2013, will likely reveal additional findings (other inefficiencies, redundancies, flaws, and so on) and will provide recommendations that the CMS and the HHS can choose to act upon. The second GAO study may reveal what future reforms will include, and therefore, may have a future effect on hospital organizations. Hospital organizations should remain alert for the issuance of this second study and for future developments, which can be found at www.cms.gov and www.gao.gov.

.45 Until the second study is released, the remaining findings and recommendations remain uncertain. However, health care entities may consider the types of recommendations provided to the GAO by health care industry groups during the study process, including

- more oversight of RAC auditors;
- increased transparency of proposed RAC audit issues, including public notice and a comment period;
- increased time for practices to respond to RAC audits (from 15 to 30 days);
- a mechanism or department within the CMS where providers can convey their concerns about RAC auditors; and,
- the implementation of a penalty or monetary fee for those RAC auditors that are identified as having invalid audits.

.46 In advance of the completion of the second GAO study, readers should be aware of some recent related actions being taken:

- On August 2, 2013, the CMS issued a final rule updating fiscal year 2014 Medicare payment policies and rates for inpatient stays at general acute care and long-term care hospitals (LTCHs). Among other requirements designed to improve value and quality in hospital care, the final rule provides greater clarity regarding when inpatient hospital admissions are generally appropriate for Medicare Part A payment. This portion of the new rule is intended to address concerns about Medicare beneficiaries having long stays in the hospital as outpatients and to improve program integrity. This rule is expected to improve clarity for hospital organizations, and in turn, will provide clarity to Medicare program auditors as they interpret and apply program rules during their audits. You can download the final Inpatient Prospective Payment System (IPPS)//LTCH PPS rule from the Federal Register at www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf.
- The CMS recently published an online tool, the Medicare Administrative Contractor Satisfaction Indicator (MSI), at their website (www.cms.gov). The CMS has explained that they are providing the tool to measure the level of satisfaction providers and suppliers experience with their contract auditors and the audit process. The MSI allows providers the opportunity to influence the CMS' understanding of Medicare contractor performance. The goal of the MSI is to evaluate these experiences and determine the key drivers of customer satisfaction. In addition, the CMS will use the results of the MSI to monitor trends, improve oversight, and increase the efficiency of the Medicare program.

RAC Recoveries and Receivables Accounting Issues

.47 The Tax Relief and Health Care Act of 2006 made permanent the Medicare Recovery Audit Contractor program to identify improper Medicare payments in all 50 states. As of March 31, 2013, $1.4 billion had been recovered for federal fiscal year 2013. Top issues were consistent with those disclosed for federal fiscal year 2012 and included the following:

- *Cardiovascular procedures (medical necessity)*. Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.

- *Minor surgery and other treatment billed as inpatient (medical necessity)*. When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for fewer than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, regardless of whether a bed was used and whether they remained in the hospital after midnight.

.48 In 2011, the CMS released a final rule detailing implementation of a similar RAC audit program for Medicaid. States were required to implement Medicaid RACs by January 1, 2012. However, many states chose not to participate and those that have agreed to participate have been slow to implement audit activities. Some aspects of the Medicaid RAC program will mirror the Medicare approach. The CMS estimates that RACs will save the Medicaid program $2.1 billion over the next five years.

.49 RAC audits have the potential to result in significant payment recoupments. In estimating net revenues from the Medicare and Medicaid programs, health care entities should consider, among other things, estimates of expected future adjustments to revenue from regulatory reviews, audits, billing reviews, investigations, or other proceedings (for instance, due to potential interpretation issues or potential documentation issues). Health care entities may review common RAC audit findings and consider whether their organization may have similar circumstances.

.50 However, when a health care organization has undergone a RAC audit and the RAC has concluded that an amount is owed, the organization should record an estimated liability related to their RAC exposure. The health care organization may also consider whether it is appropriate to record an estimate of recoveries from appeals. In doing so, an organization should critically evaluate all facts and circumstances and then conclude whether persuasive evidence exists that they have met all revenue recognition criteria. The threshold for revenue recognition is relatively high; therefore, when persuasive evidence does not exist, organizations may consider recognizing recoveries from appeals in the period in which the recovery is realized (in accordance with gain contingency guidance in Financial Accounting Standards Board [FASB] *Accounting Standards Codification* [ASC] 450-30).

.51 The recorded estimated RAC exposure liability should be evaluated by management on a periodic basis and changes to the estimate recorded in the period in which better information becomes available to provide for a more refined estimate.

.52 Statement of Position (SOP) 00-1, "Auditing Health Care Third-Party Revenues and Related Receivables" (AICPA, *Technical Practice Aids*, AUD sec. 14,360), the Audit and Accounting Guide *Health Care Entities*, and the Healthcare Financial Management Association's (HFMA's) June 2010 Issue Analysis, *Accounting For RAC Audit Adjustments and Exposures* also provide relevant guidance and supplemental information for auditors when addressing these matters.

Premium Stabilization Programs—the "Three R's"

.53 Under the ACA, there are three premium stabilization programs that become effective on January 1, 2014. Those programs, often referred to as the

"Three R's," are Risk Adjustment, Reinsurance, and Risk Corridor. The Risk Adjustment program, the only permanent program of the three, is intended to allow health insurers price and offer individual and small-group products without consideration for the underlying health status of individuals purchasing the products. In each state, an average risk score will be calculated for each individual and small-group plan. The magnitude and direction of the risk adjustment settlement will depend on the relative measure of the plan's enrollees compared to all enrollees in the market. Plans will receive notice of payment or receipt on June 30 of the year following the plan year.

.54 The Reinsurance and Risk Corridor programs are temporary and expected to be in existence for the 2014–2016 calendar years. The Reinsurance program is designed to mitigate potential increased incidence of large claims in the individual market. The program will be funded by a per capita contribution from health insurers and self-insured group plans. The per capita contribution for 2014 is $63 per member and is intended to fund both the $10 billion reinsurance pool and a payment of $2 billion directly to the U.S. Treasury. Only those plans covering individuals will be eligible for reinsurance payments, which are 80 percent of paid claims from $60,000 to $250,000. Plans will submit claims by April 30 after the plan year and receive payment from the program no later than June 30.

.55 The Risk Corridor program is designed to provide some aggregate protection against variability for insurers in the individual and small-group market by limiting gains and losses. The program applies to only qualified health plans (QHPs) both on and off the exchange. The Risk Corridor program is similar to the risk corridors used under Medicare Part D. QHPs will submit all risk corridor information by July 31 based on a defined calculation of allowable costs, which includes the payments and receipts from the Risk Adjustment and Reinsurance programs.

.56 Many insurance companies are currently considering what accounting framework is applicable under generally accepted accounting principles (GAAP). For those companies that issue statutory-basis financial statements, the Statutory Accounting Principles Working Group is currently debating the appropriate accounting and plan to expose guidance before the National Association of Insurance Commissioners' Fall National Meeting in December 2013.

Proposed Changes to Hospital OPPS Payments and Policies

.57 On July 8, 2013, the CMS issued proposed rule (CMS-1601-P) that describes proposed policy and payment rate changes to the 2014 hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center payment system. The proposed rule intends to update and streamline these programs in order to encourage high-quality care consistent with the policies included in the ACA. The proposed rule would expand the categories of related items and services packages into a single payment for a primary service under the OPPS, in order to make the OPPS more of a prospective payment system (rather than the existing system, which is a hybrid between a prospective payment system and a fee-for-service system). The category "packaged items and services" would be expanded by adding seven additional categories for supporting services. The proposed rule also includes proposed payment updates for ambulatory surgical centers and partial hospital program rates. Finally, the proposed rule would make a variety of changes to quality programs, including, among others, five new measures for the hospital outpatient

quality reporting program, new measures for the ambulatory surgical center quality reporting program, and performance and baseline periods for various measures of the hospital VBP program. The CMS accepted comments on the proposed rule through September 6, 2013, and will respond to comments in a final rule expected to be issued in November 2013. Readers can access the release at www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-07-08-3.html and can access the proposed rule at www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf. Readers should also monitor the CMS's website at www.cms.gov for continued developments and a final rule.

Monitoring Meaningful Use Certification

.58 The CMS pays billions of dollars to eligible professionals, eligible hospitals, and critical access hospitals (CAHs) that demonstrate meaningful use of EHR technology. Audits are performed under the EHR Incentive Program to determine if the attested results reported by an eligible participant meet the eligibility criteria, performance thresholds, and standards set by the program regulations. The amount of eligible hospital incentive payments vary; they are determined by a formula based on number of discharges, Medicare admissions, amount of charity care, and so on. These incentive payments do not constitute federal awards or federal financial assistance subject to single audit requirements in the Office of Management and Budget Circular A-133, *Audits of States, Local Governments and Non-Profit Organizations*.

.59 Five percent of the providers attesting to meaningful use through the EHR Incentive Program are likely to get a letter from the CMS's contract auditor, listing them as a participant selected for an audit. Eligible participants include providers that use certified EHRs for various clinical care delivery and population health functions, including e-prescribing, electronic exchange of health information to improve quality of health care, or clinical quality and other measures. These audits can happen both before a provider receives payment and after they get a check and can be either random or based on red flags in reported data. Medicare providers may be subject to prepayment audits beginning with attestations submitted after January 2013, based on edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. States will have separate audit processes for their Medicaid EHR Incentive Program.

.60 At the conclusion of the audit, an audit documentation letter should be sent to the provider indicating whether the requirement for meaningful use of electronic health records was met. If a provider is found not to be eligible for an EHR incentive payment, the payment will be recouped in full. If fraud is detected, punishment may involve imprisonment, significant fines, or both. In addition, providers may lose their licenses in some states or may be excluded from Medicare or Medicaid participation for a specified length of time, or both. To ensure adequate preparation for an audit, it is imperative to prepare and maintain documentation that supports the payment calculations and other information that is entered in the attestation.

Critical Access Hospitals' Accounting for Meaningful Use Incentive Payments

.61 As discussed in the previous section, "Monitoring Meaningful Use Certification," CAHs (smaller hospitals with 25 or fewer beds, primarily operated

in rural areas) are eligible to receive incentive payments under the Medicare and Medicaid programs when they can demonstrate meaningful use of an EHR technology. As explained in the August 21, 2013, *Journal of Accountancy* article, "How critical access hospitals might choose to recognize revenue from meaningful-use incentive payments," in the absence of authoritative GAAP on the subject, diversity in practice exists related to the accounting for such incentive payments. The article may be useful to practitioners and auditors of CAHs who are eligible for or have received these incentive payments. It provides an explanation and illustration of the incentive payment model for CAHs, explores some of the most common accounting viewpoints currently observed in practice, and provides a decision-making approach (based on FASB ASC 105-10-05) that CAHs can consider utilizing when establishing a meaningful use incentive payment accounting policy. You can access the full text of this article at www.journalofaccountancy.com/News/20138275.htm.

Disproportionate Share Hospital Payments

.62 Hospitals that treat a disproportionately large share of low-income patients and have high uncompensated care costs receive federal funding through state Disproportionate Share Hospital (DSH) allotments. As required by the ACA, significant changes in DSH payments will be implemented effective October 1, 2013, leading to reduced payments to these hospitals. The CMS issued a final rule on September 13, 2013, establishing the DSH reduction methodology for fiscal years 2014–2015, which will reduce total DSH payments by $1.1 billion in those years. The rule establishes separate DSH reduction pools for low-DSH states and non-low-DSH states and creates a formula for distributing the reductions in each pool that gives one-third weight to the "uninsured percentage factor" in the state, one-third weight based on high volume of Medicaid inpatients, and one-third based on high level of uncompensated care. As a result, the methodology encourages states to target DSH payments to high Medicaid volume hospitals and hospitals with high levels of uncompensated care. For fiscal years 2014 and 2015, states' decisions to expand Medicaid will not affect the amount of reduction in DSH allotments. The CMS will revisit the methodology and promulgate new rules for 2016 and beyond.

.63 Although many hospitals will receive less in DSH payments, some hospitals will experience an increase in their DSH payments as a result of the changes, and the impact by hospital may vary greatly. As such, auditors need to understand the implications of the final rule and how the methodology to pay hospitals has changed as a result of health care reform. The final rule is available at www.gpo.gov/fdsys/pkg/FR-2013-09-18/pdf/2013-22686.pdf.

Stark Law Update

Background

.64 The federal Stark Law[5] is a civil statute that applies in circumstances where a physician has a financial arrangement with a hospital or other entity that furnishes any of the following services, collectively referred to as designated health services (DHS): clinical laboratory services; physical therapy, occupational therapy and speech-language pathology services; radiology

[5] The Stark Law, also known as the Ethics in Patient Referrals Act of 1989, became effective on January 1, 1992. The act, as amended over time along with its associated regulations, is frequently referred to as the "Stark Law."

and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. If a physician has a financial arrangement with an entity that furnishes any DHS, the physician cannot make any Medicare or Medicaid referrals to the entity for any DHS, and the entity cannot bill for any such DHS referred by the physician, unless the financial arrangement between the physician and the entity qualifies for an exception under the Stark Law. A violation of the Stark Law subjects the parties to substantial penalties and fines, including recoupment of all funds paid by Medicare or Medicaid for any prohibited DHS referrals and exclusion from the Medicare and Medicaid programs.

