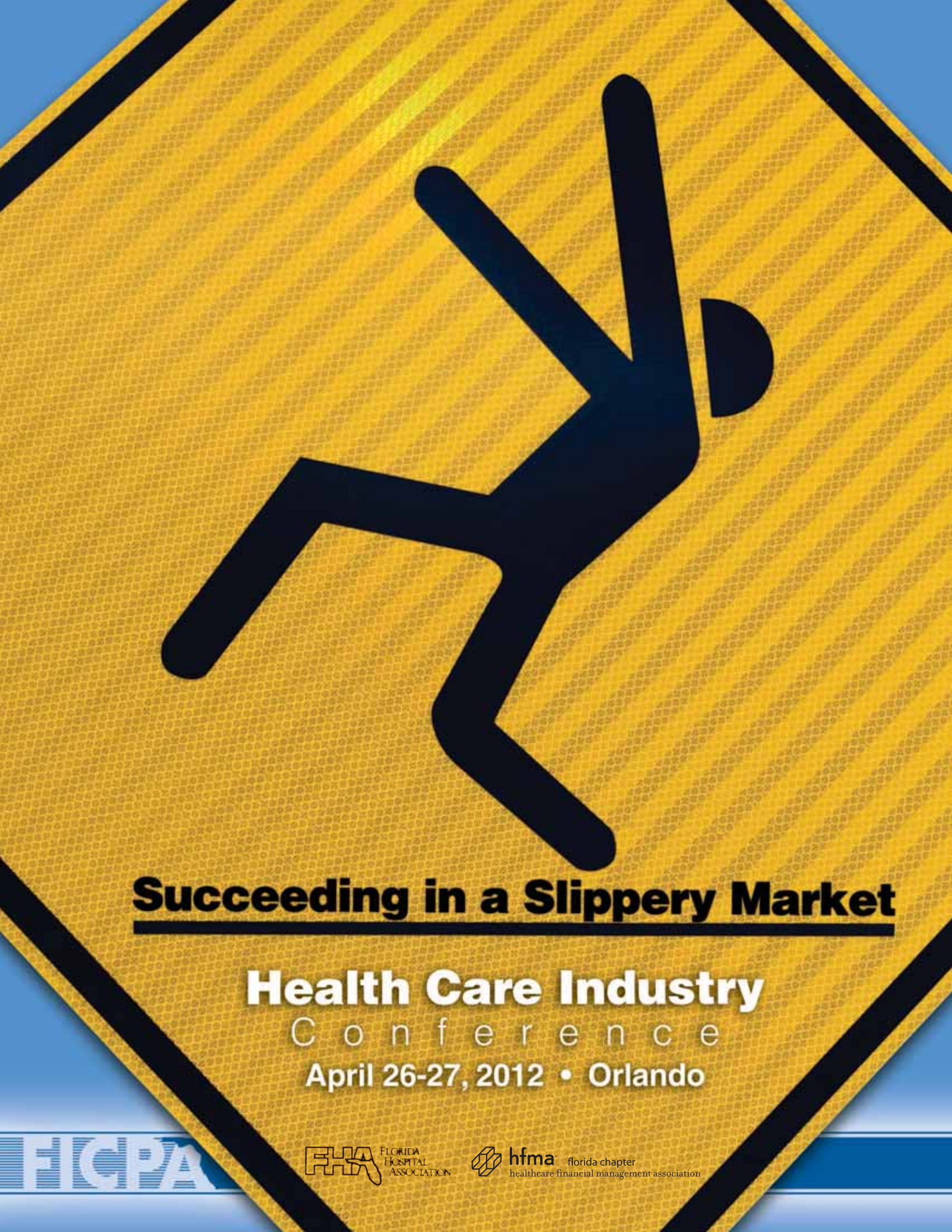
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Wednesday, April 25, 2012

3:50pm-5:30pm

Pre-Con Workshop: Acquisition of Physician Practice 1
Linda Fleming, Esq
Shareholder/Carlton Fields
and
Michael Massey
Senior VP of Development/HCA Physician Services
and
Robert Wilson
Executive Director, Healthcare Advisory/Grant Thornton LLP

Thursday, April 26, 2012

7:30-8:15 am

Registration and Continental Breakfast

8:00-8:05 am

Opening Remarks
Kathleen Hargreaves, CPA, CFP
Committee Chair

8:20am-9:10am

Keynote Address: The Past, Present and Future of Health Care in the U.S..... 45
Ruben King-Shaw, Jr.
Managing Partner and CIO/Mansa Capital

9:10am-10:00am

Keynote Address: The Future of Healthcare in Florida 59
Alex Sink
Chair of FL Next Foundation/Hyde Park Capital

10:15am-11:05am — Emerging Issues 62
Ken Weixel, CPA
Partner/Deloitte and Touche

11:10 a.m.-12:00 p.m. — **Concurrent Breakouts – Please Choose One**

Breakout 1: — Art of Accounting for Contributions 81
Scot E. Aurelius, CPA
Shareholder/Moore Stephens Lovelace, PA
and
Russell J. Goolsby, CPA, MACC
Principal/Moore Stephens Lovelace, PA

Breakout 2: — Optimizing Value Based Purchasing Payment through Hospital Process Integration 106
Sandra Sieck
Chief Operating Officer/Society of Chest Pain Centers

Breakout 3: — ACO's Practical Applications 136
David A. Schuh, CPA
Principal/CliftonLarsonAllen LLP

12:00pm-1:10pm — Lunch Presentation: The New Health Age: The Future of Health Care in America 153
Jonathan D. Fleece
Attorney and Advisor/Blalock Walters, P.A.

1:15 -2:05 p.m. — **Concurrent Breakouts – Please Choose One**

Breakout 4: — The New AICPA Audit and Accounting Guide for Health Care Entities is Here! 169
C. Cline Comer, CPA
Principal/CliftonLarsonAllen LLP

Breakout 5: — Hospital and Physician Alignment 171
George C. Batalis, CPA
Director, Health Industries Advisory/PricewaterhouseCoopers LLP
and
Jeff Whitcomb
Manager, Health Industries Advisory/PricewaterhouseCoopers LLP

Breakout 6: — The Calm Before the Next Malpractice Storm 187
Matt Gracey
Founder & President/Danna-Gracey and Medical Defense Solutions

2:10 - 3:00 p.m. — **Concurrent Breakouts – Please Choose One**

Breakout 7: — The New AICPA Audit and Accounting Guide for Health Care Entities is Here! (Part II) 194
C. Cline Comer, CPA
Principal/CliftonLarsonAllen LLP

Breakout 8: Maintaining Cash Flow During ICD-10 and HIT Conversions..... 196
Simon Hughes
President/FirstSource Solutions

Breakout 9: CIO Panel Discussion..... 198
Rick Schooler, FACHE, FCHIME
VP & CIO/Orlando Health
and
Mary C. Ford, FHIMSS
VP & CIO/Lakeland Regional Medical Ctr

3:15 - 4:05 p.m. Concurrent Breakouts – Please Choose One

Breakout 10: IFRS: Prepare Your Organization for Adoption 201
Richard Stuart
Partner/McGladrey & Pullen, LLP

Breakout 11: Accountants & Attorney's: A Team Approach to Health Care Audit Defense..... 222
Michael A. Igel
Attorney/Trenam Kemker, Attorneys at Law

Breakout 12: Rebuilding the Revenue Cycle @ 50,000 Feet 237
Patrick McDermott
Senior VP, Revenue Services/Resurrection Health Care

4:05 - 4:55 p.m. Concurrent Breakouts – Please Choose One

Breakout 13: New Accounting for Healthcare..... 239
David A. Rood, CPA
Partner/KPMG LLP

Breakout 14: Bundled Payments and Acute Care Episode - Risks & Rewards .. 261
Stephen W. Forney, MBA, CPA, FACHE, FHFMA
VP & CFO/Lovelace Health Systems

Breakout 15: Access to Financing For Healthcare Providers..... 278
Pierre M. Bogacz
Managing Director/HFA Partners

5:00pm-5:50pm Legislative and Regulatory Update..... 294
Lawrence Goldberg
Senior Advisor, Health Care Practice/Grant Thornton LLP

Friday, April 27, 2012

7:30-8:00 am — **Continental Breakfast**

8:00am-9:40am — **Panel: Future Challenges for Health Care Organizations** 315
Jeffrey M. Herschler (moderator)
President/FHIcommunications, LLC
and
Michael Mueller
CFO/Health Central
and
Michael W. Garner, Ph.D.
President and CEO/Florida Association of Health Plans

10:00 -10:50 a.m. — Concurrent Breakouts – Please Choose One

Breakout 16: **OMB Circular-A133 and Government Auditing Standards Update** 320
John P. DiSanto
Executive Director/Ernst & Young LLP

Breakout 17: **Third Party Reimbursement and Operational Issues for Long-Term Care** 351
Steven R. Jones, CPA
Shareholder/Moore Stephens Lovelace, PA

Breakout 18: **Positioning Your Healthcare Organization for the Future** 359
Carlos G. Hernandez
Senior Manager/Crowe Horwath LLP
and
James P. Grigg
Partner/Crowe Horwath LLP
and
Donald Sibery, MHA, FACHE
President & Managing Partner/Decisive Consultiung Solutions
and
Michael B. Zenn, MBA
Partner/Decisive Consultiung Solutions

10:55 -11:45 a.m. — Concurrent Breakouts – Please Choose One

Breakout 19: **RAC Audits Update** 366
Rebecca K. Hart, RHIA
Partner - Health Care Industries/PricewaterhouseCoopers LLP

Breakout 20: **Slaying Demons in the Revenue Cycle - A Physician Perspective** 368
Bernard J. Emkes, MD
Medical Director,Managed Care Services/St. Vincent Health

Breakout 21:	**An Operational Perspective on the Form 990 and Community Based Assessment Requirements ..... 385** Nicole Bencik, CPA, MST Tax Partner/Crowe Horwath LLP and Cindy B. Kushner, CPA Tax Partner/Crowe Horwath LLP
11:45am-1:00pm	**Lunch Presentation: Charting Your Course to Tremendous Success 405** Ford Kyes Partner & Master Coach/ActionCOACH Pinellas

1:00 - 1:50 p.m.	**Concurrent Breakouts – Please Choose One**
Breakout 22:	**Healthcare Merger & Acquisition: Physician Plan Integration & Accounting ..... 421** Richard Sacher, CPA Senior Manager/Grant Thornton LLP and Robert Wilson Executive Director, Healthcare Advisory/Grant Thornton LLP
Breakout 23:	**Diagnosimetrics: The Science of Diagnostic Cost Reduction & Quality Improvement ..... 441** David A. Hernandez, PhD, MPH Chief Science Advisor/The Center of Excellence In Diagnosimetrics
Breakout 24:	**The CEO/CFO Relationship - What Are They Thinking ..... 453** Ford Kyes, Partner & Master Coach/ActionCOACH Pinellas
2:05pm-3:45pm	**Accounting and Auditing Update ..... 456** Lynda M. Dennis, CGFM, CPA, PhD Accounting Instructor/University of Central Florida

Pre-Con Workshop: Acquisition of Physician Practice

Linda Fleming, Esq
and
Michael Massey
and
Robert Wilson

Linda L. Fleming

Shareholder

Carlton Fields

Linda Fleming is a transactional attorney who assists clients in formation of new entities, joint ventures and other mergers and acquisitions. With over 20 years of legal experience, she has concentrated her practice in health care matters for the last 15 years. She represents hospitals, health systems, and other providers in the health care system. In her role as a health care lawyer, Ms. Fleming attends board meetings, participates in client teams for acquisitions, drafts asset and stock purchase agreements and related documents, advises hospitals on tax-exempt matters and is an advisor on other corporate, health care and transactional matters.

Michael W. Massey, Jr.

Vice President of Development

HCA Inc.