Halifax Hospital Court Case

.65 A currently pending case in Florida federal district court is bringing hospital employment and independent contractor arrangements with referring physicians into focus—it is raising concerns among hospital organizations about whether current arrangements and related monitoring activities could place them at risk under the Stark Law. In the case of *U.S. ex. rel. Elin Baklid-Kunz v. Halifax Hospital Medical Center* (the Halifax Hospital case), the government asserts that Halifax Hospital (the hospital) violated the Stark Law by billing the Medicare and Medicaid programs for DHS referred by a number of physicians who allegedly received compensation based on their DHS referrals to the hospital.

.66 To summarize the facts of the case, the hospital employed physicians through a subsidiary entity, and those physicians made referrals to the hospital for DHS. Typically, each professional service performed by any of these physicians at the hospital was accompanied by a corresponding facility fee paid to the hospital for the services furnished by the hospital. The government is alleging that this correlation between the physicians' professional services and the hospital's facility fees means that none of these physicians could be receiving fair market value compensation for their services because: (*a*) the Stark definition of the term "fair market value" expressly excludes compensation that varies with the volume or value of a physician's DHS referrals; and (*b*) the previously mentioned correlation shows that each of these physicians receives compensation that varies with his or her DHS referrals to the hospital. As further support for its position that the physicians' compensation varied with the volume of value of their referrals, the government asserts that two internal hospital emails show that the hospital was tracking the referral volume and trend information for at least two of these physicians.

.67 Readers can continue to monitor the Halifax Hospital case as it develops. The case is currently scheduled to go to trial in November 2013.

Industry Considerations

.68 While the Halifax Hospital case plays out, other hospital organizations may be reconsidering whether similar compliance and litigation risk exists in their own organization. Specifically, organizations may be trying to determine when a hospital's physician compensation arrangements and referral review processes are permissible under the Stark Law, and when they may cross the line and are considered violations.

.69 Organizations may consider the following when attempting to assess their own physician compensation agreements and referral requirement review processes for compliance:

- The Stark regulations expressly permit hospitals to direct where their employed or contracted physicians make referrals that relate solely to such physicians' services for the hospital, provided that the referral requirement satisfies certain criteria stated in the regulations. There is no Stark Law provision that expressly prohibits the monitoring of physician referrals, and it seems apparent that a hospital which imposes a Stark-compliant referral requirement would need to monitor its employed and contracted physicians' referrals for compliance with such a requirement. However, hospitals must ensure that the monitoring of a physician's referrals does not lead to the hospital's use of information on a physician's actual or anticipated DHS referrals for purposes of establishing or modifying the physician's financial arrangement with the hospital.
- Practitioners should consider evaluating the terms of existing and new hospital-physician compensation arrangements for compliance with the Stark Law. Prior court rulings have indicated that the compensation terms on the face of a hospital-physician employment or independent contractor agreement are essential when determining whether the agreement complies with the Stark Law. For instance, it is critical that the terms of a hospital-physician agreement do not provide for increases or decreases in payment (based on the number or value of the physician's actual or anticipated referrals to, or business generated for, the hospital).

.70 Organizations are encouraged to involve legal counsel during any attempt to assess physician compensation agreements and referral requirement review processes for Stark Law compliance.

HIPAA Final Rule

.71 In January 2013, HHS released a final rule that enhances the privacy and security of protected health information (PHI) protected under the Health Insurance Portability and Accountability Act (HIPAA). The new rule, which requires compliance starting on September 21, 2013, includes the following provisions:

- Business associates,[6] their subcontractors, and any other parties who receive health information have become exposed to HIPAA and related rule requirements. The covered party's responsibility has been expanded out to all these external parties who are included in the information flow, and as a result, the covered party (generally, the hospital or physician practice) must perform

[6] The rule specifies that business associates are generally contractors for the covered party. Business associate designations include patient-safety organizations, health information exchange organizations, e-prescribing gateways, and certain vendors of personal records (excluding public health records owned by individual consumers).

due diligence and obtain assurances from these associates regarding rule compliance. This requirement is perhaps the single most impactful and costly aspect of the new rule, and entities should ensure they have adjusted policies and procedures accordingly.

- Expands requirements pertaining to PHI breaches to
  - — increase the maximum penalty to $1.5 million per year for compromised PHI.
  - — include clarification on when breaches need to be communicated to patients and HHS. Under the new rule, the unauthorized use or disclosure of protected health information is presumed to be a reportable breach unless a covered entity can, through a documented assessment, conclude that there is a "low probability" the information has been compromised. (This is in contrast to the previous model, wherein covered entities would only report breaches to patients and the HHS if it was determined, based on an entity's own assessment, that the incident posed significant risk of financial or reputational harm.)
- Expands patient rights in various ways to
  - — prohibit the sale of patient information without a patient's consent.
  - — allow patients to request copies of their electronic health records in electronic form.
  - — ensure that patients that pay for treatment in full out-of-pocket have the right to instruct the provider not to share their care records with their insurance company.
- Places new limitations on the use of patient records for marketing of health information. Further, the sale of health information requires patient consent.

.72 The requirements under this rule will increase costs, as security policies and procedures are enhanced. Furthermore, the more stringent rules can lead to a broad increase in malpractice risk; specifically, as it relates to PHI breaches and resulting fines that can be levied.

Intergovernmental Transfers

.73 The Medicaid program is set up on a state-by-state basis to provide medical assistance to the indigent. Although state-administered, the program is actually a joint federal and state program for which the federal government picks up a portion of the cost. Under this arrangement, the federal government "matches" a percentage of the total amount paid by the state to health care providers. This matching is referred to as *federal financial participation*.

.74 States have attempted to increase the amount of federal matching funds for which they are eligible by increasing the amount of medical assistance they provide. In order to pay for the increased medical assistance, more and more states have: (*a*) changed rules that impose taxes (for example, bed tax) on health care entities; (*b*) developed arrangements that have sought donations or other voluntary payments from them; or (*c*) done both *a* and *b*.

.75 The HFMA's Principles and Practices Board Statement No. 17, *Assessments and Arrangements Similar to Taxes*, also explains that the accounting for transactions under these arrangements is dependent on the individual facts and circumstances. However, the statement does attempt to define and suggest accounting policies for three of the most common types of payments made by health care entities under these arrangements. These are the three common types of payments made by health care entities:

a. *Governmental services*. Payments for governmental services, including for example, sanitation services or fire protection.

b. *Charity pools*. Payments to a government agency which, in turn, provides funds to compensate providers for health care services provided to medically indigent patients.

c. *General governmental support*. Payments made to a governmental agency that has no relationship to specific governmental services received by the health care entity.

.76 Paragraph 2.1 of the HFMA Principles and Practice Board Statement No. 17 explains

> [a]s state and local governments face rising costs and a limited ability to increase revenue, they increasingly examine the status of entities that are tax-exempt. A variety of challenges to tax exemption have been attempted by government agencies to compel tax-exempt providers to share the cost of local services normally supported by tax revenues. Results have been mixed. Some tax-exempt providers have granted various concessions, such as discounted health care services to government employees in lieu of tax payments. In some cases, tax-exempt providers have voluntarily agreed to pay for governmental services.

.77 Taxes and donations from these arrangements have allowed states to generate additional federal matching funds without expending additional state funds. In practice, health care entities continue to face challenges when determining how to account for these taxes or donations made to the state, which, in substance, are a return of the state's own funds. Practitioners faced with the accounting for such taxes or donations should consider the available nonauthoritative guidance provided by the AICPA and the HFMA, as discussed or referenced in the following paragraphs.

.78 TIS section 6400.30, "Accounting for Transactions Involving Medicaid Voluntary Contribution or Taxation Programs [Amended]" (AICPA, *Technical Practice Aids*), explains that the accounting for these types of programs is dependent on the individual facts and circumstances. For example, if there is a guarantee that specific monies given to the state by the health care entity will be "returned" to the entity from the state, those amounts should be recorded as receivables. In addition, if the health care entity has met all requirements to be legally entitled to additional funds from the state, the revenue/gain should be recognized.

.79 However, if the monies go into a pool with other contributions which are then disbursed based on factors over which the health care entity has little or no control, the payments should be recognized as an expense. Any

subsequent reimbursements would be recognized as revenue or gain when the provider is entitled to them and payment is assured.

.80 Care should be taken to avoid delayed recognition of expenses or to improperly recognize contingent gains. Because of complexities involved, it may be necessary to consult with legal counsel.

.81 Practitioners may also consider recognition and reporting guidance provided in the HFMA Principles and Practice Board Statement No. 17. This guidance is broadly consistent with the previously discussed TIS section 6400.30 and is structured around the aforementioned three common types of payments made by health care entities. The statement can be accessed on the HFMA's website at www.hfma.org/Content.aspx?id=1079.

Municipal Adviser Registration

.82 Section 975 of the Dodd-Frank Act amended Section 15B of the Securities Exchange Act of 1934 to, among other things, require the registration of municipal advisers with the SEC and to provide for their regulation by the Municipal Securities Rulemaking Board, effective October 1, 2010.

.83 Under the Dodd-Frank Act, the term *municipal advisers* refers to persons and organizations that provide advice about the issuance of municipal securities; the investment of bond proceeds; or related financial products, such as derivatives. That definition is much broader than the definition historically used by the market, and it would potentially cover many more individuals and companies. The SEC had proposed new rules 15Ba1-1 through 15Ba1-7 and related forms under the Securities Exchange Act, as published in Release No. 34-63576, File Number S7-45-10, "Registration of Municipal Advisors." The proposed rule broadly defined a *municipal adviser* to include any accountant, unless the accountant is preparing financial statements, auditing financial statements, or issuing letters for underwriters for, or on behalf of, a municipal entity or obligated person. Comment letters on the proposed rules, including a letter from the AICPA, raised concerns that the definition of *municipal adviser* would encompass accountants who are performing "customary and usual" services incidental to, or inextricably linked to, the practice of accountancy and whom, comments suggested, should not be subject to required registration. Concerns related to the various services that CPA firms provide for entities that issue (or are conduit obligors) municipal bonds (for example, inclusion consent letters, comfort letters, agreed-upon procedures reports used by underwriters in conducting their due diligence on an offering, and so on) and whether the performance of those services would subject the firms to this registration process with the SEC.

.84 In September 2013, the SEC issued Final Rule Release No. 34-70462, "Registration of Municipal Advisors" (the final rule). The final rule provides clarity on the definition of a municipal adviser and establishes a permanent registration process for those municipal advisers. The final rule requires a municipal adviser to permanently register with the SEC if it provides advice on the issuance of municipal securities or about certain "investment strategies" or municipal derivatives. The final rule becomes effective sixty days after being published in the Federal Register. Section V of the final rule describes the various compliance dates for municipal advisers to complete their applications for permanent registration. The earliest compliance date described therein is

July 31, 2014, for certain municipal advisory firms that are currently registered under the existing temporary registration rules. A municipal advisory firm that enters into the municipal advisory business on or after October 1, 2014, and does not have a temporary registration number as of October 1, 2014, must file a complete application for registration under the permanent registration regime on or after October 1, 2014, and be registered with the SEC before engaging in municipal advisory activities.

.85 The final rule excludes from the definition of *municipal adviser* accountants providing audit and attest services, preparing financial statements, or issuing letters for underwriters for, or on behalf of, a municipal entity or obligated person. The SEC believes that it was appropriate to exclude all audit and attest services because all such services are generally subject to regulation and professional standards, including independence requirements. However, nonattest services, such as tax services (including arbitrage rebate services) and advice relating to GAAP are not part of the accountant exemption because these activities or services could also be performed by nonaccountants. Accountants performing such nonattest services will need to evaluate the services to determine whether they are providing advice, as described in the final rule. The term *advice* is not explicitly defined in the final rule, but the rule does provide clarity by explaining that advice excludes, among other things, the provision of general information that does not involve a recommendation regarding municipal financial products or the issuance of municipal securities, including with respect to the structure, timing, terms, and other similar matters concerning such financial products or issues. If an accountant determines that nonattest services being performed are advice, registration with the SEC would likely be required.

.86 Auditors with clients who are issuers or conduit obligors in municipal securities offerings should consider all provisions of the final rule, including whether they meet the definition of a *municipal adviser* and the related accountant exemption rule. For the full text of the final rule, please visit www.sec.gov/rules/final/2013/34-70462.pdf.

IRS Developments—Medical Devices Tax

.87 The ACA introduced a variety of new provisions intended to partially offset the cost of the broadening health care coverage by raising additional revenues. Among these provisions is Internal Revenue Code Section 4191, which imposes an excise tax on the sale price of certain medical devices[7] by the manufacturer or importer of the device. The excise tax is 2.3 percent of the sale price of the taxable medical device.

Effective Date

.88 This new excise tax is effective for sales of taxable medical devices occurring on or after January 1, 2013. Like other manufacturers' excise taxes, the medical device excise tax is reported on IRS Form 720 and is filed quarterly with the following due dates.

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[7] In general, a taxable medical device is a device that is listed as a device with the Food and Drug Administration under Section 510(j) of the Federal Food, Drug, and Cosmetic Act and Title 21 U.S. *Code of Federal Regulations* Part 807, unless the device falls within an exemption from the tax, such as the retail exemption.

For the Months:	*Due By:*
January, February, March	April 30
April, May, June	July 31
July, August, September	October 31
October, November, December	January 31

Scope

.89 The excise tax affects entities that are considered manufacturers or importers of taxable medical devices. As they relate to the taxable medical devices excise tax, the terms manufacturer and importer are defined in Chapter 5 of IRS Publication 510 (Rev. July 2012):

- The term *manufacturer* includes a producer or importer. A manufacturer is any person who produces a taxable article from new or raw material, or from scrap, salvage, or junk material, by processing or changing the form of an article or by combining or assembling two or more articles. *If you furnish the materials and keep title to those materials and to the finished article, you are considered the manufacturer even though another person actually manufactures the taxable article.* (Emphasis added)
- A manufacturer who sells a taxable article in knockdown (unassembled) condition is liable for the tax. *The person who buys these component parts and assembles a taxable article may also be liable for tax as a further manufacturer depending on the labor, material, and overhead required to assemble the completed article if the article is assembled for business use.* (Emphasis added)
- An importer is a person who brings a taxable article into the United States, or withdraws a taxable article from a customs bonded warehouse for sale or use in the United States.

.90 Third-party medical device supplier entities that sell medical devices to health care entities clearly fall within scope of the previously provided definition of a *manufacturer*.

.91 Health care entities (or their subsidiary entities) that assemble medical device component parts (known as *kits*) may be subject to the excise tax. A key factor to consider in making this determination is whether the assembled kit is on the FDA list of medical devices. Additionally, the final regulations issued by the IRS clarified that, because health care entities are exempt from the Food and Drug Administration's (FDA's) registration and listing requirements, any kits assembled only for the health care entities' own use would not be subject to the excise tax. Health care entities and their auditors may consider evaluating whether the entity meets the manufacturer definition, given the entity's unique facts and circumstances.

Accounting Considerations

.92 Entities within the scope of this excise tax (the manufacturer or importer of a taxable medical device) are responsible for filing Form 720, "Quarterly Federal Excise Tax Return," and for paying the tax to the IRS. Although the excise tax may appear to be a simple calculation—2.3 percent of the sales

price of taxable medical device sales—practitioners may need to utilize judgment and conduct evaluations to determine (*a*) the appropriate sales price and (*b*) which medical devices are taxable and which are exempt:

- *Sales price*. The U.S. Treasury Department issued Notice 2012-77 "Interim Guidance and Request for Comments; Medical Device Excise Tax; Manufacturers Excise Taxes; Constructive Sale Price; Deposit Penalties" on December 5, 2012. The Treasury issued the notice to provide guidance on the determination of the sale price of a taxable medical device for purposes of calculating the related excise tax. Notice 2012-77 can be accessed on the IRS website at www.irs.gov/pub/irs-drop/n-12-77.pdf.
- *Taxable medical devices and exemptions*. In general, a taxable medical device is a device that is listed as a device with the U.S. Food and Drug Administration under Section 510(j) of the Federal Food, Drug, and Cosmetic Act (FFDCA) and Title 21 U.S. *Code of Federal Regulations* Part 807 that is intended for humans, unless the device falls within an exemption from the tax. The FFDCA is written very broadly to include instruments, machines, implants and in vitro reagents, among others. Section 201(h) also includes associated parts and accessories, which are (*a*) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them; (*b*) intended for use in the diagnosis, cure, treatment, or prevention of disease or other conditions; or (*c*) intended to affect the structure or any function of the body, excluding products relying on a chemical reaction within or on the body or being metabolized to achieve their primary intended purposes. The primary exemption is the retail use exemption, which generally includes eyeglasses, contact lenses, hearing aids, or any other medical device determined by the secretary as generally purchased by the general public at retail for individual use. Other exceptions include (*a*) products exported or destined for export; (*b*) components for further manufacture; and (*c*) products sold for nonhuman use.

.93 Entities and their auditors may consider evaluating these common implementation issues within in the context of the entity's unique facts and circumstances. The IRS has prepared Medical Device Excise Tax: Frequently Asked Questions on their website, which may be useful as entities and their auditors evaluate the excise tax position in the current year (www.irs.gov).

Fraud and Abuse

Health Care Fraud Prevention and Enforcement Action Team Activities

.94 In May 2009, the DOJ and the HHS jointly established the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to combat Medicare fraud while investing new resources and technology to prevent fraud and abuse. HEAT efforts have included expansion of the DOJ-HHS Medicare Fraud Strike Force that has been successful in fighting fraud in recent years.

.95 In May 2013, HHS announced that a nationwide takedown by Medicare Fraud Strike Force operations in 8 cities resulted in charges against 89 individuals, including doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving

approximately $223 million in false billings. The defendants were accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statutes, and money laundering. The alleged fraud schemes involved submitting claims to Medicare for treatments that were medically unnecessary and often never provided. In many cases, patient recruiters, Medicare beneficiaries, and others were paid cash kickbacks in return for supplying beneficiary information to providers who then submitted fraudulent billing to Medicare.

.96 This most recent enforcement effort marks the latest step forward in the DOJ-HHS efforts to combat fraud and abuse in the health care system. Such efforts have been reinforced by the ACA, which has provided organizations such as the DOJ-HHS and the CMS with tools to preserve Medicare and prevent the occurrence of fraud and abuse.

OIG Work Plan

.97 The OIG's 2013 Work Plan includes several risk areas carried forward from previous years:

- Hospital admissions with conditions coded present on admission
- Inpatient and outpatient payments to acute care hospitals
- Outpatient observation services during outpatient visits
- Hospital same-day readmissions
- Acute-care inpatient transfers to inpatient hospice care
- Inpatient and outpatient hospital claims for the replacement of medical devices
- Inpatient outlier payments
- Medicare's reconciliations of outlier payments
- Duplicate graduate medical education payments

.98 Significant new hospital risk areas that the OIG is focusing on during 2013 include the following:

- *Inpatient billing for Medicare beneficiaries*. The OIG will describe how hospital billing for inpatient stays changed from fiscal year 2008 to fiscal year 2012. In addition, the OIG describes how billing for inpatient stays in fiscal year 2012 varied among different types of hospitals and how hospitals ensure compliance with Medicare requirements for inpatient billing. In 2010, Medicare paid hospitals $100 billion for inpatient stays. Most hospitals are paid under the IPPS that the CMS changed substantially in fiscal year 2008. Under the IPPS, each inpatient stay is classified into 1 of 747 Medicare Severity Diagnosis-Related Groups (MS-DRG) based on the beneficiary's diagnoses and the procedures the hospital performed, as well as other factors. Medicare pays hospitals a different amount for each MS-DRG.
- *DRG window*. Medicare currently bundles all outpatient services delivered 3 days prior to an inpatient hospital admission. Medicare does not pay separately for such preadmission services when they are delivered in a setting owned or operated by the admitting hospital. This policy is commonly known as the *DRG window*. Prior OIG work identified improper payments in the DRG window.

OIG work has also concluded that the CMS could realize significant savings if the DRG window was expanded from 3 days to 14 days. The OIG will analyze claims data to determine how much the CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the DRG payment.

- *Hospital-owned physician practices using provider-based status*. The OIG will determine the effect of hospital-owned physician practices billing Medicare as provider-based physician practices and will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider; however, it can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services.
- *Compliance with Medicare's transfer policy*. The OIG will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers and will determine whether such claims were appropriately processed and paid. The OIG will also review the effectiveness of the Medicare administrative contractors' claims processing edits used to identify claims subject to the transfer policy. Pursuant to federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate, not to exceed the full DRG payment that would have been made if the beneficiary had been discharged without being transferred.
- *Acquisitions of ambulatory surgical centers*. The OIG will determine the extent to which hospitals acquire ambulatory surgical centers and convert them to hospital outpatient departments and will also determine the effect of such acquisitions on Medicare payments and beneficiary cost sharing. Medicare reimburses outpatient surgical services performed in hospital outpatient departments at a higher rate than similar services performed in ambulatory surgical centers. Hospitals may be acquiring ambulatory surgical centers and providing outpatient surgical services in that setting.
- *Long-term care hospitals—payments for interrupted stays*. The OIG will determine the extent to which Medicare made improper payments for interrupted stays in LTCHs in 2011 and will also identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. LTCHs are generally defined as inpatient acute care hospitals with an average length of stay greater than 25 days. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days. Interrupted stays in LTCHs cause an adjustment in Medicare payments. Prior OIG

work has identified vulnerabilities in the CMS's ability to detect readmissions and appropriately pay for interrupted stays.

.99 The complete 2013 OIG Work Plan is available at https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf.

Fraud Considerations for Auditors and Preparers

.100 According to a survey conducted by the Association of Certified Fraud Examiners, nearly 6 percent of fraud losses occur in the health care industry, with an average loss of $150,000 per fraud case. These cases are growing, presumably because of a reduction in staff and thus fewer resources performing a wider range of tasks, thus increasing opportunities for fraud. Fraud schemes that are more common in the medical industry include the following:

- Unauthorized adjustments to patient receivable accounts; such as skimming of cash receipts received from patient co-pays at the front desk, and writing off patient account balances when payments were actually received
- Refund checks to friends or relatives
- Payments to fictitious vendors and to accounts outside of the practice
- "Kickbacks" to practice administrators for steering business toward a particular vendor
- Adjustments to wage rates, the number of hours worked, and amount of vacation time accrued for staff
- Falsified expense reimbursements
- Inappropriate use of credit cards for personal expenses
- Inappropriate billings as a result of fraudulent medical coding

.101 It is important for preparers to implement proper internal controls to prevent these fraud cases and for auditors to prepare and execute audit plans to gain an understanding of whether their clients are involved in such fraud schemes.

Medical Coding

.102 Accurate medical coding and sufficient clinical documentation support is critical to ensure proper billing. Although not currently mandated by law, regulators are often less inclined to place sanctions on health care entities if they have seen that an audit and subsequent education has taken place. Health care entities typically develop compliance plans that entail both an internal audit, as well as an external audit around coding and documentation.

.103 Internal coding review findings should be well documented and corrective action plans developed to ensure effective remediation occurs. Hospital staff involved in clinical documentation should be well educated on the results of such audits to prevent future errors. Peer reviews of physician documentation are also recommended as a means to establish a baseline and ongoing reference points for proper coding and documentation.

.104 In addition to internal audits, external audits are recommended on a periodic basis to expand efforts of compliance and allow for greater objectivity and fresh insights. In addition to conducting clinical documentation audits, external auditors may be asked to review an entity's compliance plan, internal

audit processes and controls, or both. They may also be engaged to provide risk-based audit services by following up on internal audit findings to see how and whether they've been remediated.

.105 Because very little training is provided in this specific area in medical school, residency, and fellowship, errors are likely to occur and often go unnoticed even after several rounds of review and audits.

Accounting and Auditing Developments

Private Equity Health Care M&A Transactions—Preparer and Auditor Considerations

.106 With recent health care reform legislation and broad changes in provider reimbursement under the Medicare Shared Savings Program, merger and acquisition activity involving private equity firms has increased. (See the industry trend discussions titled "Physician Practice Acquisitions" and "Private Equity Participation in Health Care" of this alert for further information.)

.107 If management of a smaller sized health care entity (a physician practice, for example) is considering a sale transaction strategy in the near future, management should consider several important accounting readiness steps prior to the acquisition. These steps may include, among others, the following:

- Converting the entity's books and records from a cash basis of accounting to accrual basis
- Preparing and assembling and organizing the support for the financial statements to be audited
- Maintaining documentation to support the amounts reported in the financial statements for a minimum period of three years prior to an acquisition

Converting to the Accrual Basis of Accounting

.108 Some smaller sized health care entities may maintain their accounting records using the cash basis of accounting. The acquiring private equity firm and its due-diligence team will typically prefer to review the accounting records under the accrual basis of accounting, as required by U.S. GAAP. In order to make the conversion from cash to accrual basis, management must perform analyses and develop various estimates, including an estimate of the amount of receivables and payables as of each historical year end date, and related revenues and expenses for each respective historical period.