Mike Massey is the Vice President of Development for Nashville-based HCA, the nation's leading provider of healthcare services. His responsibilities include managing the department that is involved in all of the company's physician practice acquisitions, divestitures and contracting models; to include physician Employment Agreements, Professional Services Agreements and Medical Directorships at the company's 163 hospitals. Mr. Massey joined HCA in 1992 and has served in a variety of capacities throughout his tenure with the company to include Vice President of Operations for HCA Physician Services in both the Southeast and Carolinas Divisions. Prior to joining HCA, he worked in the Roper Health System in Charleston, South Carolina.

Originally from Greenville, South Carolina, Mr. Massey earned a bachelor's degree from The College of Charleston in 1987 where he was a four-year letterman on the basketball team. He obtained his Masters in Business Administration from The Citadel in 1989. In addition to his work duties, Mr. Massey serves as a member of the Federation of American Hospital's Board of Governors and a participant on its Hospital Leadership committee. He is also Vice President of the College of Charleston Alumni Association Board of Directors.

Bob Wilson

Executive Director, Health Care Advisory Services

Grant Thornton, LLP

Bob Wilson is an executive director in the Health Care Advisory Services practice of Grant Thornton, focusing on health system strategy and performance improvement. He also leads the firm's physician strategy and operations improvement practice. He is based in the firm's Phoenix, Arizona office.

Industry experience

Bob has over 30 years of experience in the health care industry as a financial auditor and advisor, strategy and operations performance improvement consultant, senior health system executive and board member.

Bob has:

- Led teams focusing on improving the financial and operational performance of hospitals and physician enterprises (primarily health system sponsored).

- Focused on the core dimensions of: revenue cycle; clinic operations and support staff productivity and staffing levels; provider work contribution and productivity; physician compensation and incentive alignment; and physician network strategic capacity and discernment.

- Consulted health systems on a variety of physician alignment and integration issues and models.

- Served in the role of chief implementation officer for comprehensive, integrated enterprise-wide performance improvement projects

Previously, Bob led the physician services practice of Huron Healthcare (formerly Wellspring Partners) and was a partner in Arthur Andersen LLP. In addition, he was the chief financial officer for a $400+ million revenue physician-driven, integrated health care provider organization with 200+ multi-specialty physician group. He also had been on the governing board of several health care organizations, including one of the five largest faith-based health systems in the U.S.

Education

- BA Business Administration, University of Washington
- MBA, California State University, Los Angeles

Acquisition of a Physician Practice

Linda L. Fleming, Esq.
Carlton Fields, P.A.

April 25, 2012

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Acquisition of a Physician Practice

I. Letter of Intent/NDA

II. Due Diligence

III. Structuring the Transactions

IV. Key Considerations

V. Regulatory Matters

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I. Letter of Intent

- Nondisclosure Agreement is necessary
- LOI is optional: To sign or not to sign?
- If LOI is drafted, key issues:
  - Preliminary Purchase Price (FMV)
  - Transaction/Structure
  - No Shop

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Letter of Intent (cont.)

- Other Matters Important to the Physician
  - Employment Terms
  - Compensation and Benefits
  - Employment of Other Staff
  - Post Closing Practice Location
  - Noncompetition Covenants

- Binding or Nonbinding
  - Usually some provisions are binding (e.g., no shop; governing law; nondisclosure) while others are not (e.g., transaction structure; purchase price)

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II. Due Diligence

- Compliance Issues
  - Self Disclosure
  - Transferee Liability
- Licensure and Disciplinary Issues
- Practice Locations
- Medical Staff Privileges
- Financial Performance

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Due Diligence (cont'd.)

- Managed Care Contracts
- Staffing/Salary/Benefits
- Ownership of Assets
- Encumbrances
- Litigation
- Electronic Medical Records (or lack thereof)
- Need for Indemnity Escrow

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III. Transaction Structure

- Asset Purchase/Employment Model
- Asset Purchase/PSA Model
- MSO Model
- Ownership Interest Purchase/Merger

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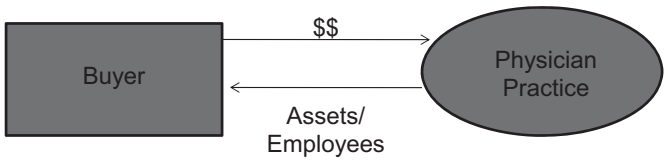
Typical Transaction Structures
Asset Purchase/Employment



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Typical Transaction Structures
Asset Purchase/Employment

- Assets of Physician Practice are purchased at fair market value
- Physicians, along with clinical and non-clinical staff, become employees of Buyer
- Physician employees are compensated at FMV under Stark Law compliant employment arrangements

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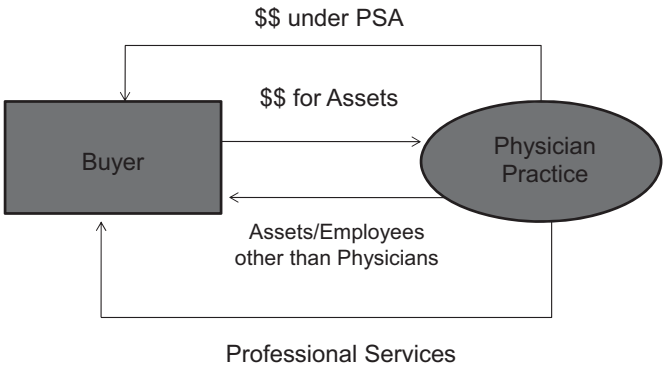
Typical Transaction Structures
Asset Purchase/PSA Arrangement



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Typical Transaction Structures
Asset Purchase/PSA Arrangement

- Assets of Physician Practice are purchased at fair market value
- Staff (other than physicians) become employees of Buyer
- Physicians remain employed by Physician Practice and enter into a long-term professional services arrangement
- Compensation under PSA must be at fair market value compensation; may include a medico-administrative fee
- Buyer bills and collects for physician services

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Typical Transaction Structures
Asset Purchase/PSA Arrangement (Cont'd.)

- Model works best in states where corporate practice of medicine is an issue
- Physicians relieved of burden of capital investment and administration of Physician Practice
- Physicians remain responsible for their compensation; funded through utilizing PSA compensation

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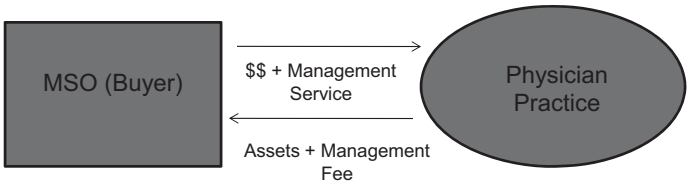
MSO Model



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Typical Transaction Structures

MSO Model

- MSO acquires tangible assets of the Physician Practice
- Physician Practice remains independent
- MSO provides turn-key management services to Physician Practice
  - Equipment
  - Physician extenders
  - Billing/Collections
  - I.T./EMR

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Typical Transaction Structures

MSO Model

- Purchase price limited to value of hard assets
- Physicians relieved of burdens of:
  - Capital investment
  - Administration of practice
- Physician Practice remains at risk for reimbursement and physician compensation
- MSO services must be provided at FMV
- Be cautious of fee splitting restrictions in Florida

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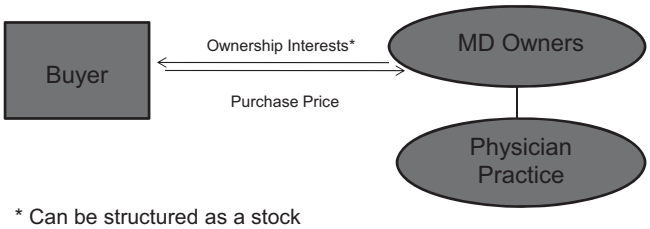
Typical Transaction Structures

Ownership Interest Purchase/Merger



* Can be structured as a stock purchase, membership interest purchase, or merger

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Typical Transaction Structures
Ownership Interest Purchase/Merger

- If possible, can be used to avoid double tax on physicians
- May avoid licensure or anti-assignment clauses
- Only in non-CPM states
- In certain states, physicians practice can be converted from professional corporation (or LLC) to a traditional for profit corporation (or LLC) to allow for ownership by non-physicians

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IV. Key Considerations

- Real Estate
- Physician Compensation
- Valuations
- Purchase Price

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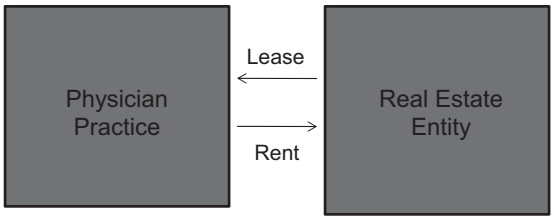
Real Estate Component



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Real Estate Component

- Physicians may hold practice real estate in a separate entity
- Transactions often structured to allow physicians to retain real estate and enter into lease with Buyer at fair market value
- Current lease can be renegotiated to longer term arrangements
- Lease valuations are advisable

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Physician Compensation Models

- "Guaranteed" salary models are disfavored ("The wise man learns from the mistakes of others")
- Trend is toward production based models
  - Revenue *minus* expenses
  - Base compensation *plus* incentive compensation (incentive at risk)
  - Work relative value until production (WRVUs allocated to CPTs)
  - Incentives for quality, good citizenship, patient satisfaction
- Hybrid – one year guaranty then production based
- Physician participation in ancillaries (unless Hospital is the Buyer)

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Physician Compensation

- Physician compensation must meet Stark Law bona-fide employment exception
- Anti-Kickback statute is less stringent; only requires that physicians are bona-fide employees
- If Buyer is tax-exempt, excess benefit transactions and private inurement/private benefit issues
- Possible to structure compensation to include ancillaries (DHS) if physician is employed by group practice
- FMV is a critical threshold

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Valuation Matters

- All regulatory analyses turn on FMV
- Formal valuations close the gap between perception and reality
- Most tax exempt systems insist on third party valuations of physician practices
- Physician professional component generally has relatively low valuation
- Most value embedded in ancillary businesses that spin off cash flow (imaging, ASC, lab)
- Certain intangible assets have value
    1. Workforce in place
    2. Medical records
    3. Trademarks and trade names
- Use of “stay bonuses”
- Payments for covenants not to compete

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Purchase Price

- Consider tax consequences to physicians
- Installment payments v. lump sum payment
- Other Concerns
    - Certain percentage of physicians contracts signed as a condition to closing
    - Regulatory approvals
    - Indemnity escrow
    - Noncompetition covenants
        - In Florida, term, geographic area and scope of activities must be reasonable
        - Statutory guidance is available (F.S. §542.335)
        - Courts will redraw if restrictions are overly broad

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V. Regulatory Matters

- Federal
  - Anti-Kickback Statute
  - Stark Law
  - False Claims Act
  - Civil Monetary Penalty Laws
  - HIPPA/HITECH
- State
  - Anti-kickback
  - Stark equivalents
  - Corporate Practice of Medicine (California, Illinois, Texas, Others)
  - Fee Splitting
  - Noncompetition
  - Licensure

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Conclusion

- Focus on Big Picture
  - Purchase Price
  - Physician Compensation
  - Integration and Post-Closing Performance
- Regulatory Compliance
  - Fair Market Value
  - Valuations are Paramount
- Get the Right Team Involved Early
  - Attorney
  - Accountant
  - Valuation Expert

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FICPA
Pre-Conference Workshop:
Acquisition of a Physician Practice

Mike Massey

April 25, 2012

Contents

- What to look for in a practice
- Considerations used in choosing a Valuation Expert
- Pre-Acquisition Financial Analysis
- Operational issues that need to be addressed

What to look for in a Practice

1. Existing Physician Relationship
2. Community Needs Assessment
3. Physician Alignment Models

Choosing a Valuation Expert

1. Credentials
   - AICPA
   - ASA
   - IBI
   - NACVA
2. Significant healthcare valuation experience
3. Review of Report
   - Credentialing bodies standards followed
   - All three methods are considered (but not necessarily utilized)
   - Intangibles are arrived at via a Cash Flow base analysis

Financial Analysis

1. **Valuation Information Request / Checklist**
2. Due Diligence Checklist
3. Budget / Pro Forma

Valuation Checklist

PHYSICIAN PRACTICE VALUATION PRELIMINARY INFORMATION REQUEST LISTING

1. Name, address, phone, fax and date of inception for the subject physician practice.

2. Copies of all relevant agreements relating to the medical practice including *Employment Agreements, Medical Director Agreements, Management Service Agreements, Partnership Agreements, Asset Purchase Agreements* and *Articles of Incorporation.*

*** PLEASE RUN ALL YEAR-TO-DATE REPORTS WITH THE SAME ENDING DATE (i.e. February 31) ***

If possible, please provide production reports in Excel format

3. 2009, 2010, 2011 and year-to-date 2012 (please include the corresponding year-to-date period in 2011 as well) *income statements* and *balance sheets* for the medical practice.