.109 In order to record the accounts receivable, management may run reports detailing cash collections subsequent to year end with a date of service (DOS) relating prior to year end (for example, collections in 20X4 relating to a DOS in 20X3). When doing so however, management would need to determine an appropriate time period for such an analysis. Receivables typically tend to be collected within a three to four month period, but it is also possible for certain accounts to be collected after a four month period. If that is determined to be the case, management may need to estimate the uncollected amounts in order to complete the analysis prior to finalizing the financial statements. Once management has arrived at an amount it believes is reasonable and can be supported, it must consider whether an allowance for doubtful accounts is

necessary. A similar analysis can be utilized when estimating and recording an entity's accounts payable and accrued expenses. When estimating these balances, management would look at subsequent disbursements relating to invoice dates prior to year end (for example, disbursements paid in 20X4 relating to a service date in 20X3).

.110 Management will also need to consider whether an accrual is necessary for professional liability claims incurred but not yet reported (IBNR). In doing so, management may consider whether the entity's malpractice policy is a claims-made policy or an occurrence basis policy. If the entity has a claims-made malpractice policy, an IBNR accrual estimate analysis will likely be necessary. If management concludes that material IBNR may exist, management may consider engaging a licensed third party actuary to perform the IBNR accrual calculation. Alternatively, if the entity has an occurrence basis policy, there are typically no additional reserves to consider, unless a successful suit has gone against the entity beyond its policy limits, in which case re-insurance or stop-loss policies may provide coverage.

.111 Auditors should understand and scrutinize the analyses conducted by management during the basis of accounting conversion, then determine certain selected audit procedures that are relevant in connection with the performance of an initial audit of a health care entity. In the planning phase of the audit, auditors should identify and respond to inherently unique risks associated with initial audit engagements. Such risks may be associated with all accounting assertions, including cut-off. Auditors are reminded of relevant auditing standards, which may include AU-C section 510, *Opening Balances—Initial Audit Engagements, Including Reaudit Engagements*, and AU-C section 540, *Auditing Accounting Estimates, Including Fair Value Accounting Estimates, and Related Disclosures* (AICPA, *Professional Standards*).

Preparation of Financial Statements

.112 Management should also maintain its financial statements in a manner that facilitates an audit by an independent accounting firm (regardless of whether there is a current audit requirement) as well as review by the due diligence team of the acquiring company. This means management should maintain all accounting records supporting the amounts reflected on its accrual basis trial balance, which may include bank statements, invoices, and supporting documentation for any amounts estimated by management. Management is also responsible for maintaining a sound internal control structure which includes the design, implementation, and maintenance of internal controls relevant to the preparation and fair presentation of the financial statements. Both the auditors and the due diligence team will assess the entity's internal control structure and document any significant deficiencies and material weaknesses.

.113 After the financial statements are produced by management in accordance with U.S. GAAP, management should maintain all supporting records for a minimum period of three years prior to an acquisition. This is a necessary time period because the acquirer generally requires three years of historical financial information, as well as future projections and the documentation to support the assumptions used to generate the projections, to determine their purchase price. It is imperative that management allows for sufficient time to properly plan and execute these steps if a sale transaction strategy is anticipated in the future. When planned and executed appropriately, these steps typically improve the overall efficiency of the due diligence and audit processes,

and allow management to properly present their financial condition and performance during the negotiation process.

.114 As part of a private equity firm's due diligence work, the auditor may be engaged to perform a "Quality of Earnings" review of the entity's reported earnings before interest, taxes, depreciation, and amortization. In connection with such an engagement, the auditor should evaluate his or her independence pursuant to the AICPA Code of Professional Conduct (ET section 100, *Independence, Integrity, and Objectivity* [AICPA, *Professional Standards*]) and, based on the scope of the engagement, determine which AICPA standards are applicable (for instance, U.S. Auditing, Attestation, Accounting and Review or Consulting Services).

Impairment and Recoverability of Assets—Preparer and Auditor Considerations

.115 Smaller health care entities, for example, small hospitals and physician practices, hold various asset types assets that require periodic impairment evaluations. In practice, financial management at smaller entities may rely heavily on their auditors to assist them with performing these impairment or recoverability assessments. This may occur for a variety of reasons, including limited resources or lack of expertise in the entity's accounting department, complexity of the required analyses, or a general misconception that the auditor is primarily responsible for conducting the analysis and drawing conclusions related to impairment charges. Entity management is reminded that they are primarily responsible, with the oversight of those charged with governance, for all amounts and disclosures reported in their financial statements, including those assets required to be assessed for impairment in accordance with U.S. GAAP. This responsibility lies with management in all reporting entities, regardless of the entity's size or its available resources. In the following paragraphs, some key considerations and best practices are outlined for reporting entity management.

.116 The following asset types are those that commonly require a form of impairment evaluation on the part of management:

- *Investments*. Health care entities may hold various types of debt and equity securities without a readily determinable fair value that are accounted for under the cost method. These investments are evaluated for other than temporary impairment (OTTI), which is primarily described in FASB ASC 320-10-35. Paragraphs 4.49–.59 of the 2013 edition of the AICPA Audit and Accounting Guide *Health Care Entities* may also be a helpful resource when applying guidance from FASB ASC 320, *Investments—Debt and Equity Securities*, and conducting an analysis of OTTI because it includes industry-specific considerations. Furthermore, nonprofit businesses-oriented health care entities should ensure all OTTI charges are appropriately considered in conjunction with performance indicator presentation (see FASB ASC 320-10, FASB ASC 954-320 and FASB ASC 958-320).
- *Property and equipment*. Long lived fixed assets are often significant to the financial position of health care entities. Property and equipment assets are tested for recoverability in accordance with FASB ASC 360-10-35, when events or changes in circumstances indicate that carrying value may not be recoverable. Example

events and circumstances are listed in FASB ASC 360-10-35-21, and industry-specific examples (nonauthoritative) are provided in paragraph 6.22 of the AICPA Audit and Accounting Guide *Health Care Entities*.

- *Intangibles*. As discussed in paragraph 6.02 of the AICPA Audit and Accounting Guide *Health Care Entities*, health care entities may hold a variety of intangible assets on their balance sheets. For example, physician practices may have medical records, noncompete agreements, managed care contracts, patient lists, trade names, and goodwill recorded as intangible assets. Impairment considerations for amortizable intangible assets follow the same model previously described for property and equipment; therefore, the recoverability events or circumstances would generally be the same. Goodwill and nonamortizable intangibles are tested annually (or more frequently if impairment indicators exist at an interim date) for impairment in accordance with guidance in FASB ASC 350-20. Entity management is reminded that FASB Accounting Standards Update (ASU) No. 2012-02, *Intangibles—Goodwill and Other (Topic 350): Testing Indefinite-Lived Intangible Assets for Impairment*, provides an optional qualitative assessment to determine if it is more-likely-than-not that the fair value of the reporting unit is less than the carrying amount before performing the quantitative analysis discussed in paragraphs 4–19 of FASB ASC 350-20-35. This qualitative assessment option may relieve the burden of the complexities that can come along with the quantitative valuation analysis.

.117 The FASB guidance generally indicates that the consideration of impairment or recoverability indicators should be monitored on a continuous basis. As a best practice, management may consider developing processes that allow for continuous monitoring to identify changes in the industry and regulatory environment, as well as changes in the entity's operational trends and strategy. When changes occur, management should proactively consider whether the changes (*a*) may be impairment or recoverability indicators, (*b*) may affect management's intent or ability to hold assets (for example, cost method investments), or (*c*) require adjustments to assumptions within existing valuation models utilized during annual tests (for example, reporting unit valuation estimates during annual goodwill impairment tests).

.118 Impairment assessments performed by management should be robust, thoughtful, and objective. Significant assumptions applied within qualitative or quantitative analyses should be properly supported and documented in the entity's files. All relevant data and information should be considered—including that which may be contradictory to the primary information trends. Thoughtful analysis and documentation will provide greater transparency across the entity and will generally facilitate a more efficient audit process.

.119 In some instances, entity management may need to decide whether to engage a third-party valuation specialist. When deciding whether to engage a third party specialist, management may consider various factors, including the following:

- Materiality of the asset or asset group being evaluated

- The complexity of the valuation model used to assess the asset for impairment
- The ability to access data and other information relevant to the significant valuation assumptions
- The level of expertise and competency of internal finance and accounting personnel tasked with performing the analysis
- The industry reputation, expertise, objectivity, and competence of the third-party valuation specialist (in other words, conducting appropriate due diligence)

.120 During the decision making process, management typically weighs the costs and benefits associated with engagement of a valuation specialist, and may consider engaging in open dialogue with their auditor.

.121 Auditors should remain cognizant of their responsibility to remain independent and objective under the AICPA Code of Professional Conduct and AU-C section 200, *Overall Objectives of the Independent Auditor and the Conduct of an Audit in Accordance With Generally Accepted Auditing Standards* (AICPA, *Professional Standards*). In doing so, auditors should avoid any accounting preparation activities that could bear on independence, whether in fact or in appearance. The preparation of an impairment assessment for an entity's long-lived assets may be considered an activity that diminishes the auditor's ability to remain professionally skeptical, and ultimately may bear on independence. As a best practice, an auditor should ensure a clear distinction exists between management's preparation of an analysis and impairment and recoverability conclusions, and the auditor's testing procedures and independent conclusions. Auditors may consider reminding entity management of the auditor's professional responsibilities under GAAS, and may refer management to the best practices described previously. Further, when a third party valuation specialist is engaged by management, the auditor may consider, as a best practice, obtaining a confirmation from the specialist that the specialist is independent from the entity and its management.

Third-party Verification Letters

.122 CPAs are increasingly being requested by health insurance providers to confirm client information through third-party verification letters. Such information may include a business verification document from a CPA that the listed, eligible employees worked the minimum hours required under state law, and that the business is a bona fide business qualifying as a small employer under state law and health plan underwriting guidelines. Due to this increase, practitioners may find that this process is becoming more and more confusing and that information regarding comfort letters and third party verification is increasingly important to assure that practitioners are providing optimal service. The AICPA has gathered a variety of helpful resources on the Concerns Regarding Comfort Letters/Third Party Verification webpage of the AICPA's Financial Reporting Center (www.aicpa.org/FRC) to provide clarity on this issue.

Use of Specialists

.123 With the growing complexity surrounding the valuation of assets and liabilities, it is becoming increasingly important for engagement teams to sufficiently understand the work performed by specialists. AU-C section 620,

Using the Work of an Auditor's Specialist (AICPA, *Professional Standards*), defines an auditor's specialist as an individual or organization possessing expertise in a field other than accounting or auditing, whose work in that field is used by the auditor to assist the auditor in obtaining sufficient appropriate audit evidence.

.124 When an audit engagement team determines to use a specialist, the engagement partner retains sole responsibility for the audit opinion expressed. If the engagement partner concludes that the work of an auditor's specialist is adequate in accordance with AU-C section 620, he or she may accept the specialist's findings or conclusion as appropriate audit evidence. Although the engagement partner is not expected to have the same expertise, knowledge, or skillset of the auditor's specialist, the auditor should obtain a sufficient understanding of the field of expertise of the specialist to

- determine the nature, scope, and objectives of the work of the auditor's specialist for the auditor's purposes and
- evaluate the adequacy of that work for the auditor's purposes.

.125 The use of specialists is pervasive in the audits of health care entities. For example, specialists may be needed to audit the valuation assertions related to investments or the recording of net patient service revenue. Of particular concern is that many valuation consultants (reimbursement specialists and fair value specialists, for example) are not regulated or are not required to follow accreditation standards, or both. AU-C section 620 requires the auditor to evaluate whether the specialist has the necessary competence, capabilities, and objectivity for the auditor's purposes.

.126 More specifically, the medical record documentation and coding that is required in order to get reimbursed by third-party payors is a highly specialized area. SOP 00-1 provides interpretive guidance that, among other things, attempts to provide auditing guidance in this highly specialized area. Although SOP 00-1 specifically acknowledges that auditors are not responsible for many aspects of coding, specialists are often used to audit controls surrounding the coding system in order for auditors to obtain comfort over the revenue cycle of a health care entity. Therefore it is important for auditors to evaluate whether the specialist has the necessary competence, capabilities, and objectivity; evaluate the adequacy of the work of the specialist, and obtain an understanding of the assumptions and methods used by the specialist, all in accordance with AU-C section 620.

.127 In addition to auditor requirements for the use of an auditor's specialist, there are also requirements to consider when using the work of a management's specialist, which is defined as an individual or organization possessing expertise in a field other than accounting or auditing, whose work in that field is used by the entity to assist the entity in preparing the financial statements. In accordance with AU-C section 500, *Audit Evidence* (AICPA, *Professional Standards*), if the auditor uses the work of a management's specialist, the auditor should

- evaluate the competence, capabilities, and objectivity of that specialist;
- obtain an understanding of the work of that specialist; and
- evaluate the appropriateness of that specialist's work as audit evidence for the relevant assertion.

Application of AU-C Section 250 for Health Care Organization Audits

.128 Though AICPA's clarified auditing standards did not significantly change existing requirements regarding auditors' considerations of laws and regulations in an audit of financial statements, AU-C section 250, *Consideration of Laws and Regulations in an Audit of Financial Statements* (AICPA, *Professional Standards*), did have changes from the pre-clarity standards and auditors of health care entities need to be mindful of the GAAS requirements related to this section, as health care entities are subject to numerous laws and regulations that can have an effect on these entities. Laws and regulations that affect health care entities include the following:

- False Claims Act
- The antikickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987
- Stark I, II, and III
- Emergency Medical Treatment and Active Labor Act
- The Privacy Rule of the Health Insurance Portability and Accountability Act of 1996
- Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009
- Health Care and Education Reconciliation Act of 2010
- Patient Protection and Affordable Care Act of 2010

.129 The pre-clarity standards did not require the auditor to perform procedures to identify instances of noncompliance unless specific information concerning possible illegal acts came to the auditor's attention. In contrast, AU-C section 250 provides specific responsibilities of the auditor, which are discussed in the following paragraphs.

.130 Pursuant to AU-C section 250, the auditor has responsibilities regarding compliance with two categories of laws and regulations:

a. The provisions of those laws and regulations generally recognized to have a direct effect on the determination of material amounts and disclosures in the financial statements.

b. The provisions of other laws and regulations that do not have a direct effect on the determination of the amounts and disclosures in the financial statements but compliance with which may be fundamental to the operating aspects of the business, fundamental to an entity's ability to continue its business, or necessary for the entity to avoid material penalties.

.131 There are differing requirements for each of the preceding categories of laws and regulations. For the category referred to in item *a*, the auditor's responsibility is to obtain sufficient appropriate audit evidence regarding material amounts and disclosures in the financial statements that are determined by the provisions of those laws and regulations. For the category referred to in item *b*, the auditor's responsibility is limited to performing specified audit procedures that may identify noncompliance with those laws and regulations that may have a material effect on the financial statements.

.132 Paragraph .14 of AU-C section 250 states the two of the key audit procedures related to identifying instances of noncompliance include the following:

- Inquiring of management, and when appropriate, those charged with governance about whether the entity is in compliance with such laws and regulations
- Inspecting correspondence from relevant licensing or regulatory authorities

.133 Although auditors of health care entities are familiar with making direct inquiries of management and those charged with governance, they should also be alert to the possibilities that inquiries of others within the entity during the normal course of audit fieldwork might also bring potential noncompliance issues to the auditor's attention. For example, individuals responsible for cost reporting, billing, and coding, human resources, in-house counsel, or internal audit, may reveal potential matters to the auditor.

.134 In addition, auditors should be prepared to request correspondence from health care regulators, such as the Medicare fiscal intermediary, state regulators such as Departments of Health and Medicaid programs, insurance companies, Recovery Audit Contractors, and other similar third-parties. The auditor should document their review and conclusions regarding their inspection of correspondence in the audit working papers.

.135 In the absence of identified or suspected noncompliance, auditors are not required to go above and beyond inquiry, inspection, and professional skepticism. However, if the auditor becomes aware of noncompliance or suspected noncompliance, further understanding and evaluation of the nature of the act and the circumstances under which it has occurred is required in order to evaluate the possible effect on the financial statements.

Overhaul—Audit and Accounting Guide *Not-for-Profit Entities*

.136 The AICPA Financial Reporting Executive Committee, the AICPA Not-for-Profit Entities Expert Panel, and the AICPA Not-for-Profit Guide Task Force issued a new comprehensive revision of the Audit and Accounting Guide *Not-for-Profit Entities* in May 2013. This is the guide's first comprehensive revision since 1996. The guide now addresses many new accounting issues that have emerged over the years and includes guidance dedicated specifically to not-for-profit (NFP) entities.

.137 The Audit and Accounting Guide *Health Care Entities* references the Audit and Accounting Guide *Not-for-Profit Entities* as a source of additional guidance on contribution-related transactions (for example, promises to give, split interest agreements, and so on). Thus, the contribution-related guidance in the revised guide is likely to be of interest to not-for profit health care entities and their auditors.

Recent AICPA Independence and Ethics Developments

Nonattest Services

.138 Several changes to Interpretation No. 101-3, "Nonattest Services," under Rule 101, *Independence* (AICPA, *Professional Standards*, ET sec. 101 par. .05), were made effective August 31, 2012. The AICPA Professional Ethics Executive Committee (PEEC) believes these revisions will add clarity to the

nonattest services guidance and enhance practitioners' understanding of the interpretation's requirements. Changes adopted affecting nonattest services included the following:

- Providing a limited exception to the period of impairment
- Clarifying language regarding the general requirements for performing nonattest services, including enhanced definitions of management responsibilities
- Defining activities related to attest services and, therefore, not constituting a nonattest service subject to Interpretation No. 101-3
- Technical corrections to compliance requirements with independence regulations of certain regulatory bodies

More detailed information on each of the changes follows.

Period of Impairment—Limited Exception When Performing Nonattest Services

.139 Interpretation No. 101-3 states that members performing attestation services must remain independent during the period covered by the financial statements and the period of the professional engagement. This interpretation was modified to provide a limited exception if prohibited services were performed during the period covered by the financial statements, provided that the nonattest services were provided prior to the period of the professional engagement; the nonattest services related only to periods prior to the period covered by the financial statements; and the financial statements for the period to which the nonattest services relate were audited by another firm (or in the case of a review engagement, reviewed by another firm).

Management's Responsibilities When Performing Nonattest Services

.140 The term *management responsibilities* replaces the term *management functions*. PEEC believes that the term *management responsibilities* will better help members distinguish between management responsibilities and other types of services. In addition, this change converges terms used by other standard-setting bodies. A member assuming management responsibilities for an attest client would create a management participation threat so significant that no safeguards could reduce the threat to an acceptable level and, therefore, would impair independence. The interpretation adds explanatory language on what constitutes *management responsibilities*, which are defined as involving leading and directing an entity, including making significant decisions regarding the acquisition, deployment, and control of human, financial, physical, and intangible resources.

.141 Examples of activities that would be considered a management responsibility and would impair independence if performed for an attest client include

- setting policies or strategic direction for the client.
- directing or accepting responsibility for the actions of the client's employees, except to the extent permitted when using internal auditors to provide assistance for services performed under auditing or attestation standards.

- authorizing, executing, or consummating a transaction or otherwise exercising authority on behalf of a client or having the authority to do so.
- preparing source documents, in electronic or other form, evidencing the occurrence of a transaction.
- having custody of client assets.
- deciding which recommendations of the member or other third parties to implement or prioritize.
- reporting to those in charge of governance on behalf of management.
- serving as a client's stock transfer or escrow agent, registrar, general counsel, or its equivalent.
- accepting responsibility for the management of a client's project.
- accepting responsibility for the preparation and fair presentation of the client's financial statements in accordance with the applicable financial reporting framework.
- accepting responsibility for designing, implementing, or maintaining internal controls.
- performing ongoing evaluations of the client's internal control as part of its monitoring activities.

.142 Additional examples of nonattest services when independence would not be impaired were added for performance of reconciliations and network maintenance services.

.143 Members are cautioned that regulatory bodies, such as the SEC and GAO, may have different requirements and, therefore, should be consulted when performing attestation work under those standards.

Activities Not Considered Nonattest Service Because the Activities Are Considered to Be Related to Attest Services

.144 PEEC also clarified that when performing attest services, members often have communications with the client that are a routine part of the engagement and, therefore, are not considered nonattest services and subject to the general requirements of Interpretation No. 101-3. Such communications may include the following:

- Client's selection and application of accounting standards or policies and financial statement disclosure requirements
- Appropriateness of a client's methods used in determining the accounting and financial reporting
- Adjusting journal entries that the member prepared or proposed for the client's consideration
- The form or content of the financial statements

Engagements Subject to Independence Rules of Certain Regulatory Bodies

.145 Changes to Interpretation No. 101-3 added the Public Company Accounting and Oversight Board as an example authoritative regulatory body for which compliance is required when performing nonattest services for a client for which independence is required under regulations of the regulatory body.

The Auditing Standards Board's Clarity Project

.146 The goal of the Clarity Project is to make GAAS easier to read, understand, and apply. As the Auditing Standards Board (ASB) redrafted the standards for clarity, it also converged the standards with the International Standards on Auditing (ISAs) issued by the International Auditing and Assurance Standards Board.

.147 At this point, auditors should be well on their way to transitioning to the clarified standards that became effective for periods ending on or after December 15, 2012. The new requirements may involve planning discussions with clients, affect interim testing and other fieldwork, and require changes to the auditor's report.

.148 Although the Clarity Project was not intended to create additional requirements, some revisions have resulted in substantive changes and primarily clarifying changes that may require auditors to make adjustments in their practices.

.149 In January 2013, the AICPA issued Statement on Auditing Standards (SAS) No. 127, *Omnibus Statement on Auditing Standards—2013* (AICPA, *Professional Standards*).

.150 With the issuance of SAS No. 127, the ASB has redrafted all but one of the auditing sections, which now reflect the ASB's established clarity drafting conventions.

.151 For information on the final clarified auditing standard, *The Auditor's Consideration of the Internal Audit Function in an Audit of Financial Statements*, to be released as part of the Clarity Project, see the "On the Horizon" section of this alert.

Substantive Changes

.152 The following AU-C sections in AICPA *Professional Standards* are considered likely to affect firms' audit methodology and engagements because they contain substantive or other changes, defined as having one or both of the following characteristics: (*a*) a change or changes to an audit methodology that may require effort to implement or (*b*) a number of small changes that, although not individually significant, may affect audit engagements:

- AU-C section 250
- AU-C section 265, *Communicating Internal Control Related Matters Identified in an Audit*
- AU-C section 550, *Related Parties*
- AU-C section 600, *Special Considerations—Audits of Group Financial Statements (Including the Work of Component Auditors)*
- AU-C section 700, *Forming an Opinion and Reporting on Financial Statements*
- AU-C section 705, *Modifications to the Opinion in the Independent Auditor's Report*
- AU-C section 706, *Emphasis-of-Matter Paragraphs and Other-Matter Paragraphs in the Independent Auditor's Report*

Primarily Clarifying Changes

.153 The following AU-C sections have clarifying changes that are intended to explicitly state what may have been implicit in the previous standards that, over time, resulted in diversity in practice. Certain clarified standards address management responsibilities that may need to be communicated to clients early in the planning stage. Some of these requirements may already be performed in practice, although not explicitly required by the previous standards. Most notably, certain new requirements shift the timing of requirements from the reporting stage of an audit to the planning stage. The new requirements in this section may not have a substantial effect but may result in adjustments to the timing and responsibilities of the auditor and his or her clients and will need to be reviewed by the auditor to ensure that all requirements have been properly addressed. These AU-C sections are as follows:

- AU-C section 210, *Terms of Engagement*
- AU-C section 220, *Quality Control for an Engagement Conducted in Accordance With Generally Accepted Auditing Standards*
- AU-C section 402, *Audit Considerations Relating to an Entity Using a Service Organization*
- AU-C section 501, *Audit Evidence—Specific Considerations for Selected Items*
- AU-C section 505, *External Confirmations*
- AU-C section 510
- AU-C section 620
- AU-C section 708, *Consistency of Financial Statements*
- AU-C section 800, *Special Considerations—Audits of Financial Statements Prepared in Accordance With Special Purpose Frameworks*
- AU-C section 805, *Special Considerations—Audits of Single Financial Statements and Specific Elements, Accounts, or Items of a Financial Statement*
- AU-C section 810, *Engagements to Report on Summary Financial Statements*
- AU-C section 905, *Alert That Restricts the Use of the Auditor's Written Communication*
- AU-C section 910, *Financial Statements Prepared in Accordance With a Financial Reporting Framework Generally Accepted in Another Country*

Resources for the Clarity Standards

.154 A wealth of information about the clarity standards is available at www.aicpa.org/SASClarity. Also, two publications specifically discuss the clarity standards:

- The AICPA Audit Risk Alert *Understanding the Clarified Auditing Standards—2012* (product nos. ARACLA12P, ARACLA12E, or ARACLA12O) identifies the substantive and clarifying changes in requirements from the Clarity Project and includes a mapping schedule tracking the pre-clarity standards to the clarified standards.

- Additionally, the AICPA Audit Risk Alert *Understanding the Responsibilities of Auditors for Audits of Group Financial Statements—2013* (product nos. ARAGRP13P, ARAGRP13E, or ARAGRPO) provides additional guidance for implementing AU-C section 600.

.155 These publications are available at www.cpa2biz.com. Additionally, see the following section, "Resource Central," for ways to obtain the codified clarity standards.