Valuation Checklist

PHYSICIAN PRACTICE VALUATION PRELIMINARY INFORMATION REQUEST LISTING

4. *CPT Code* reports *by provider* for 2009, 2010, 2011 and year-to-date 2012 (please include the corresponding year-to-date period in 2011 as well) including total charges, payments and adjustments by CPT code. *Please include all modifiers as appropriate.*

5. *Total charges, adjustments, and receipts by provider* for 2009, 2010, 2011 and year-to-date 2012 (please include the corresponding year-to-date period in 2011 as well).

6. *Total charges, adjustments, and receipts by payer* for 2009, 2010, 2011 and year-to-date 2012 (please include the corresponding year-to-date period in 2011 as well).

7. *Capitation information* for 2009, 2010, 2011 and year-to-date 2012 (please includet he corresponding year-to-date period in 2011 as well), including member months, copayments and encounters by capitated plan. (If applicable)

Valuation Checklist

PHYSICIAN PRACTICE VALUATION PRELIMINARY INFORMATION REQUEST LISTING:

8. *Current medical practice staffing roster* including name, position, date-of-hire, average number of hours worked per week, and salary.

9. Copies of 2009, 2010 and 2011 *W2s for each physician and mid-level provider* in the practice.

10. Most recent *accounts receivable aging summary*.

11. *Most recent fixed asset listing* including description, original cost, date of purchase, and current book value of all medical equipment, office equipment, leasehold improvements and furniture in the medical practice. (If available)

12. Copies of *current office and equipment lease agreement(s)*.

13. *Physician CV*(s), start date and *weekly schedule.*

14. *Malpractice policy statement*(s) including current annual premium(s).

Financial Analysis

1. Valuation Information Request / Checklist
2. **Due Diligence Checklist**
3. Budget / Pro Forma

Due Diligence Checklist

1.0 Financial Statements:

- Audited/ unaudited financial statements for past 3 years
- Year-to-date financial statements
- Growth and Expansion Plans
- Detailed procedure productivity report (in electronic format) for: Prior 3 years and Current year-to-date.
- Other Income and Revenues
- Detailed General Ledger for the 6 months prior to request date

2.0 Tax Returns

- State and Federal tax returns for past 3 years
- Tax Depreciation Schedules
- Property Tax Schedules

3.0 Practice Bank Accounts

- Bank Accounts
- Bank Account Register
- Bank Account Agreements

Due Diligence Checklist

4.0 Accounts and Other Receivables
- A/R Aging
- Charges, Payments and Adjustments Report
- Notes and Other Receivables

5.0 Audit of Billing Practices
- Payor Audit reports, including cost, billings, coding assessment and UM/QA audits (within past 3 years) (if applicable)

6.0 Liabilities and Encumbrances
- Liens or Encumbrances on assets
- Termination Statements (UCC-3) and Estoppel Letters
- Debt and Loans
- Loan agreements, security agreements and promissory notes
- Accounts Payable Aging Report
- Accounts Payable Vendor Report
- IBNR ('incurred but nor reported") calculation for past 12 months

Due Diligence Checklist

7.0 Inventory of Practice Assets
- Detail of practice Assets
- List of Excluded Assets

8.0 Employee Information
- Roster of Non-Physician Employees
- Employee benefit plans information (medical, dental, life and disability insurance, 401-k, etc.)
- Schedule of accrued employee benefits (retirement/pension plan, vacation pay, sick pay, etc.)

9.0 Real Estate Issues
- Existing office lease agreements
- Inspection of office facility (i.e.potential concerns)

Due Diligence Checklist

10.0 Contracts and Agreements
- Medical Equipment
- Copy Machines
- Fax Machines
- Information Technology Equipment
- Furniture
- Credit Card Billing System
- Office Equipment
- Storage
- Postage meters
- Other lease agreements
- Management services
- Consulting Services
- Equipment Maintenance
- Answering Service
- Paging Service
- Software License(s)
- Transcription Service
- Cellular Service (non-clinician)
- Copy Machine/Fax Machine
- Telephone
- Medical Equipment
- Pest Control
- Cleaning
- Security System
- Medical Waste
- Refuse Collection
- Other Service Agreements
- Third Party Payor Contracts
- Medicare/Medicaid provider agreements

Due Diligence Checklist

11.0 Licenses and Permits
- All Licenses and Permits
- Occupational License(s)
- Hazardous Materials permit
- CLIA/COLA Certificates
- Medicare and Medicaid Provider Numbers and PINs

12.0 Physician Information
- Schedule of Physicians
- Recruiting Agreements
- Medical License(s)
- Bourd Certifications(s)
- DEA Certificate
- Schedule o disciplinary action(s) by payors/plans and hospitals
- Hospital and Medical Staff Privileges

13.0 Insurance Information
- Insurance Policies Schedule
- Physicans Malpractice Insurance
- Workers Compensation Policy
- Premises Liability
- General Business

Due Diligence Checklist

14.0 Information Systems, Security and Intellectual Property Information

- Patents, Trademarks, other Intellectual Property
- Network Diagram
- Application Inventory Overview
- Hardware Inventory
- Provide Info about Department Summary/Overview of IS
- Policies and Procedures
- Risk Assessment
- Internet Domains
- Plans
- Provide Information about Telecommunications Inventory
- Agreements and Other Commitments

15.0 Legal Information

- Agreements between or among Seller and any Shareholder, Partner, Affiliate, Director, or Officer
- Seller's Articles of Incorporation and Amendments
- Seller's Articles of Incorporation and Amendments
- Seller's Certificate of Good Standing from Secretary of State
- Seller's Corporate By-Lawas and Amendments

Due Diligence Checklist

16.0 Provider Employment Agreements

- Existing Employment Agreements w/Shareholder Physicians
- Review Employment Agreements w/non-Shareholder physicians
- Review of Employment Agreements w/ Mid-Level Employees
- Review of Employment Agreements w/non-Provider Employees
- Review of non-competes and other material terms
- Review of independent contractor agreements

17.0 Other Legal Information

- Schedule of Malpractice Claims, Pending Litigation, Governmental Proceedings, and Investigations for all Claims Arising w/in Past Five Years.
- Schedule of Fictitious Names

Financial Analysis

1. Valuation Information Request / Checklist
2. Due Diligence Checklist
3. **Budget / Pro Forma**

Financial Analysis: Proforma

Cardiology Proforma - Annual Summary

	Year 1	Year 2	Historical	COMMENTS:
Total Gross charges	17,400,000	17,400,000		
Revenue deductions	9,925,000	9,925,000		
Net Revenue	**7,085,000**	**7,085,000**	**7,950,000**	Historical Net Revenue also includes Nuc Med ancillary revenue. Y1 & Y2 does
Salaries and wages	1,140,000	1,157,000	5,271,000	Historical S&W includes staff and providers. Y1 & Y2 only includes staff.
Benefits	228,000	231,500	756,000	Historical Benefits includes staff and providers. Y1 & Y2 only includes staff.
MD & Mids (SWB & malpractice)	4,943,000	4,943,000	0	
Supply expense	96,000	98,000	587,000	Historical includes supplies for Nuc Med ancillaries.
Contract services	540,000	550,800	554,600	
Repairs & maintenance	61,600	62,300	109,650	Historical includes R&M for Nuc Med ancillaries. Y1 & Y2 does not.
Rents & leases	432,000	440,640	647,000	Historical R&M includes hospital leased space for Nuc Med ancillaries. Y1 & Y2 does not. Historical includes rent amount for main office above FMV that will not be included in practice sublease for Y1 & Y2.
Utilities	43,300	44,200	43,300	
Insurance (including tail mth 1)	6,000	6,100	157,000	Malpractice will be covered by group in MD&Mids line above.
Bad debt	390,000	390,000	0	Historical numbers are CASH basis. No Bad Debt.
Marketing and advertising	30,000	30,600	7,000	
Postage and transportation costs	30,000	30,600	75,000	
Dues and subscriptions	31,200	31,900	31,200	
Other	42,000	42,840	111,180	Historical Other includes miscellaneous physician expenses i.e. car allowance, expense allowance, etc.
Total Expenses	8,013,100	8,059,480	8,349,930	
EBDITA	**(928,100)**	**(974,480)**	**(399,930)**	

Operational issues that need to be addressed:

1. Credentialing / New Payor ID's
2. Staffing Issues / Benefit Conversion
3. Policies & Procedures
4. Maintaining/Enhancing Physician Motivation

Questions?

Grant Thornton
An instinct for growth™

How to Optimize Your Investment in Your Physician Enterprise: *Operational and Financial Considerations*

Florida Institute Annual Healthcare Conference
Orlando, Florida
April 27, 2012

Robert Wilson, Managing Director
Richard Sacher, Senior Manager

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Objectives

- Understand the elements of high performance physician enterprises and the key financial drivers of physician group financial performance
- Describe tools to self-evaluate the performance of a physician enterprise
- Identify and quantify areas for significant improvement and the path
- Describe initial and ongoing accounting considerations

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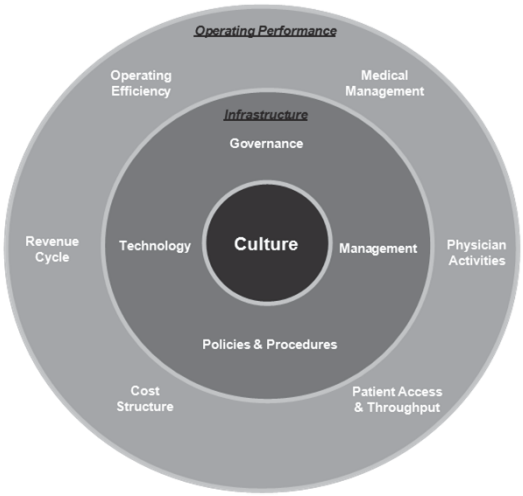
Elements of high performing medical groups



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Understanding physician financial performance

Organizing financial information

	Medical Group A
Revenue	
Gross Patient Revenue	$208,472,135
Total Deductions	(91,554,544)
Total Net Patient Revenue	**$116,917,591**
FFS Collection %	44%
Other Operating Revenue	2,446,170
Total Operating Revenue	**$119,363,761**
Expenses	
Non-Physician Provider and Staff Salaries	37,893,951
All Provider and Staff Benefits	106,558
Non-Physician Provider and Contract Support Staff	3,144
Total Non-Physician HR Expense	**$38,003,653**
Administrative Supplies and Services	1,466,281
Billing Expense	6,583,184
Building and Occupancy	7,945,511
Contracted Services	447,404
Laboratory Expense	3,499,529
Drug Supplies	15,002,504
Furniture and Equipment	1,042,354
Depreciation	2,528,704
Goodwill Ammortization	941,081
Information Technology	110,114
Medical Supplies	2,052,991
Other Operating Costs	455,796
Professional Fees	1,706,813
Purchased Services	1,718,918
Liability Insurance	288,254
Radiology and Imaging	141,503
Bad Debt	12,781,618
Total Operating Expense	**$96,716,216**
Net Income/(Loss) bef Physician Comp	**$22,647,545**

Physician Salaries & Benefits	93,376,628
Net Income/(Loss) Before Allocation	($70,729,083)
General Unallocated Administrative Expense	12,512,641
Net Income/(Loss) after Allocations	($83,241,724)
Net Income/(Loss) Per Physician	($316,505)
Physician	263.00

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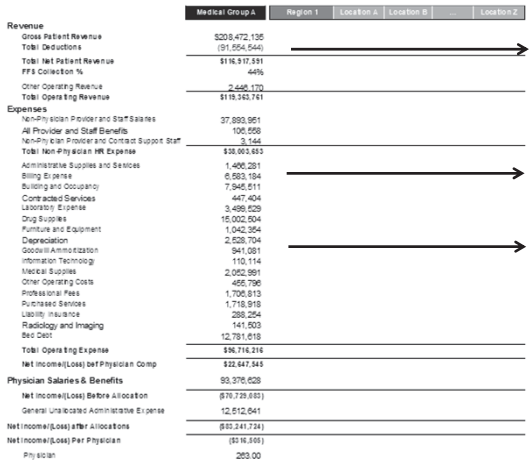
Understanding physician financial performance

Creating transparency into group and individual practices and providers



	Medical Group A	Region 1	Location A	Location B	...	Location Z
Revenue						
Gross Patient Revenue	$208,472,135					
Total Deductions	(91,554,544)					
Total Net Patient Revenue	**$116,917,591**					
FFS Collection %	44%					
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Net Income/(Loss) after Allocations	($83,241,724)					
Net Income/(Loss) Per Physician	($316,508)					
Physician	263.00					

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Revenue drivers

	Medical Group A
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- Physician productivity/volumes
  - Ambulatory Visits
  - Hospital Visits
  - Procedures
- Coding
  - Office E/M Coding – Time and Complexity
- Strategic Pricing

- Government and Contracted Commercial Payer Rates
- Billing Denials
  - Eligibility
  - Medical Necessity/Coding
  - Timely Filing
- Collections at Point of service -Copays
- Accounts Receivable
- Bad Debt Collections

- Rental Revenue
- Outside Services Provided

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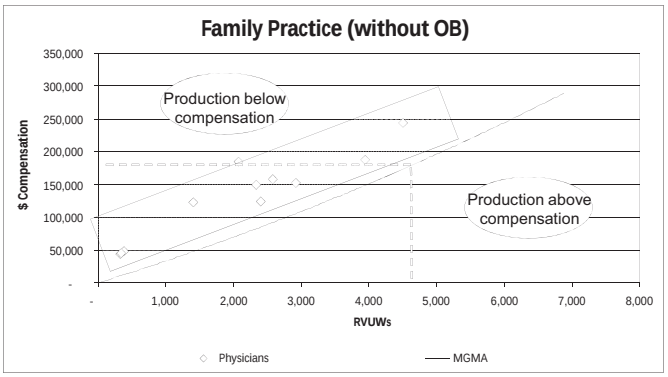
Revenue drivers

Patient access and provider clinical productivity

Measures of Physician Volume

- Gross Charges
- Collections
- Visits
- Procedures
- RVUw
  - Government set values assigned to all work a providers does



National Surveys with large N used to compare productivity and Compensation

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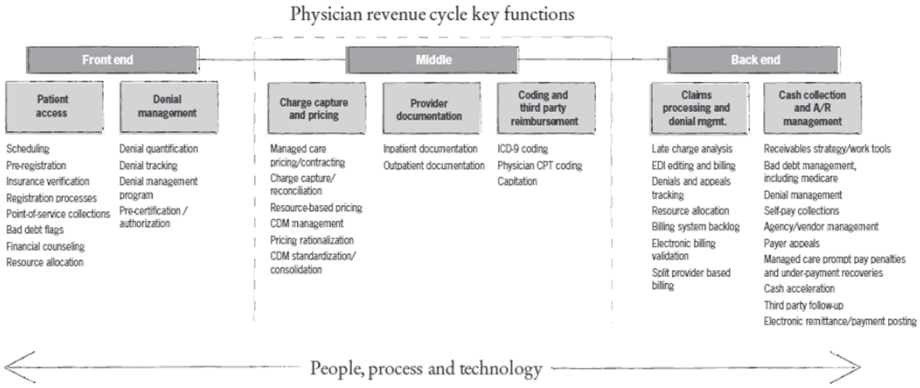
Revenue drivers

Revenue cycle management



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Expense drivers

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Staffing

- Front office support staff
- Clinical support
- Medical records
- Coders
- Management – Span of Control

Building and Occupancy

- Own vs. rent
- Providers per office
- Exam rooms per provider
- Locations relative to practices/hospital
- Technology and infrastructure

Provider Compensation

- Plan design - incentives
  - Salary
  - Productivity driven
  - Other components

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Expense drivers

Staffing expense

- Front Office and Clinical Support Staff
  - Specialty specific
    - per physician FTE
    - per visit/encounter
    - per RVUw
  - Key is proper alignment of resources to volume
    - Too few; throughput and revenue cycle suffer
    - Too much; misalignment of expenses
- Span of Control
  - Common to have extensive use of managers, assistant directors, directors
  - Key is balance

Have a defined staffing model

Strategically Planned Org Structure

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Expense drivers
Occupancy expense

- Common practice; practices are acquired space is not strategically aligned
- Capacity Utilization
  - Exam room utilization
  - Providers per office
- Alignment of providers in market
  - Practice locations relative to hospitals and complimentary specialties

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Expense drivers
Provider compensation

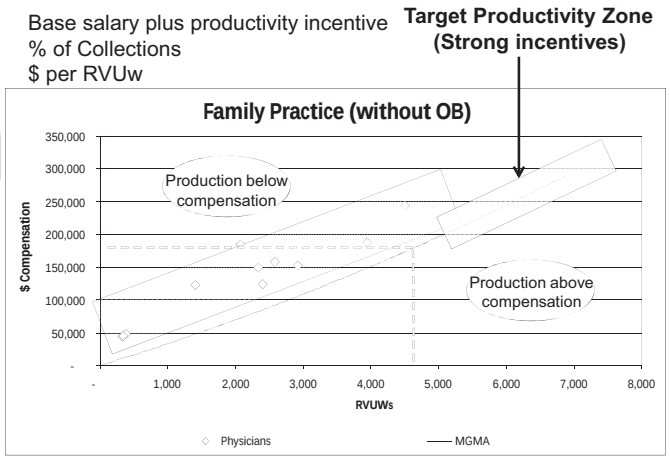
Productivity Models

- Salary
- % of Collections
- $ per RVUw

- Base salary plus productivity incentive
- % of Collections
- $ per RVUw

Keys to Success

- Physician participation in design
- Alignment with market and production
- If a hybrid base salary set low enough to encourage productivity
- Include quality



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Identifying areas of opportunity for operational improvement

Using internal and external metrics

- Fully allocated investment per physician > $100,000 (recent literature says average is > $200,000—that is unacceptable and unnecessary!)
- Investment per physician varies internally within specialties
- Collection rates vary internally within specialties
- Denial rates >10%, days in AR >40, bad debt expense >3-5%
- Use outside surveys AMGA/MGMA to identify productivity and compensation percentiles
  - RVUw's @ 30th and compensation at 60th = trouble
- No standardized staffing model
- No consistently deployed physician compensation model and compensation expense > 70% of net patient revenue
- Occupancy expense > 6% of Net patient revenue

Spotting "early warning" indicators before the investment becomes unsustainable is imperative

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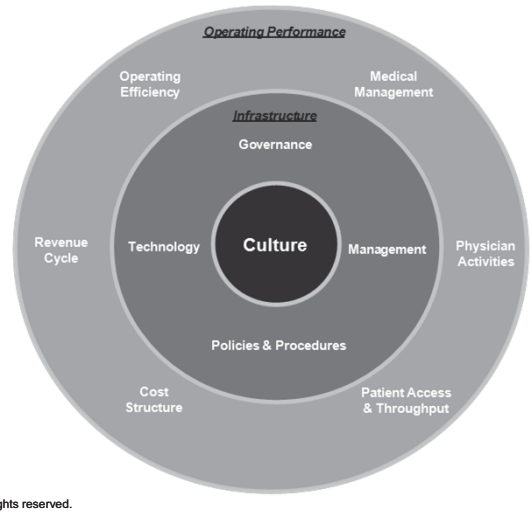
Implementing change

The interrelationship between operating performance and infrastructure



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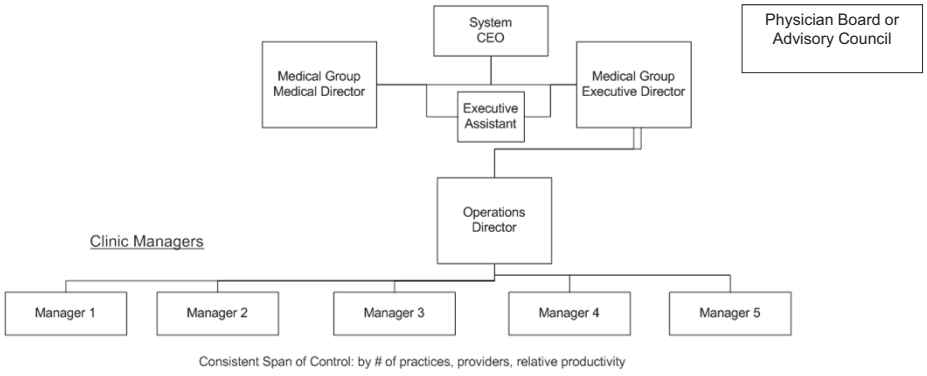
Implementing change

Designing an effective management structure



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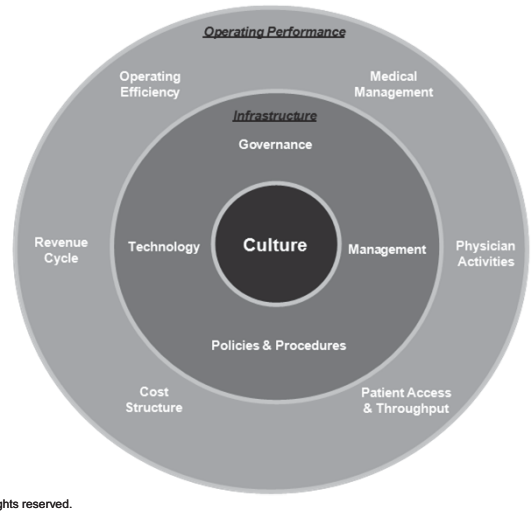
Implementing sustainable change

….of course, in the end it's all about….



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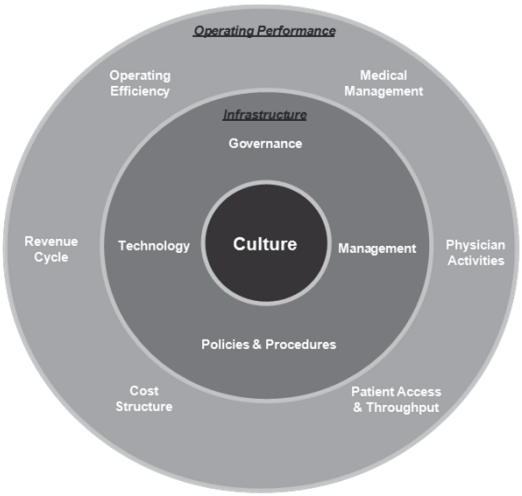
A short self-diagnostic survey



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Culture

- There is a clear sense of multi-specialty interdependence ("group-ness") among the various physician practices and specialty groups.
- Physicians have a clear understanding of how as individual practitioners they contribute to the overall mission and strategic objectives of the system.
- Physicians have a clear understanding of how as a medical group they contribute to the overall mission and strategic objectives of the system.
- Physician performance expectations are clearly documented.