Recently Issued FASB ASUs and GASB Pronouncements

FASB ASUs

.156 The following table presents, by codification area, a list of recently issued ASUs through the issuance of ASU No. 2013-11, *Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists (a consensus of the FASB Emerging Issues Task Force)*. However, this table does not include ASUs that are SEC updates or ASUs that are technical corrections to various topics. FASB ASC does include SEC content to improve the usefulness of FASB ASC for public companies, but content labeled as SEC staff guidance does not constitute rules or interpretations of the SEC nor does such guidance bear official SEC approval.

Recent Accounting Standards Updates	
Presentation Area of Financial Accounting Standards Board (FASB) *Accounting Standards Codification* (ASC)®	
Accounting Standards Update (ASU) No. 2013-07 (April 2013)	*Presentation of Financial Statements (Topic 205): Liquidation Basis of Accounting*
ASU No. 2013-02 (February 2013)	*Comprehensive Income (Topic 220): Reporting of Amounts Reclassified Out of Accumulated Other Comprehensive Income*
ASU No. 2013-01 (January 2013)	*Balance Sheet (Topic 210): Clarifying the Scope of Disclosures about Offsetting Assets and Liabilities*
ASU No. 2012-05 (October 2012)	*Statement of Cash Flows (Topic 230): Not-for-Profit Entities: Classification of the Sale Proceeds of Donated Financial Assets in the Statement of Cash Flows (a consensus of the FASB Emerging Issues Task Force)*
Liabilities Area of FASB ASC	
ASU No. 2013-04 (February 2013)	*Liabilities (Topic 405): Obligations Resulting from Joint and Several Liability Arrangements for Which the Total Amount of the Obligation Is Fixed at the Reporting Date (a consensus of the FASB Emerging Issues Task Force)*

Recent Accounting Standards Updates—continued	
ASU No. 2013-11 (July 2013)	*Income Taxes (Topic 740): Presentation of an Unrecognized Tax Benefit When a Net Operating Loss Carryforward, a Similar Tax Loss, or a Tax Credit Carryforward Exists (a consensus of the FASB Emerging Issues Task Force)*
ASU No. 2013-10 (July 2013)	*Derivatives and Hedging (Topic 815): Inclusion of the Fed Funds Effective Swap Rate (or Overnight Index Swap Rate) as a Benchmark Interest Rate for Hedge Accounting Purposes (a consensus of the FASB Emerging Issues Task Force)*
ASU No. 2013-09 (July 2013)	*Fair Value Measurement (Topic 820): Deferral of the Effective Date of Certain Disclosures for Nonpublic Employee Benefit Plans in Update No. 2011-04*
ASU No. 2013-05 (March 2013)	*Foreign Currency Matters (Topic 830): Parent's Accounting for the Cumulative Translation Adjustment upon Derecognition of Certain Subsidiaries or Groups of Assets within a Foreign Entity or of an Investment in a Foreign Entity (a consensus of the FASB Emerging Issues Task Force)*
ASU No. 2013-03 (February 2013)	*Financial Instruments (Topic 825): Clarifying the Scope and Applicability of a Particular Disclosure to Nonpublic Entities*
ASU No. 2012-06 (October 2012)	*Business Combinations (Topic 805): Subsequent Accounting for an Indemnification Asset Recognized at the Acquisition Date as a Result of a Government-Assisted Acquisition of a Financial Institution (a consensus of the FASB Emerging Issues Task Force)*
Industry Area of FASB ASC	
ASU No. 2013-06 (April 2013)	*Not-for-Profit Entities (Topic 958): Services Received from Personnel of an Affiliate (a consensus of the FASB Emerging Issues Task Force)*

GASB Pronouncements

.157 The following summaries are for informational purposes only and should not be relied upon as a substitute for a complete reading of the applicable statements. The full texts of all Governmental Accounting Standards Board (GASB) statements are available at www.gasb.org.

GASB Statement No. 70

.158 In April 2013, GASB issued GASB Statement No. 70, *Accounting and Financial Reporting for Nonexchange Financial Guarantees*. This statement requires a government that extends a nonexchange financial guarantee

to recognize a liability when qualitative factors and historical data, if any, indicate that it is more likely than not that the government will be required to make a payment on the guarantee. The amount of the liability to be recognized should be the discounted present value of the best estimate of the future outflows expected to be incurred as a result of the guarantee. When there is no best estimate but a range of the estimated future outflows can be established, the amount of the liability to be recognized should be the discounted present value of the minimum amount within the range. The statement requires a government that has issued an obligation guaranteed in a nonexchange transaction to report the obligation until legally released as an obligor and also requires a government that is required to repay a guarantor for making a payment on a guaranteed obligation or legally assuming the guaranteed obligation to continue to recognize a liability until legally released as an obligor. When a government is released as an obligor, the government should recognize revenue as a result of being relieved of the obligation. The statement also provides additional guidance for intra-entity nonexchange financial guarantees involving blended component units. The statement specifies the information required to be disclosed by governments that extend nonexchange financial guarantees and requires new information to be disclosed by governments that receive nonexchange financial guarantees. The provisions of GASB Statement No. 70 are effective for reporting periods beginning after June 15, 2013. Earlier application is encouraged. Except for disclosures related to cumulative amounts paid or received in relation to a nonexchange financial guarantee, the provisions of this statement are required to be applied retroactively. Disclosures related to cumulative amounts paid or received in relation to a nonexchange financial guarantee may be applied prospectively.

GASB Statement No. 69

.159 GASB Statement No. 69, *Government Combinations and Disposals of Government Operations*, issued in January 2013, establishes accounting and financial reporting standards related to certain government combinations and disposals of government operations. As used in this statement, the term *government combinations* includes a variety of transactions referred to as mergers, acquisitions, and transfers of operations. However, it does not include transactions involving acquisition of another organization that remains legally separate and will be reported as a component unit of the acquiring government (as is often the case in transactions involving health care entities).

.160 The distinction between a government merger and a government acquisition is based upon whether an exchange of significant consideration is present within the combination transaction. Government mergers include combinations of legally separate entities without the exchange of significant consideration. This statement requires the use of carrying values to measure the assets and liabilities in a government merger. Conversely, government acquisitions are transactions in which a government acquires another entity, or its operations, in exchange for significant consideration. This statement requires measurements of assets acquired and liabilities assumed generally to be based upon their acquisition values. This statement also provides guidance for transfers of operations that do not constitute entire legally separate entities and in which no significant consideration is exchanged. This statement defines the term *operations* for purposes of determining the applicability of this statement and requires the use of carrying values to measure the assets and liabilities in a transfer of operations.

.161 A disposal of a government's operations results in the removal of specific activities of a government. This statement provides accounting and financial reporting guidance for disposals of government operations that have been transferred or sold.

.162 This statement requires disclosures to be made about government combinations and disposals of government operations to enable financial statement users to evaluate the nature and financial effects of those transactions. The requirements of GASB Statement No. 69 are effective for government combinations and disposals of government operations occurring in financial reporting periods beginning after December 15, 2013, and should be applied on a prospective basis. Earlier application is encouraged.

On the Horizon

.163 Auditors should keep abreast of accounting developments and upcoming guidance that may affect their engagements. The following sections present brief information about some ongoing projects that have particular significance to state and local governments. Remember that exposure drafts are nonauthoritative and cannot be used as a basis for changing existing standards.

.164 Information on, and copies of, outstanding exposure drafts may be obtained from the various standard-setters' websites. These websites contain in-depth information about proposed standards and other projects in the pipeline. Many more accounting and auditing projects exist in addition to those discussed in this alert. Readers should refer to the Audit Risk Alert *General Accounting and Auditing Developments—2013 / 14* (product nos. ARAGEN13P, ARAGEN13E, or WGE-XX) for further information.

.165 The following table lists the various standard-setting bodies' websites through which information may be obtained on outstanding exposure drafts, including downloading exposure drafts. These websites contain in-depth information about proposed standards and other projects in the pipeline. Many more accounting and auditing projects exist in addition to those discussed here. Readers should refer to information provided by the various standard-setting bodies for further information.

Standard-Setting Body	***Website***
AICPA Auditing Standards Board	www.aicpa.org/Research/Standards/AuditAttest/ASB/Pages/AuditingStandardsBoard.aspx
Financial Accounting Standards Board	www.fasb.org
Governmental Accounting Standards Board	www.gasb.org
Professional Ethics Executive Committee	www.aicpa.org/InterestAreas/ProfessionalEthics/Pages/ProfessionalEthics.aspx
Securities and Exchange Commission	www.sec.gov

Current FASB Projects

Leases

.166 In May 2013, FASB issued the proposed ASU *Leases (Topic 842): a revision of the 2010 proposed FASB ASU, Leases (Topic 840)*. The International Accounting Standards Board (IASB) and FASB have jointly developed a revised draft standard on leases. The boards developed the proposals in this revised exposure draft after considering responses to their Discussion Paper, *Leases: Preliminary Views*, which was issued in March 2009, and the IASB's initial exposure draft, *Leases*, and the proposed FASB Accounting Standards Update, *Leases (Topic 840)*, which were issued in August 2010.

.167 The core principle of the proposed requirements is that an entity should recognize assets and liabilities arising from a lease. This represents an improvement over existing leases requirements, which do not require lease assets and lease liabilities to be recognized by many lessees.

.168 In accordance with that principle, a lessee would recognize assets and liabilities for leases with a maximum possible term of more than 12 months. A lessee would recognize a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the leased asset (the underlying asset) for the lease term.

.169 The recognition, measurement, and presentation of expenses and cash flows arising from a lease by a lessee would depend on whether the lessee is expected to consume more than an insignificant portion of the economic benefits embedded in the underlying asset. For practical purposes, this assessment would often depend on the nature of the underlying asset.

.170 For most leases of assets other than property (for example, equipment, aircraft, cars, trucks), a lessee would classify the lease as a type A lease and would do the following:

- Recognize a right-of-use asset and a lease liability, initially measured at the present value of lease payments
- Recognize the unwinding of the discount on the lease liability as interest separately from the amortization of the right-of-use asset

.171 For most leases of property (that is, land, a building or part of a building, or both), a lessee would classify the lease as a type B lease and would do the following:

- Recognize a right-of-use asset and a lease liability, initially measured at the present value of lease payments
- Recognize a single lease cost, combining the unwinding of the discount on the lease liability with the amortization of the right-of-use asset, on a straight-line basis

.172 Similarly, the accounting applied by a lessor would depend on whether the lessee is expected to consume more than an insignificant portion of the economic benefits embedded in the underlying asset. For practical purposes, this assessment often would depend on the nature of the underlying asset.

.173 For most leases of assets other than property, a lessor would classify the lease as a type A lease and would do the following:

- Derecognize the underlying asset and recognize a right to receive lease payments (the lease receivable) and a residual asset (representing the rights the lessor retains relating to the underlying asset)
- Recognize the unwinding of the discount on both the lease receivable and the residual asset as interest income over the lease term
- Recognize any profit relating to the lease at the commencement date

.174 For most leases of property, a lessor would classify the lease as a type B lease and would apply an approach similar to existing operating lease accounting in which the lessor would do the following:

- Continue to recognize the underlying asset
- Recognize lease income over the lease term typically on a straight-line basis

.175 When measuring assets and liabilities arising from a lease, a lessee and a lessor would exclude most variable lease payments. In addition, a lessee and a lessor would include payments to be made in optional periods only if the lessee has a significant economic incentive to exercise an option to extend the lease or not to exercise an option to terminate the lease.

.176 The existing accounting model for leveraged leases would not be retained, and the proposals described for lessors would be applied to all leases currently accounted for as leveraged leases.

.177 For leases with a maximum possible term (including any options to extend) of 12 months or less, a lessee and a lessor would be permitted to make an accounting policy election, by class of underlying asset, to apply simplified requirements that would be similar to existing operating lease accounting.

.178 An entity would provide disclosures to meet the objective of enabling users of financial statements to understand the amount, timing, and uncertainty of cash flows arising from leases.

.179 On transition, a lessee and a lessor would recognize and measure leases at the beginning of the earliest period presented using either a modified retrospective approach or a full retrospective approach.

.180 The boards will set the effective date for the proposed requirements when they consider interested parties' feedback on this revised exposure draft. The boards are aware that the proposals affect almost every reporting entity. Some of those entities have many leases, and the proposed changes to accounting for leases are significant. The boards will consider these and other relevant factors when setting the effective date.

Revenue Recognition

.181 The income statement shows an entity's financial performance and position. However, revenue recognition requirements in U.S. GAAP differ from those in International Financial Reporting Standards (IFRS), and both sets of requirements need improvement. U.S. GAAP comprises broad revenue recognition concepts and numerous requirements for particular industries or transactions that can result in different accounting for economically similar transactions. Although IFRS has fewer requirements on revenue recognition, the

two main revenue recognition standards, IAS 18, *Revenue*, and IAS 11, *Construction Contracts*, can be difficult to understand and apply. In addition, IAS 18 provides limited guidance on important topics such as revenue recognition for multiple-element arrangements.