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Infrastructure

- The medical group governance structure is well respected by physicians, has sufficient authority to promote accountability throughout the organization and to make difficult decisions for the good of the physician organization and the System.
- The information architecture and metrics are sufficient to enable the governing board to measure and monitor performance at the individual physician, department or division and overall physician enterprise levels.
- There is a strong, explicit interconnection between the medical group's governance and the health system's board of directors.
- All practice sites and departments share a common IT platform.
- The IT system is state of the art and meets the enterprise's needs.

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Operations

- There are group and individual performance standards or practice for physicians in terms of clinical effort, administrative time and responsibilities, and research and/or teaching.
- There are processes or tools in place to enable physicians to achieve performance standards.
- Processes in the physician enterprise that support achievement of performance standards include (check all that apply):
  - centralized scheduling
  - common scheduling template
  - workspace and staffing that facilitates efficient patient access and through-put,
  - patient contact hour expectations
  - clear administrative duty expectations and standards

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Operations

- Physician compensation is in line with the market.
- Physician compensation is commensurate with actual physician performance.
- The design of the compensation plan promotes and creates adequate incentives to drive actual performance toward expected performance levels.
- Patient access processes (patient contact hours, scheduling, fill process for no-shows) facilitate timely and convenient access to providers.

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Operations

- The revenue cycle processing functions (contracting, rate setting, billing and collection) are sufficient to reduce revenue leakage to an acceptable level and optimize revenue.
- Revenue cycle staffing levels are acceptable to reduce revenue leakage and optimize revenue.
- Support staffing levels are in line with industry comparative benchmarks.
- Some of our physicians or geographic practice sites are performing at a sub-par level and/or are not a preferred strategic fit for the physician enterprise or the system.
- We have a strategic discernment process for evaluating and making alternative disposition decisions for these physicians or practices.

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Accounting considerations – identifiable intangibles

ASC 805-20-25-10

The acquirer shall recognize separately from goodwill the identifiable intangible assets acquired in a business combination. An intangible asset is identifiable if it meets either the separability criterion or the contractual-legal criterion described in the definition of identifiable.

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Accounting considerations – identifiable intangibles

An identified intangible asset must be recognized as a separate asset from goodwill if either or both of the following criteria are met:

- The intangible asset is separable; that is, it is capable of being separated or divided from the acquired entity and sold, transferred, licensed, rented or exchanged (regardless of whether there is an intent to do so). An intangible asset that cannot be sold, transferred, licensed, rented or exchanged individually is considered separable if it can be sold, transferred, licensed, rented, or exchanged in combination with a related contract, asset or liability
- The intangible asset arises from contractual or other legal rights, regardless of whether those rights are in fact transferable or separable from the acquired entity or from other rights and obligations.

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Accounting considerations – identifiable intangibles

Potential acquired intangible assets in a physician practice acquisition:

- Non compete arrangements
- Medical records
- Favorable / unfavorable leases
- Other contracts
- Licenses

Valuation method considerations:

- Cost approach
- Market approach
- Income approach

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Accounting considerations – purchase consideration vs. compensation expense

ASC 805-10-55-24

Whether arrangements for contingent payments to employees or selling shareholders are contingent consideration in the business combination or are separate transactions depends on the nature of the arrangements. Understanding the reasons why the acquisition agreement includes a provision for contingent payments, who initiated the arrangement, and when the parties entered into the arrangement may be helpful in assessing the nature of the arrangement.

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Accounting considerations – purchase consideration vs. compensation expense

ASC 805-10-55-25

If it is not clear whether an arrangement for payments to employees or selling shareholders is part of the exchange for the acquiree or is a transaction separate from the business combination, the acquirer should consider the following indicators:

- Continuing employment
- Duration of continuing employment
- Level of compensation
- Incremental payments to employees
- Number of shares owned
- Linkage to the valuation
- Formula for determining consideration
- Other agreements and issues

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Ongoing accounting considerations

- Fair value of contingent consideration (re-measurement)
- Allocation of overhead costs to physician practices
- Methodology for estimating contractual allowances and allowances for doubtful accounts
- Integration of physician billing with central business office

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Ongoing accounting considerations – impairment considerations - goodwill

ASC 350-20-35-1

Goodwill shall not be amortized. Instead, goodwill shall be tested for impairment at a level of reporting referred to as a reporting unit.(Paragraphs 350-20-35-33 through 35-46 provide guidance on determining reporting units.)

ASC 350 was recently amended to permit an entity to first assess qualitative factors, as described in paragraphs 350-20-35-3A through 35-3G, to determine whether it is necessary to perform the two-step goodwill impairment test. (i.e. an entity may assess qualitative factors to determine whether it is more likely than not (that is, a likelihood of more than 50 percent) that the fair value of a reporting unit is less than its carrying amount, including goodwill). If determined to be necessary, the two-step impairment test shall be used to identify potential goodwill impairment and measure the amount of a goodwill impairment loss to be recognized (if any).

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Ongoing accounting considerations – impairment considerations - goodwill

In evaluating whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, an entity shall assess relevant events and circumstances. Examples of such events and circumstances include the following:

- Macroeconomic conditions
- Industry and market considerations
- Cost factors
- Overall financial performance
- Other relevant entity-specific events
- Events affecting a reporting unit
- If applicable, a sustained decrease in share price

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Ongoing accounting considerations – impairment considerations – indefinite lived intangible assets

ASC 350-30-35-18

An intangible asset that is not subject to amortization shall be tested for impairment annually, or more frequently if events or changes in circumstances indicate that the asset might be impaired. Paragraph 360-10-35-21 includes examples of impairment indicators. The impairment test shall consist of a comparison of the fair value of an intangible asset with its carrying amount. If the carrying amount of an intangible asset exceeds its fair value, an impairment loss shall be recognized in an amount equal to that excess.

There currently is no qualitative testing option, although there is a currently outstanding proposed accounting standard update that, if approved, will permit such an option.

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Ongoing accounting considerations – impairment considerations – other intangible assets

ASC 350-30-35-14

An intangible asset that is subject to amortization shall be reviewed for impairment in accordance with the *Impairment or Disposal of Long-Lived Assets Subsections* of Subtopic 360-10 by applying the recognition and measurement provisions in paragraphs 360-10-35-17 through 35-35. In accordance with the *Impairment or Disposal of Long–Lived Assets Subsections* of Subtopic 360-10, an impairment loss shall be recognized if the carrying amount of an intangible asset is not recoverable and its carrying amount exceeds its fair value. After an impairment loss is recognized, the adjusted carrying amount of the intangible asset shall be its new accounting basis. Subsequent reversal of a previously recognized impairment loss is prohibited.

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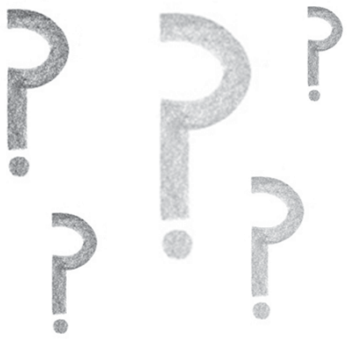
Any questions?



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Keynote Address: The Past, Present and Future of Health Care in the U.S.

Ruben King-Shaw, Jr

Ruben J. King-Shaw Jr.

Managing Partner & CIO & Chairman

Mansa Capital Management

Ruben J. King-Shaw Jr. is Managing Partner and Chief Investment Officer, Chairman the Management Board, and Chairman of Mansa Capital Management in Boston's Investment Committee. King-Shaw directs the Mansa Capital Management's deal-sourcing efforts and oversees the firm's value-creation strategies. He has lead responsibility for the recruitment and retention of Mansa's highly effective team of accomplished professionals. King-Shaw earned his bachelor's degree in industrial and labor relations with a specialty in labor economics from Cornell University in 1983. He earned his master's degree in health services administration from Florida International University in 1986; his master's in international business from the Center for International Studies in Madrid, Spain, in 1987. He earned his Corporate Governance Portfolio at the Harvard Business School in 2009.

King-Shaw is a member of the Medicare's Program Advisory and Oversight Commission, which advises the Obama Administration on value-based procurement strategies for healthcare reform; lead director and Chairman of the Litigation Committee and Audit Committee Member at athenahealth, Inc, (NASDQ: ATHN); Chairman of the Compliance Committee and Member of the Executive Committee at Steward Health LLC (Cerberus); Audit Committee Member, iHealth Technologies, Inc. (Oak and Goldman); Audit Committee Member, APS Healthcare (GTCR); member of the Strategy and Policy Board, Abbott Pharmaceuticals (NASDAQ: ABT).

His prior experience includes serving as chief operating officer and deputy administrator of the Centers for Medicare and Medicaid Services; Senior Advisor to the Secretary of the Treasury for health care tax policies; Secretary of the Florida Agency for Health Care Administration from; chief operating officer of the Neighborhood Health Partnership Inc. in Miami; and executive director of Jackson Memorial Health Plan in Miami.

HEALTH CARE REFORM

WTF:

What's The Future?

By
Ruben J. King-Shaw Jr.
Managing Partner, Mansa Capital

Table of Contents

- **Mansa Capital Introduction**
- **The World Pre-Health Care Reform**
  - Demographics Drive Healthcare Costs
  - Sequestration Cuts Loom Large
  - Medicaid Budget Busts
  - Never-Ending Search for Savings
  - HCIT Adoption Continues
- **Health Care Reform**
  - Origins of PPACA
  - Core Provisions of PPACA
  - Constitutional and Legal Issues
  - Severability and Medicaid Arguments
  - Odds and Outlook from Wall Street
- **The World Post Health Care Reform**

MANSA CAPITAL INTRODUCTION

Mansa Capital Introduction

Executive Summary

- Private equity firm founded in 2003
- Invested in nine companies
- Returned 14x initial investment (745% IRR)
- Three IPO's (ATHN, WCG, LUCID)
- Raising a $100mm health care growth fund

Mansa's Core Competencies

Mansa's principals integrate domain expertise in health care operations, marketing and finance with senior-level experience in health care policy, regulation, and reimbursement. The firm's core competencies include:

- Medicare & Medicaid Coverage and Payment Policy
- Health care for Hispanic populations
- Sales and Marketing Support
- Risk Management

Mansa Investment Strategy

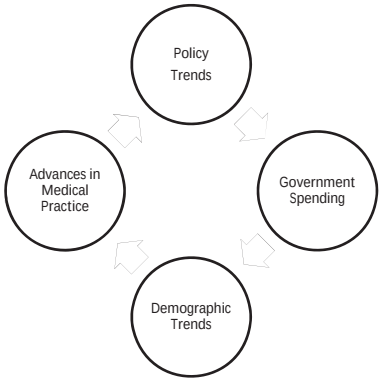
Our strategy is a derivation of four key trends:

Policy Trends:
- What are State and Federal legislative priorities?
  - Universal Coverage
  - Cost Containment
- What are State and Federal agency priorities?
  - Risk Contracting
  - Care Coordination

Government Spending:
- Where is the money going?
  - Healthcare Information Technology
  - Long Term and Community-based care models
- Where are we in the spending cycle?

Demographic Trends:
- What is driving service utilization?
  - Explosion of chronic conditions
  - Patterns of US population growth
- How where are the under-served markets?

Advances in Medical Practice:
- What innovations are changing care delivery?
  - Healthcare Information Technology
  - Multidisciplinary Integration and Collaboration



Mansa Introduction > Pre-Reform > Health Care Reform > Post-Reform

THE WORLD PRE-PPACA

Demographics Drive Healthcare Costs

Chronic conditions:
48% of Medicare beneficiaries have at least three chronic conditions and 21 percent have five or more conditions. 60 million Americans have multiple morbidities, a number that is expected to increase to 81 million by 2020.

Hispanic Americans:
Half of all US population growth since 2010 is Hispanic. The US Hispanic/Latino population will grow 24% from 47.8 million in 2011 to 59.7 million in 2020 – including non-traditional areas. As an underserved population, Hispanics disproportionately suffer from diabetes, hypertension and asthma yet are least likely to be treated for both chronic and acute conditions.

Elder and long term care:
The elder population has been the fastest growing and most costly segment of the healthcare economy. Elders have driven the demand for MLTC and related strategies.

Sequestration Cuts Loom Large

- Under current legislations, Medicare sustains a maximum of 2% cuts, which equates to ~$123bn over 10 years, per the CBO.
  - Hospitals receive 2% cut,
  - Nursing homes receive a 2% cut
  - MA plans receive a 2% cut.
- To avoid sequestration cuts set for 2013, Congress could agree to Medicare/Medicaid cuts at ~$300-$350bn, the range of the Biden, Simpson-Bowles and White House proposals.
  - Hospital rate cuts
  - DME rate cuts
  - DSH payment adjustments as outlined under the Simpson-Bowles proposal

Source: Morgan Stanley Research

Medicaid Budget Busts

- Center on Budget and Policy Priorities (CBPP) reports that 44 states expect to face budget shortfalls during FY12, despite budget cuts from '09-11.
- The CBPP report also predicts that 24 states will cut $4.7b from their Medicaid programs ahead of 2014, including provider rate cuts of up to 15%.
- For most states, Medicaid is the first or second largest spending area for states (along with education), comprising on average 22% of state budgets (as per Moody's), with these costs growing much more rapidly than those associated with other categories of spending.
- The State Expenditure Report from the National Association of State Budget Officers (December 2010), predicts that Medicaid will replace elementary & secondary education as the largest component of total state spending.

Source: Morgan Stanley Research

Never-Ending Search for Savings

When the debt ceiling debate returns, these CBO options will likely be the starting point (in billions):

- Block grant for Medicaid LTC: $287
- Changes to Pt. B & D Premiums: $221
- Medicaid FMAP Reform: $181
- Raise to 67 Medicare Eligibility age: $125
- Reform DGME and IME payment: $69
- Medical Malpractice Reform: $62
- Reduce Medicare Rates in high areas: $48
- Reform Rural Hospital Payments: $42

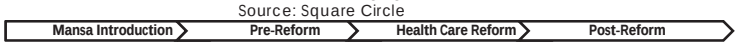
Source: Office of Management and Budget and Congressional Budget Office

HCIT Adoption Continues

- Electronic Medical Record: The Holy Grail
  - 57% of office based docs use an EMR; up from 51% last year.
  - 52% of office based docs plan on applying for Meaningful Use incentive payments.
  - 43% of these will likely meet core functionality.
  - 40% of hospitals expect to pay $8m+ for an EMR.

- E-prescribing: Mango bajito*
  - 52% (291,000) of office-based physicians have adopted e-Rx, up from 10% three years ago.
  - 357,000 practitioners (MDs, NPs and PAs) e-prescribe today.
  - 94% of retail pharmacies receive e-scripts.
  - Massachusetts has the highest rate of e-prescribing; Florida not in the top ten.

* Translation: "low hanging fruit".
Source: Square Circle



ENTER PPACA

The origins of PPACA

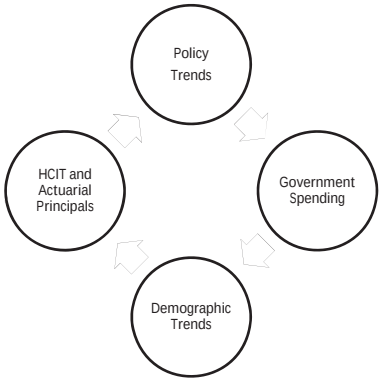
Candidate Obama made "universal coverage" a central theme in his bid for the White House. The underlying trends include:

Policy Trends:
Universal coverage has been a priority for the Democrats since it failed in the Clinton Administration. For them, PPACA was "unfinished business."

Government Spending:
Public sector spending now accounts for over 50% of all health care spending. Such buying power gives the Government market and political leverage.

Demographic Trends:
Aging and chronic conditions continue to drive utilization and thus costs. Rising healthcare costs threaten the financial security of firms and families.

Health Care Information Technology:
Once coverage is universal, broad application of HCIT and the actuarial principal of pooled risk will ultimately lower healthcare costs.



Core Provisions of PPACA

The legislation contains the following provisions:

- Individual and Corporate Mandates
- Guaranteed Issue
- Community Rating
- Insurance Exchanges
- Medicaid Expansion

Constitutional Issues

- **Taxing Power**. The Government argues that The Court should uphold the mandate on the basis of the taxing power of Congress. Thus the court must determine:
  - Is the penalty related to the individual mandate a tax?
  - If not a tax , are the mandate and related penalty permitted nonetheless under Congress's ability to levy taxes?

- **Limited Power of Federal Government**. The Constitution constructs a Federal Government of limited and enumerated powers, leaving the vast majority of powers with the States and the people .
  - The Court must determine if the individual mandate, guaranteed issue and community rating provisions of PPACA fall within the Federal Government's enumerated powers given that...
  - States have historically held regulatory jurisdiction over the insurance markets.

Legal Issues

- **Can the court rule on this case before 2015 when PPACA's penalties would apply?**
  - In essence, are the penalties "taxes"?
  - If so, does the Anti-Injunction Act -- which would prevent the Court from ruling until a tax is actually paid -- apply?

- **Is the individual mandate constitutional?**
  - If so, would such authority change the relationship between the Federal Government the States and the individual in a fundamental way not provided by the Constitution?
  - If not, is the individual mandate severable from the rest of PPACA?

- **Is the Medicaid expansion constitutional?**
  - If not, is the Medicaid expansion severable from the rest of PPACA?

Severability Arguments

- **The States argue:**
  - the individual mandate, guaranteed issue, community rating all are core provisions of the act and are requited to make the health insurance exchanges work.
  - the exchanges critical to tax credits and the employer mandate.
  - these components are connected to yet more provisions of the bill.
  - without the mandate and the elements to which it is connected, all that is left is a hollowed out shell of a bill -- a bill that likely would not have passed Congress in that form.
  - If for any PPACA provisions that are constitutional, nothing would prevent Congress from passing them again.

- **The Federal Government argues:**
  - that the legislation should be left intact for the same reasons, except for the last of the above.

Medicaid Arguments

- **The States argue:**
  - The Medicaid expansion is coercive because the Secretary of HHS can remove a State from entire Medicaid program if it doesn't elect to accept the "optional" expansion.
  - This power is uniquely coercive due to:
    - the sheer size of the Medicaid program,
    - it is tied to a non-voluntary individual mandate.
  - As the Federal Government increases taxes to pay for its share of the Medicaid program, it undermines the states' ability to generate their own revenue, further exacerbating state dependence on the Federal Government.

- **The Federal Government argues:**
  - The Medicaid expansion is consistent with its history.

Odds from Wall Street

As seen by Morgan Stanley Research, Wall Street's odds are:

PPACA Provision	Yes	No
Applicability of the Injunction Act	5%	95%
Individual Mandate is Constitutional	45%	50%
Individual Mandate is Severable	5%	30%
Medicaid Expansion is Constitutional	95%	5%
Medicaid Expansion is Severable	95%	5%

- If PPACA falls, MCO shares could rise ~20% above Base Case. This reflects Morgan Stanley's analysis of (1) estimated rebate-driven earnings headwinds and (2) pre-reform valuation trends.
- If PPACA stands, MCO stocks could pull back ~10+% until investors gain clarity on achievability of EPS growth amid reform.

Outlook from Wall Street

Sector	2011E EBITDA	NTM EBITDA	2012E EBITDA	2013E EBITDA	3 year EBITDA CAGR (E)
Acute Care Hospitals	$11,875	$12,653	$12,757	$13,345	8.7%
Post-Acute Care	$840	$882	$888	$946	8.9%
Diversified MCOs	$20,869	$20,961	$20,974	$23,065	4.1%
Medicare HMOs	$2,980	$2,957	$2,954	$3,265	13.8%
Medicaid HMOs	$1,218	$1,204	$1,202	$1,419	12.8.%
All MCOs	$25,067	$25,122	$25,129	$27,750	7.7%

Source: Morgan Stanley Research

THE WORLD POST-PPACA

Summary: The Fork In The Road

The following summary of an exchange between the lead attorneys for the States and the Federal Government capsulizes two distinct visions for the future of our nation's healthcare system.

- Verrilli, for the Federal Government:
  - "…this population will receive health care that they cannot now afford …unshackled from the disabilities that those diseases put on them and will have the opportunity to enjoy the blessings of liberty. In a very fundamental way, this Medicaid expansion, as well as the provisions we discussed yesterday, secure the blessings of liberty.
- Clement, for the states:
  - "I would respectfully suggest that it's a very funny conception of liberty that forces somebody to purchase an insurance policy whether they want it or not. And it's a very strange conception of federalism that says that we can simply give the States an offer that they can't refuse, and through the spending power which is premised on the notion that Congress can do more because it's voluntary, we can force the States to do whatever we tell them to. That is a direct threat to our federalism."

THANK YOU

Keynote Address: The Future of Healthcare in Florida

Alex Sink

Alex Sink

Senior Advisor

Hyde Park Capital

Alex Sink serves as a Senior Advisor with Tampa-based Hyde Park Capital. The firm offers investment banking services focused on mergers, acquisitions, and capital raising. She also is serving as founder and chair of the Florida Next Foundation, a non-profit, non-partisan organization focused on diversifying Florida's economy through the growth of small businesses and entrepreneurship.

Sink served as Florida's Chief Financial Officer (CFO) from 2007 to 2011 as one of four statewide, elected officials. She managed more than $15 billion in state treasury funds, was responsible for state accounting, and implemented reforms in contracting and transparency for citizens. She also directed the state's insurance consumer advocacy work, focusing on strengthening laws to protect seniors against insurance fraud. In 2010, she was the state's Democratic nominee for Governor.

Prior to elected office, Alex had a 26-year career with Bank of America. She retired as president of Florida operations in 2000, managing the state's largest bank with $40 billion in deposits, leading 9,000 employees in more than 800 branches.

Sink has been a statewide business leader, serving as chair of Leadership Florida, chair of Take Stock in Children, chair of The Nature Conservancy Florida Chapter, chair of the Hillsborough Education Foundation, vice-chair of Florida Taxwatch, vice-chair of the board at Wake Forest University, and a member of the Florida Council of 100.

Sink has been honored as an inductee into the Tampa Bay Business Hall of Fame. She also is the recipient of numerous awards including the Jewish National Fund Tree of Life Award, Associated Industries of Florida Champion of Business Award, Florida Chamber of Commerce Volunteer of the Year, and Wake Forest Distinguished Alumnus Award.

Sink lives in Thonotosassa with her husband Bill McBride, an attorney. They have two children; Bert, a recent graduate of Stanford University and current law student at the University of Florida; and Lexi, a recent graduate of Wake Forest University.

There is no PowerPoint presentation for this session.

Emerging Issues

Ken Weixel, CPA

Kenneth H. Weixel, CPA

U.S. Managing Partner, Life Sciences & Health Care

Deloitte & Touche, LLP

Ken is a senior partner with Deloitte & Touche, LLP and one of the leaders of the firm's Life Sciences & Health Care industry practice. Ken started his career with Deloitte over 30 years ago, and focuses exclusively on providers, health plans and life sciences companies. He has served as the managing partner of the healthcare and life sciences industry practices in Ohio and Los Angeles as well as the Central and Western regions. Ken spent three years building and leading the Life Sciences & Health Care Transaction Services Group that serves many of the industry's most substantial strategic and financial buyers. Ken has served in national leadership roles with the provider and health plan sectors and currently serves as the U.S. managing partner for audit and advisory services to the firm's life sciences & health care clients where he advises CXO's of the firm's largest clients.