.182 Accordingly, FASB and the IASB initiated a joint project to clarify the principles for recognizing revenue and to develop a common revenue standard for U.S. GAAP and IFRS that would accomplish the following:

- Remove inconsistencies and weaknesses in existing revenue requirements
- Provide a more robust framework for addressing revenue issues
- Improve comparability of revenue recognition practices across entities, industries, jurisdictions, and capital markets
- Provide more useful information to users of financial statements through improved disclosure requirements
- Simplify the preparation of financial statements by reducing the number of requirements to which an entity must refer

.183 To meet those objectives, FASB and the IASB have proposed amendments to FASB ASC and to IFRS, respectively.

.184 The core principle of this proposed guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

.185 To achieve that core principle, an entity would apply all of the following steps:

- Step 1: Identify the contract with a customer
- Step 2: Identify the separate performance obligations in the contract
- Step 3: Determine the transaction price
- Step 4: Allocate the transaction price to the separate performance obligations in the contract
- Step 5: Recognize revenue when (or as) the entity satisfies a performance obligation

.186 The boards have tentatively decided to require an entity to apply the revenue standard for reporting periods beginning on or after December 15, 2016. That timing would ensure that for an entity providing two years of comparative annual financial information (in addition to information for the current year), the standard would be issued before the beginning of the earliest comparative annual period presented. FASB decided that early application would not be permitted. The IASB decided that early application would be permitted. The final document is expected in the fourth quarter of 2013.

Financial Instruments

.187 In February 2013, FASB issued proposed ASU *Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities* and in April 2013, FASB issued proposed ASU *Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities—Proposed Amendments to*

the FASB Accounting Standards Codification®. The guidance in the first proposed ASU focuses on creating a comprehensive framework for the classification and measurement of the financial instruments within its scope. An entity would determine the classification and measurement of a financial asset, upon initial recognition, by first considering whether the contractual terms of the asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding (the contractual cash flow characteristics criterion). If so, an entity then would consider the business model in which the asset is managed along with other financial assets to determine its classification and measurement. An entity would be required to measure financial assets that do not meet the contractual cash flow characteristics criterion at fair value with all changes in fair value recognized in net income.

.188 The second proposed ASU includes amendments to FASB ASC 825-10 to reflect the board's decision to eliminate the fair value options in FASB ASC 825-10-15-4 for financial instruments that are not in the scope of the proposed ASU on financial instruments.

.189 The board believes that retaining the unconditional fair value options has the potential to impair comparability and, thus, make financial statements less useful in decision making. The board further believes that such fair value options are no longer needed given the board's projects on financial instruments, insurance contracts, and revenue recognition. Thus, the board decided to link the transition and effective date for eliminating these fair value options to those respective projects.

.190 Additionally, in December, 2012, FASB issued proposed ASU *Financial Instruments—Credit Losses (Subtopic 825-25)*. FASB's proposed ASU intends to improve financial reporting about expected credit losses on loans and other financial assets held by banks, financial institutions, and other public and private entities. The proposed model would utilize a single "expected credit loss" measurement objective for the recognition of credit losses, replacing the multiple existing impairment models in U.S. GAAP. The current models generally require that a loss be "incurred" before it is recognized. Under the FASB proposal, management would be required to estimate the cash flows that it does not expect to collect using all available information, including historical experience and reasonable and supportable forecasts about the future.

Disclosure Framework

.191 The objective and primary focus of this project is to improve the effectiveness of disclosures in notes to financial statements by clearly communicating the information that is most important to users of each entity's financial statements. Although reducing the volume of notes to financial statements is not the primary focus, the board hopes that a sharper focus on important information will result in reduced volume in most cases.

.192 Achieving the objective of improving effectiveness will require development of a framework that promotes consistent decisions about disclosure requirements by the board and the appropriate exercise of discretion by reporting entities. The board also is considering whether and how to provide guidance to improve the organization, formatting, and style of notes to financial statements.

Private Company Decision-Making Framework

.193 The FASB and the Private Company Council (PCC) have an active project with an objective to develop a private company decision-making framework (the guide). The FASB and the PCC will use the guide in determining whether and in what circumstances to provide alternative recognition, measurement, disclosure, display, effective date, or transition guidance for private companies reporting under U.S. GAAP. This guide is not intended to be an entirely new conceptual framework that would lead to a basis for preparing financial statements of private companies that is fundamentally different from the basis for preparing financial statements of public companies. Rather, this guide would augment the existing conceptual framework for financial reporting to provide additional considerations in making user-relevance and cost-benefit evaluations under the existing conceptual framework for private companies.

.194 In July 2011, the FASB staff completed an assessment of (*a*) how and why the needs of users of private company financial statements may differ from the needs of users of public company financial statements and (*b*) how the cost-benefit considerations of financial reporting may vary between private companies and public companies. The assessment identified the following six significant factors that differentiate the financial reporting considerations of private companies and public companies:

- Types and number of financial statement users
- Access to management
- Investment strategies of equity investors
- Ownership and capital structures
- Accounting resources
- Learning about new financial reporting guidance

.195 In May 2012, the Financial Accounting Foundation Board of Trustees issued a final report, *Establishment of the Private Company Council*. The PCC was created to improve the standard-setting process for private companies. At the PCC's February 12, 2013, meeting, FASB and the PCC tentatively agreed on the criteria to be included in this guide for determining whether and in what circumstances there should be alternatives for private companies within U.S. GAAP. The FASB and the PPC developed the proposed ASU *Private Company Decision-Making Framework: A Guide for Evaluating Accounting and Reporting for Private Companies* and related Invitation to Comment (ITC) based on their discussions during the February 2013 meeting. The ITC requested that stakeholders provide input on the proposed guide by June 21, 2013.

.196 The PCC will use this guide to develop, deliberate, and formally vote on proposed alternatives for private companies within U.S. GAAP. If endorsed by FASB, the proposed alternatives will be exposed for public comment (see the subsequent "Private Company Council Proposals" section of this alert for information on current proposals being proposed). At the conclusion of the public comment process, the PCC will redeliberate the proposed alternatives and then submit them to FASB for a final decision on endorsement. The board and the PCC also will use this guide to consider private company issues in standard-setting projects under active consideration on FASB's technical agenda.

.197 On July 16, 2013, FASB and the PCC voted to finalize the guide. The final guide is expected to be issued during the fourth quarter of 2013.

Private Company Council Proposals

.198 In June 2013, FASB endorsed three alternatives within U.S. GAAP that were proposed by the PCC. The proposals involve accounting for intangible assets acquired in business combinations, goodwill, and certain types of interest rate swaps. Three related exposure drafts were issued for public comment on July 1, 2013, and comments were due by August 23, 2013.

.199 The first proposal—derived from PCC Issue No. 13-01A, *Accounting for Identifiable Intangible Assets in a Business Combination*—modifies the requirement for private companies to separately recognize fewer intangible assets acquired in a business combination.

.200 The second proposal—derived from PCC Issue No. 13-01B, *Accounting for Goodwill Subsequent to a Business Combination*—would permit amortization of goodwill (the residual asset recognized in a business combination after recognizing all other identifiable assets acquired and liabilities assumed) and a simplified goodwill impairment model.

.201 The third proposal—derived from PCC Issue No. 13-03, *Accounting for Certain Receive-Variable, Pay-Fixed Interest Rate Swaps*—would give private companies, other than financial institutions, the option to use two simpler approaches to accounting for certain types of interest rate swaps that are entered into by a private company for the purpose of economically converting its variable-rate borrowing to a fixed-rate borrowing.

.202 The PCC released a fourth exposure document for public comment in August 2013 (with a comment deadline of October 14, 2013) outlining an alternative within U.S. GAAP for applying consolidation guidance to leasing companies under control. The proposed GAAP alternative, *Applying Variable Interest Entity Guidance to Common Control Leasing Arrangements* (formerly FASB Interpretation No. 46[R] and FASB Statement No. 167), would exempt many private companies from applying variable interest entity guidance to lessor companies under common control. A variable interest entity is a company in which controlling financial interest is not established based on a majority of voting rights. The proposal is intended to help lenders and other users better align the information used in assessing financial position of private companies that prepare financial statements.

.203 The effective dates will be determined after FASB and the PCC consider stakeholder feedback on the exposure drafts.

FASB Projects Originating From the Not-for-Profit Advisory Committee

.204 The FASB Not-for-Profit Advisory Committee (NAC) was established in October 2009 to serve as a standing resource for FASB in obtaining input from the NFP sector (including not-for-profit health care entities) on existing guidance, current and proposed technical agenda projects, and longer-term issues affecting those entities.

.205 The primary functions of NAC are as follows:

- Provide focused input and feedback to the FASB board and staff on existing guidance, current and proposed technical agenda projects, and longer-term issues (for example, the alternatives and recommended course for financial reporting for NFPs if the SEC mandates IFRS for SEC registrant companies).

- Assist FASB's board and staff in its communication and outreach activities to the NFP sector about recent and other existing guidance, current and proposed projects, and longer-term issues.

.206 Among other matters, NAC has recommended changes to accounting rules that would enable NFPs to better report and explain their finances to users of their financial statements. As a result of these recommendations, FASB added two NFP projects to its agenda:

- *NFP Financial Reporting: Financial Statements.* This project will reexamine existing standards for financial statement presentation by NFPs, focusing on improving (*a*) net asset classification requirements, and (*b*) information provided in financial statements and notes about liquidity, financial performance, and cash flows.
- *NFP Financial Reporting: Other Financial Communications.* The goal of this research project is to study communications other than financial statements that NFPs use to tell their financial story. The FASB staff will, for example, review existing best practices, followed by NFPs, to discern how such communications enhance the understanding of donors, creditors, and other stakeholders about the financial health and performance of the entity. Through this effort, the board expects to learn whether educational or standard-setting efforts can contribute to promoting such other effective means of communication.

.207 Readers should remain alert for continued developments on these two projects on the FASB's Project Roster & Status webpage. More information about NAC and other FASB advisory groups is available at www.fasb.org/jsp/FASB/Page/SectionPage&cid=1176154493483.

FASB Project Roster and Status Updates

.208 The following table lists additional FASB projects that may affect health care entities, including a brief description of the project objectives. Further information on each of these projects, including a summary of decisions reached to date, can be accessed from the FASB Project Roster and Status page at www.fasb.org.

FASB Current Technical Plan	
Insurance Contracts *Insurance Contracts (Topic 834)*	The objective of this joint FASB and IASB project is to develop common, high-quality guidance that will address recognition, measurement, presentation, and disclosure requirements for insurance contracts (including reinsurance), even if the contracts are not issued by an insurance entity. Specifically, the project is intended to improve, simplify, and converge the financial reporting requirements for insurance contracts and to provide investors with decision-useful information. The board plans to consider all feedback on the exposure draft and begin redeliberations on all significant issues in the fourth quarter 2013.

FASB Current Technical Plan—continued	
Definition of a Nonpublic Entity *Definition of a Public Business Entity: An Amendment to the Master Glossary*	The objective of this project is to re-examine the definitions of *nonpublic entity* and *public entity* in FASB ASC. The project will focus on defining what constitutes a public business entity to distinguish between different types of entities for standard-setting purposes and on determining which companies are to be excluded from the scope of the Private Company Decision-Making Framework. The project will also focus on whether a distinction or distinctions between not-for-profit entities is necessary and, if so, how that distinction or distinctions between particular types of not-for-profit entities might best be made. The board plans to consider all feedback on the exposure draft obtained through the comment period ending in the third quarter 2013.
Going Concern *Presentation of Financial Statements (Topic 205): Disclosure of Uncertainties about an Entity's Going Concern Presumption*	The objective of this FASB project is to provide preparers with guidance in GAAP on management's responsibilities for evaluating and disclosing going concern uncertainties and, thereby, to reduce existing diversity in footnote disclosures. In doing so, the board believes that the proposal also would improve the timeliness and the quality of footnote disclosures about going concern uncertainties. The board plans to consider all feedback on the exposure draft and begin redeliberations on all significant issues in the fourth quarter 2013.
Reporting Discontinued Operations *Presentation of Financial Statements (Topic 205): Reporting Discontinued Operations*	The primary objective of the project is to improve the definition and reporting of discontinued operations. Some stakeholders have said that too many disposals of assets qualify for discontinued operations presentation. This results in financial statements that are not decision useful for users and in higher costs for preparers. The project will also enhance convergence of FASB's and the IASB's reporting requirements for discontinued operations.
Consolidation: Policy and Procedures *Consolidation (Topic 810): Principal versus Agent Analysis*	The objective of this FASB project is to consider comprehensive guidance for consolidation of all entities, including entities controlled by voting or similar interests. This includes an evaluation of guidance for determining the capacity of a decision maker. A final ASU is anticipated for release in the fourth quarter 2013.