Ken also serves as the senior advisor to the Deloitte Center for Health Solutions based in Washington D.C. The Center for Health Solutions was founded in 2004 by Tommy Thompson, the former Secretary of Health & Human Services under President George W. Bush, and is now led by Paul Keckley. Paul was recruited from Vanderbilt University to serves as the Center's permanent Executive Director in 2006. Ken chairs the Executive Committee of the Center whose mission is developing innovative, practical solutions to systemic issues of the U.S. health care system through focused research, thought leadership and solution development.

A Certified Public Accountant, Ken regularly speaks on accounting, governance and health related topics and has been quoted in publications like Corporate Board Member, Governance Institute and The Deal. Based on his deep personal knowledge of the health care industry, Ken is called upon regularly to make presentations and respond to media requests about the impact and implementation of Health Reform and the Affordable Care Act (ACA).

Ken serves on the Board of Trustees of Capital University, his alma mater, where he earned a B.S. in Accounting in 1980. He is a graduate of the Columbia University Graduate School of Business Leadership Development Program and the Wharton School of Executive Leadership Program. Ken resides in Columbus, Ohio and can be contacted on (614) 229-5920 or kweixel@deloitte.com.

Deloitte.

Deloitte Center for Health Solutions

FICPA 2012 Health Care Industry Conference

How Health Care is Changing
Where are we?
What's next?

Kenneth H. Weixel
U.S. Managing Partner
Life Sciences & Health Care
Deloitte & Touche LLP

April 26, 2012

Outline for Our Discussion Today

- Background, Implementation & Recent Guidance
- The "Big Questions" for 2012 and Implications for Sectors
- Key Takeaways
- Deloitte Center for Health Solutions - Recent Publications and Contact Information

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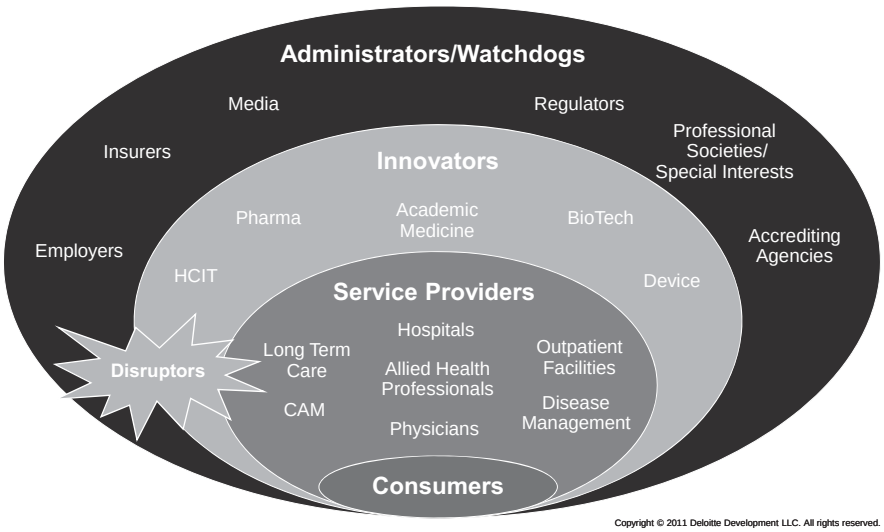
Background, Implementation and Recent Guidance

Context: the U.S. health system: fragmented, expensive, complex

Compound annual growth rate (CAGR) +7% per year, 17.6% of the U.S. GDP; 19.8% of household discretionary spending



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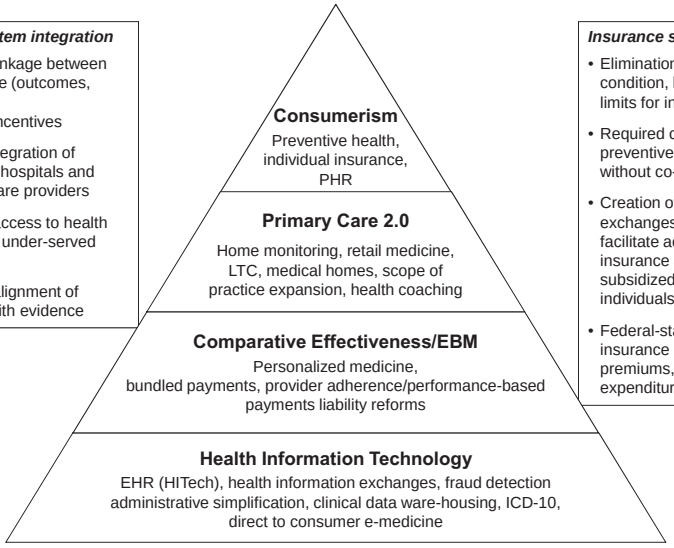
Affordable Care Act (ACA) intent: delivery system integration and insurance system reform

Three core strategies: (1) replace fee for service incentives, (2) leverage information technology to reduce cost and improve quality, (3) increase integration/coordination

Delivery system integration

- Increased linkage between performance (outcomes, costs) and payments/incentives
- Increase integration of physicians, hospitals and long term care providers
- Increased access to health services by under-served populations
- Increased alignment of coverage with evidence



Insurance system reform

- Elimination of pre-existing condition, lifetime and annual limits for insurance plans
- Required coverage of preventive health services without co-payments
- Creation of health insurance exchanges in each state to facilitate access to affordable insurance and manage subsidized purchases by individuals and employers
- Federal-state regulation of insurance plan coverage, premiums, and medical expenditures

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ACA timeline: ten years, five election cycles, and in the context of domestic and global economic volatility

Budget Control Act, HITECH, SGR Fix

2010 - 2013 | **2014 - 2016** | **2017 +**

Rules, Regulations & New Funding

- Insurance compliance: medical loss ratio (MLR), premiums, coverage
- Coordination: state-federal governments, agencies
- Rules, guidelines, task forces, agencies
- Excise taxes—insurance, medical devices, drug companies
- Patient Centered Outcomes Research Institute (PCORI)

Mandates, Pilots & Exchanges

- Individual mandate
- Health exchanges
- Employer pay or play
- Independent Payment Advisory Board (IPAB)
- Accountable Care Organizations (ACOs)
- Value-based purchasing
- Episode based payments
- Medical home
- Self referral limits
- Transparency (Physician Quality Reporting Initiative [PQRI] etc.)

"New Normal"

- Comparative effectiveness
- Delivery system re-alignment
- Value not volume
- Convergence: Public health & delivery system
- Retail insurance market
- Consumerism

ICD-10, Electronic Medical Records, Comparative Effectiveness Implementation

Budgeting health care: four major efforts underway

ACA Funding

Excise Taxes

- "Cadillac" Tax expected revenue over 10 years: $149 billion
- Tax on medical devices expected revenue 2013 – 2019: $20 billion

Medicare Payroll Tax

- Expected revenue 2013 – 2019: $87 billion

Budget Control Act of 2011 and Sequester

Spending cuts

- Largely from discretionary spending: $917 billion
- Sequester: $1.2 trillion in deficit reduction 2013 – 2021 (excludes Military benefits, Medicaid, Social Security)

Debt ceiling expansion

- President Obama may request up to 2.4 trillion through 2013 (three phases)

Budgeting Health Care

FY 2012 Budget

Sustainable Growth Rate (SGR) Two Year Fix

- Estimated cost $54 billion

Medicare

- Combined savings of at least $200 billion over 10 years (reduces spending on perscriptions, drug premiums)

Medicaid

- Combined savings of at least $100 billion over 10 years

FY 2013 Budget

President Obama's Budget

- Estimated $3 trillion in deficit reductions over 10 years
  - Medicare spending cuts: estimated $248 billion
  - Medicaid spending cuts: estimated $72 billion

Representative Paul Ryan (R-WI)

- Medicare: total spending set at $7,500 for beneficiaries turning 65 in 2023 or later
- Medicaid: contains cost trajectory of $810 billion over 10 years
- Repeals ACA, exchange subsidies (saving $808 billion)

Sources: Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT), *Updated Estimates for the Insurance Coverage Provisions of ACA, March 2012*; The White House, *Fact Sheet: Bipartisan Debt Deal;* Office of Management and Budget, *The President's Budget for FY 2013*; Representative Paul Ryan (R-WI), *The Path to Prosperity: A Blueprint for American Renewal*

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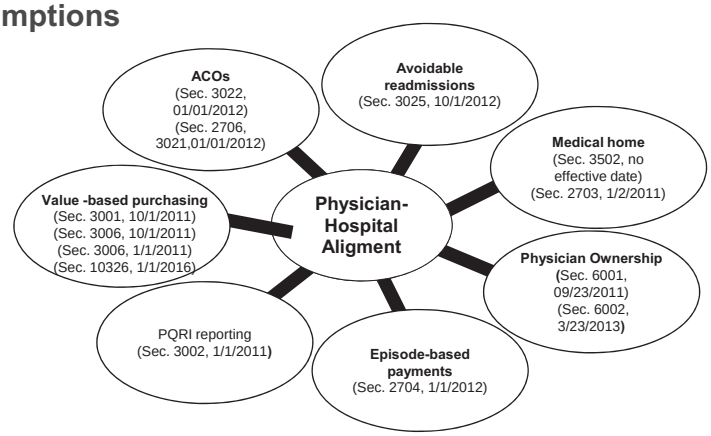
ACA 2011 implementation milestones

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Prohibition on physician-owned hospitals: prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, from participating in Medicare. *(Section 6001/1106)* **MLR rebate requirements effective:** ACA's medical loss ratio (MLR) requiring large group plans that spend less than 85% and small group and individual plans that spend less than 80% of premium revenue on clinical services and quality to pay rebates became effective. *(Section 1001/10101)* **Changes to HSAs, FSAs, and HRAs:** eliminated reimbursements for over-the counter medications from Health (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs) starting in 2011. *(Section 9003)* **Prohibits cost-sharing on Medicare preventive services:** ACA Section 4104 eliminated copayments for preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force starting in 2011. *(Section 4103/4104)*		**National strategy on health care quality:** HHS released a report to Congress outlining initial plans to implement the National Quality Strategy. *(Section 3011)*	**Repeal expanded 1099 reporting requirements:** the President signed into law bipartisan legislation repealing Section 9006 which would have required businesses to send 1099 forms for all purchases of goods and services over $600 annually. *(Section 9006)*	**Executive director appointed to PCORI:** Joe Selby, M.D., M.P.H., was appointed the first executive director of PCORI (joined from Kaiser Permanente, Northern California). *(Section 6301)* **Hospital value-based purchasing regulations:** Center for Medicare & Medicaid Services (CMS) released final regulations on the hospital value-based (VBP) incentive program. *(Section 3001)*		**HIX regulations:** HHS released proposed regulations on health insurance exchanges (HIX). States must have HIXs operational by 2014; states that do not establish exchanges will have exchanges operated by the federal government. *(Section 1311)*	**Annual fees for pharmaceutical manufacturers:** U.S. Internal Revenue Service (IRS) released temporary regulations which created annual fees payable starting in 2011 for certain manufacturers and importers of brand-name pharmaceuticals. *(Section 9008/1404)* **Medicaid bundled payment initiative:** Center for Medicare and Medicaid Innovation (Innovation Center) started accepting applications for the Medicaid bundled payment initiative. The initiative allows providers to select from four models. *(Section 3021)*		**Halting CLASS implementation:** HHS recommended halting implementation of the CLASS program—a voluntary self-funded public insurance program for long-term care services. *(Section 8002)* **ACO regulations and initiatives:** CMS released final regulations for the Medicare Shared Savings program which allows health care providers to share risk to improve outcomes, enhance patient experience and satisfaction, reduce costs/errors. *(Section 3022/3021)*		**Pathway to approve biosimilars:** ACA includes the Biologics Price Competition and Innovation Act of 2009 (BPCI Act) which creates an abbreviated FDA approval pathway for biosimilar products. December, FDA published and solicited recommendations for the user fee program for biosimilar biological products for FYs 2013 – 2017. *(Section 7001 – 7003)* **CMS halts payments for claims for Early Retiree Reinsurance Program:** HHS announced that it will deny payments for claims for the Early Retiree Reinsurance Program (ERRP) incurred after December 31, 2011, based on the projected amount of remaining funding. *(Section 1002)* **Essential health benefits bulletin:** HHS issued an informational bulletin to provide guidance to states in defining "essential health benefits" (EHB) for evaluating health plan compliance with ACA. Per ACA Section 1302 all health insurance plans must provide coverage for "essential health benefits" in ten categories. *(Section 1302)*