(continued)

FASB Current Technical Plan—continued	
Transfers and Servicing: Repurchase Agreements and Similar Transactions *Transfers and Servicing (Topic 860): Effective Control for Transfers with Forward Agreements to Repurchase Assets and Accounting for Repurchase Financings*	The objective of this FASB project is to improve the existing accounting and disclosure guidance on repurchase agreements (and other transactions involving a transfer and a forward agreement to repurchase the transferred assets at a fixed price from the transferee) to address application issues and changes in the marketplace and to ensure that investors obtain useful information about these transactions. A final ASU is anticipated for release in the fourth quarter 2013.
Not-for-Profit Financial Reporting: Financial Statements	The objective of this project is to reexamine existing standards for financial statement presentation by not-for-profit entities, focusing on improving 1. net asset classification requirements. 2. information provided in financial statements and notes about liquidity, financial performance, and cash flows. The board currently expects to release an exposure draft during the first half of 2014.

Current GASB Projects

.209 GASB currently has a variety of project in process, including the following:

- *Conceptual Framework—Recognition and Measurement Approaches*. This project has two primary objectives which will be addressed in two subprojects. One objective is to develop recognition criteria for whether information should be reported in governmental financial statements and when that information should be reported. Another objective is to consider the measurement approach or measurement approaches (for example, initial amounts or remeasured amounts) that conceptually should be used in governmental financial statements. This project ultimately will lead to a concepts statement on recognition of elements of financial statements and a concepts statement on measurement approaches. An exposure draft document on measurement approaches was issued for public comment in June 2013, with comments due by September 30, 2013. An exposure draft document on recognition is expected to be issued for public comment in early 2014.
- *Economic Condition Reporting: Financial Projections*. The objective of this project is to consider whether guidance or guidelines should be provided for additional information about economic condition, particularly financial projections, as part of general

purpose external financial reporting. This project also will include consideration of the information users identified as necessary to assess the risks associated with a government's intergovernmental financial dependencies. Deliberations on this project have been placed on hold.

- *Fair Value Measurement and Application.* The objective of this project is to review and consider alternatives for the further development of the definition of fair value, the methods used to measure fair value, the applicability of fair value guidance to investments and other items currently reported at fair value, and potential disclosures about fair value measurements. An exposure draft document on measurement approaches was issued for public comment in June 2013, with comments due by September 30, 2013.
- *GAAP Hierarchy.* This project considers possible modifications to the GAAP hierarchy, as set forth in GASB Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*. It reexamines the hierarchy levels to assess whether the standard-setting process and the governmental financial reporting environment have sufficiently evolved since the establishment of the original hierarchy by the AICPA in 1992 to warrant reconsideration or reconfiguration of certain aspects of the structure. An exposure draft document of the proposed statement is expected to be issued in December 2013.
- *Other Postemployment Benefit Accounting and Financial Reporting.* GASB will consider the possibility of improvements to the existing standards of accounting and financial reporting for other postemployment benefits (OPEB)—by state and local governmental employers and by the trustees, administrators, or sponsors of OPEB plans. One objective of this project is to improve accountability and the transparency of financial reporting in regard to the financial effects of employers' commitments and actions related to OPEB. Another objective of this project is to improve the usefulness of information for decisions or judgments of the various users of the general-purpose external financial reports of governmental employers and OPEB plans. This project also will address accounting and financial reporting for postemployment benefits that are not provided through a qualified trust (as defined in paragraph 4 of GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27*). Exposure draft documents on employer and plan OPEB accounting and financial reporting issues are expected to be issued in April 2014.

Bond Disclosure

.210 In September 2012, the National Federation of Municipal Analysts (NFMA) released for public comment a proposed update of its publication *Recommended Best Practices in Disclosure for Hospital Debt Transactions* that was originally issued in 2000. The proposed update addresses fundamental changes to the disclosure needs of investors that have arisen over the past decade, including perceived disclosure weaknesses that were brought to light by the credit

market disruptions of 2008, increased usage of complex swaps and variable rate debt instruments, and the growing use of alternative investments in hospitals' investment portfolios. The draft disclosure guidelines are available for download at www.nfma.org/assets/documents/RBP/rbp.hospital.draft.9.12.pdf. The NFMA also has available *Recommended Best Practices in Disclosure for Long-Term Care/Senior Living Debt* that was issued in 2002.

Resource Central

.211 The following are various resources that practitioners engaged in the state and local government industry may find beneficial.

Publications

.212 Practitioners may find the following publications useful. Choose the format best for you—print, eBook, or online.

- Audit and Accounting Guide *Health Care Entities* (2013) (product no. AAGHCO13P [paperback], WHC-XX [online with the associated Audit Risk Alert], or AAGHCO13E [eBook])
- Audit and Accounting Guide *Not-for-Profit Entities* (2013) (product no. AAGNFP13P [paperback], WNP-XX [online with the associated Audit Risk Alert], or AAGNFP13E [eBook])
- Audit and Accounting Guide *State and Local Government* (2013) (product no. AAGSLG13P [paperback], WGG-XX [online with the associated Audit Risk Alert], or AAGSLG13E [eBook])
- Audit Guide Government Auditing Standards *and Circular A-133 Audits* (2013) (product no. AAGGAS13P [paperback], WRF-XX [online with the associated Audit Risk Alert], or AAGGAS13E [eBook])
- Audit Guide *Assessing and Responding to Audit Risk in a Financial Statement Audit* (2012) (product no. AAGRAS12P [paperback], WRA-XX [online], or AAGRAS13E [eBook])
- Audit Guide *Special Considerations in Auditing Financial Instruments* (2012) (product no. AAGAFI12P [paperback], WDI-XX [online], or AAGAFI12E [eBook])
- Audit Guide *Auditing Revenue in Certain Industries* (2012) (product no. AAGREV12P [paperback], AAGREV12e [eBook], or WAR-XX [online])
- Audit Guide *Audit Sampling* (2012) (product no. AAGSAM12P [paperback], AAGSAM12E [eBook], or WAS-XX [online])
- Audit Risk Alert *General Accounting and Auditing Developments—2013/14* (product no. ARAGEN13P [paperback], WGE-XX [online], or ARAGEN13E [eBook])
- Alert *Independence and Ethics Developments—2012/13* (product no. ARAIET12P [paperback], WIA-XX [online], or ARAIET12E [eBook])
- *Audit and Accounting Manual* (2013) (product no. AAMAAM13P [paperback], WAM-XX [online])

Comprehensive Implementation Guide Update

.213 In October 2012, GASB issued the 2012–2013 *Comprehensive Implementation Guide*. GASB publishes an annual update to this guide, which consolidates and updates previously issued guides for subsequently issued standards and provides current guidance on standards for which no stand-alone guides have been published.

> **Help Desk**—The *Comprehensive Implementation Guide* can be ordered through GASB's order department at 800.748.0659 or via its website at www.gasb.org.

Continuing Professional Education

Online CPE

.214 AICPA CPExpress, offered exclusively through CPA2Biz, is the AICPA's flagship online learning product. Divided into 1-credit and 2-credit courses that are available 24 hours a day, 7 days a week, AICPA CPExpress offers hundreds of hours of learning in a wide variety of topics. Subscriptions are available at the CPExpress product page of www.cpa2biz.com.

Webcasts

.215 Stay plugged in to what is happening and earn continuing professional education (CPE) credit right from your desktop. AICPA webcasts are high quality, two-hour CPE programs that bring you the latest topics from the profession's leading experts. Broadcast live, they allow you to interact with the presenters and join in the discussion. If you cannot make the live event, each webcast is archived and available on CD-ROM. For additional details on available webcasts, please visit www.cpa2biz.com/AST/AICPA_CPA2BIZ_Browse/Store/Webcasts.jsp.

Member Service Center

.216 To order AICPA products, receive information about AICPA activities, and get help with your membership questions, call the AICPA Service Operations Center at 888.777.7077.

Hotlines

Accounting and Auditing Technical Hotline

.217 Do you have a complex technical question about GAAP, other comprehensive bases of accounting, or other technical matters? If so, use the AICPA's Accounting and Auditing Technical Hotline. AICPA staff will research your question and call you back with the answer. The hotline is available from 9 a.m. to 8 p.m. ET on weekdays. You can reach the Technical Hotline at 877.242.7212 or online at www.aicpa.org/Research/TechnicalHotline. Members can also e-mail questions to aahotline@aicpa.org. Additionally, members can submit questions by completing a Technical Inquiry form found on the same website.

Ethics Hotline

.218 In addition to the Technical Hotline, the AICPA also offers an Ethics Hotline. Members of the AICPA's Professional Ethics Team answer inquiries concerning independence and other behavioral issues related to the application of the AICPA Code of Professional Conduct. You can reach the Ethics Hotline at 888.777.7077 or by e-mail at ethics@aicpa.org.

AICPA Online Professional Library: Accounting and Auditing Literature

.219 The AICPA has created your core accounting and auditing library online. The AICPA Online Professional Library is now customizable to suit your preferences or your firm's needs. You can also sign up for access to the entire library. Get access—anytime, anywhere—to the Financial Accounting Standards Board *Accounting Standards Codification*; the AICPA's latest editions of *Professional Standards*, *Technical Practice Aids*, Audit and Accounting Guides, Audit Risk Alerts, *Accounting Trends & Techniques*, and more. To learn more about the subscription options available and to subscribe to this essential online service for accounting professionals, visit www.cpa2biz.com/library.

Codified Clarity Standards

.220 The best way to obtain the codified clarity standards is with a subscription to AICPA *Professional Standards* in the AICPA Online Professional Library. Although the individual SASs are available in paperback, this online codified resource is what you need to update your firm audit methodology and begin understanding how clarity standards change certain ways you perform your audits. Visit www.cpa2biz.com/AST/AICPA_CPA2BIZ_Specials/MostPopularProductGroups/AICPAResourceOnline/PRD~PC-005102/PC-005102.jsp for online access to AICPA *Professional Standards*.

.221 You can also get the clarified standards in paperback format. AICPA *Codification of Statements on Auditing Standards* is published each spring and includes the clarified auditing standards and the attestation standards. AICPA *Professional Standards*, which has the full complement of AICPA standards, is published each summer.

.222 The codification of clarified standards includes various resources:

- A preface, "Principles Underlying an Audit Conducted in Accordance With Generally Accepted Auditing Standards"
- A glossary of terms defined in the standards
- An appendix describing the differences between GAAS and the ISAs
- A table mapping the pre-clarity AU sections to the clarified AU-C sections

Financial Reporting Center of AICPA.org

.223 CPAs face unprecedented changes in financial reporting. As such, the AICPA has created the Financial Reporting Center to support you in the execution of high-quality financial reporting. This center provides exclusive member-only resources for the entire financial reporting process and can be accessed at www.aicpa.org/FRC.

.224 The Financial Reporting Center provides timely and relevant news, guidance, and examples supporting the financial reporting process. You will find resources for accounting, preparing financial statements, and performing various types of engagements, including compilation and review, audit and attest, and assurance and advisory.

.225 For example, the Financial Reporting Center offers a dedicated section to the Clarity Project. For the latest resources available to help you implement the clarified standards, visit the "Improving the Clarity of Auditing Standards" page at www.aicpa.org/SASClarity.

Health Care Industry Conference

.226 The AICPA offers the AICPA National Healthcare Industry Conference on an annual basis, typically in mid-November. Most recently, the conference was held on November 14–15, 2013, in New Orleans, LA. The annual conference is a two-day event designed to update attendees on recent developments related to the health care industry. Gain the information and techniques you need to know to stay on top of trends to benefit your practice and client offerings. With access to some of the nation's top health care specialists, you'll get up-to-the-minute comprehensive coverage of health care reform ramifications. For further information about the conference, call 888.777.7077 or visit www.cpa2biz.com.

AICPA Health Care Expert Panel

.227 The Health Care Expert Panel serves the needs of AICPA members on financial and business reporting and audit and attest matters. The expert panel protects the public interest by bringing together knowledgeable parties in the health care industry to deliberate and come to agreement on key health care issues. For information about the activities of the AICPA Health Care Expert Panel, visit the panel's webpage at www.aicpa.org/InterestAreas/FRC/IndustryInsights/Pages/Expert_Panel_Health_Care_Entities.aspx.

Industry Websites

.228 The Internet covers a vast amount of information that may be valuable to auditors of health care entities, including current industry trends and developments. Some of the more relevant sites for auditors with health care industry clients include those shown in the following table.

Organization	*Website*
American Hospital Association	www.aha.org
Atlantic Information Services, Inc.	www.aishealth.com
Centers for Medicare & Medicaid Services	www.cms.hhs.gov
Electronic Municipal Market Access	www.emma.msrb.org
Global health reporting	http://globalhealth.kff.org/
Healthcare Financial Management Association	www.hfma.org

(continued)

Organization	*Website*
Health Forum	www.healthforum.com
Henry J. Kaiser Family Foundation	www.kff.org
SEC Office of Municipal Securities	www.sec.gov/info/municipal.shtml
U.S. Department of Health & Human Services	www.hhs.gov

.229 The health care industry practices of some of the larger CPA firms also may contain industry-specific auditing and accounting updates that are helpful to auditors.