Delivery system integration is reflected in seven major areas of ACA; clinical integration, shared risk are key assumptions



Clinical Integration Operational Competencies	*Risk-based Contracting Operational Competencies*
• Evidence-based guidelines embedded in clinical IT applications system wide • Quality management and measurement: safety, outcomes, efficacy • Shared governance: physician-hospital alignment • Gain-sharing-based compensation for providers	• Contract negotiation, adjudication and distribution of funds • Medical management: provider credentialing and performance reviews • Provider discipline • Quality, cost reporting • Patient adherence management

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In addition to HHS and states, three new entities will play key roles in implementation

CMS Center for Medicare and Medicaid Innovation

- Test innovative payment and service delivery models
- Broad authority to determine what models will be tested, in what populations, and for how long, with a preference for models that address deficits in care leading to poor clinical outcomes or potentially avoidable expenditures

Independent Payment Advisory Board (IPAB)

- The purpose is to reduce the per capita rate of growth in Medicare spending
- Operates independently of MedPAC
- Recommendations take effect absent Congressional action
- May recommend changes to Part D to generate required savings

Patient-Centered Outcomes Research Institute (PCORI)

- Broad scope of research (drugs, devices, procedures, delivery system) with a focus on clinical effectiveness research
- Findings are not coverage/ payment recommendations, but can be used by HHS to inform coverage

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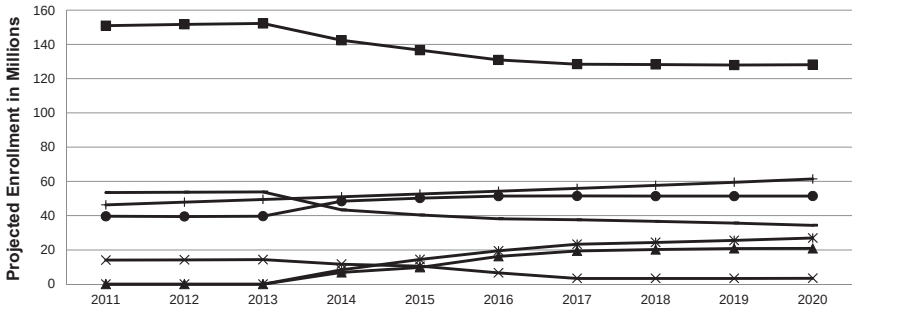
Increasing health costs may lead employers to drop coverage and modify benefits

- Deloitte's Health Reform Impact Model assessed the impact of key economic, behavioral, political, and strategic variables on insurance coverage under the ACA
- Projection scenarios are based on the impact of key variables such as:
  - Cost of ACA, rate of health care inflation, implementation of the law (e.g. delays, changes in penalty levels), design and operation of exchanges, and employer coverage decisions
- Note: Scenario A "Intended results" is a baseline per CBO and trade consensus reports

Scenario A –Baseline



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And no one knows for sure how the insurance market will look at the end of the decade

- Health costs might prompt employers to exit from coverage after 2014, if this happens, state health insurance exchanges will impact the future of insurance coverage substantially
- Legislators might stiffen individual mandate and/or employer penalties
- Major elements of ACA might NOT be implemented or funded thus limiting/delaying impact

Projected enrollment in millions (% of total) under scenarios A–D in year 2020

Health insurance market segment	2010 Actual†	Scenarios								Range
		A	B1	B2	B3	C	D1	D2	D3	
Employer sponsored: Group excluding SHOP	169	128	118	104	76	124	129	132	133	76–133
SHOP	0	21	19	18	13	20	21	21	21	13–21
Individual excluding HIX	30	3	4	5	7	3	4	3	4	3–7
HIX	0	27	35	45	65	23	31	24	28	23–65
Medicaid	49	51	51	51	51	51	51	51	51	51
Medicare	44	51	51	51	51	51	51	51	51	51
Uninsured	50	34	38	43	53	44	29	33	29	29–53

†2010 Census Data, http://www.census.gov/prod/2011pubs/p60-239.pdf

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Context: physician and consumer opinions are important

Physician opinions
• **System grading:** 60% of physicians give the U.S. health care system a poor report card rating of "C" or "D," and 35% of physicians give it an "A" or "B." • **Future physicians:** 7 out of 10 physicians believe the best and brightest who might have considered medicine as a career will think otherwise as a result of health reform. • **Payment reform:** 9 out of 10 physicians fear the new payment systems mean receiving inadequate payments for new services or bundled payments and higher administrative costs to implement and comply with new payment systems. • **Health reform law:** 44% of physicians feel that ACA is a good start, while an equal proportion feel it is a step in the wrong direction; 12% don't know.

Source: Deloitte Center for Health Solution's *Physician Perspectives about Health Care Reform and Future of the Medical Profession*, available here:
www.deloitte.com/us/physiciansurvey

Consumer opinions
• **System grading:** nearly 4 in 5 consumers (78%) give the U.S. health care system a poor report card grade of "C," "D," or "F" (12%), with similar percentages grading the system unfavorably in 2010 (76%) and 2009 (80%). • **System satisfaction:** less than a quarter (24%) of consumers believe that the U.S. health care system works better than most systems in the world, with only 16% indicating they are satisfied with its performance. • **Health care waste:** over half (51%) of consumers believe that 50% or more of health care spending is wasted (49% in 2010, 51% in 2009). • **Health reform law:** 49% of consumers believe that the new health care reform law is a good start, but 3 in 10 (30%) consumers say it is a step in the wrong direction and 21% say they did not know or had no opinion.

Source: Deloitte Center for Health Solution's *Survey of Health Care Consumers,* available here:
www.deloitte.com/us/2011consumerism

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Context: 2012 Campaign Cycle: things can change

Races	Hot spots	What to watch for
White House	• ACA repeal • Medicare eligibility, funding • Medicaid oversight, funding • State autonomy	• Costs and industry profits • Industry economic impact • Insured vs. uninsured
U.S. Senate • 33 seats up for grabs: 10 Republicans and 23 Democrats • Current: 53 Democrats and 47 Republicans	• Bipartisan balance • Medicare reforms • Immigration reform • Appointments and oversight (ACA,HHS, courts)	• Filibuster-proof majority • Committee chair changes
U.S. House of Representatives • 435 seats up for grabs • Current: 242 Republicans and 195 Democrats, 1 vacancy	• Appointments and oversight (ACA) • Private inurement and self referral • Public option	• Committee chairmanships • Caucus alignment
Governors • 11 up for grabs • Current: 29 Republicans and 21 Democrats	• Exchanges and insurance oversight • Medicaid expansion • State employee health benefits	• Employee strikes • Reduced eligibility • Managed Medicaid • Aggressive medical management: formularies, dual eligibles • Waivers from HHS

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Most think the delivery, insurance and bio-pharma industries will continue to consolidate

Three major incumbents: moving from:	to "new normal"
Provider alignment: loose affiliations • Acute: 5,800 hospitals; 25 investor owned, 1,200 system affiliated • Physicians: 360 large groups, 120 in integrated systems, 42% in small practices, 46% in tight hospital relationships	**Provider alignment: tighter integration, accelerated consolidation** • Drivers: Compensation risk, restricted access to capital, risk based contracts with employers/plans/supply chain, clinical integration penalties drive tighter alignment
Payer alignment: opportunistic expansion • 1,300 plans/250 operators • Self insured market: 30 million	**Payer alignment: accelerated consolidation** • Drivers: ACA compliance, opportunistic diversification, core operation margin compression, growth in retail market and monetization of data
Devices, diagnostics and Therapeutics Alignment: opportunistic	**Diagnostics and Therapeutics Alignment: accelerated, necessary to survival/growth/sustainability** • Drivers: Limited access to capital for early stage innovations, needed capital for globalization/growth, margin compression (commoditization) in U.S. supply chain, costs of compliance (safety, CER, post-market surveillance

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Context: analyst comments by sector

Sectors	Analysts' Comments
Acute	"We believe the many hospitals and health systems will manage under reform effectively but even the strongest hospitals are, at best, only likely to hold existing margin and liquidity levels, while weaker providers will likely see ongoing margin and balance sheet pressure leading to rating deterioration" – Standards & Poors
Bio technology	"The healthcare reform paves a clear path for generic biological drugs and provides tax breaks for smaller biotechnology operators," says Snyder. A favorable regulatory environment combined with an aging population and mounting environmental concerns will drive revenue." -IBISWorld
Prescription drugs	"Suppressed consumer spending will also negatively affect the over-the-counter (OTC) medicine sector and dent demand for discretionary prescription drugs. Nevertheless, the US market will remain the primary destination for companies selling patented, generic and over-the-counter (OTC) medicines." –Business Monitor International
Medical devices	"Valuations are attractive on an absolute basis, but we struggle to see a near-term catalyst to drive shares higher," –Goldman Sachs
Health insurance companies	""We are concerned that market structure changes, profit limitations and rebates, and ever-present political/regulatory pressures will negatively impact future profit growth and more than offset the anticipated influx of newly insured members." –Edward Jones
Health information technology companies	"HIT growth is tied to quality, but people aren't currently being paid for quality…some of the initiatives driving HIT implementation will be delayed or scaled back, which could have an impact on stock performance in that sector." –Barclays Capital
Home health	"Home care is actually the fastest-growing component of post-acute care, projected to grow 9% annually through 2020. It is also one of the higher-margin areas of post-acute care, which recently has out the industry in the cross hairs for Medicare reimbursement cuts." –BB&T Capital Markets
Acute	"The long-term trend is our friend because I foresee a big spike in utilization when the newly insured enter the system. But for 2011, I think hospitals will experience just 1 percent volume growth. I'm still bullish on hospital stocks because there's so much opportunity for consolidation." –Barclays Capital
Hospice	"There is great news for Hospice owners to start off the New Year [2011]. Values are continuing to rise. As a result of market basket increases and corresponding increases in stock values of publicly traded hospice companies, private deals are being valued at all-time high multiples." –Home Healthcare Brokers

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Key dates in ACA implementation: 2012

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
MA benchmarks: reduces Medicare Advantage (MA) benchmarks relative to current levels. Benchmarks will vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas, with benchmarks increased by five percentage points in all areas for high-quality plans, starting January 1. *(Section 1102)*		**Summary of benefits and coverage:** requires group health plans, employers, and health insurers to provide a uniform summary of benefits and coverage explanation prior to enrollment or re-enrollment by March 23. *(Section 1001)* ☆ **U.S. Supreme Court hears arguments on ACA to include:** *March 26:* whether Anti-Injunction Act (AIA) bars individuals from suing over ACA's minimum coverage provision. *March 27:* whether the individual mandate per ACA Section 1501/10106 (which requires individuals to have essential health insurance coverage starting January 1, 2014) is Constitutional under the Commerce Clause. *March 28:* whether the law is severable from the individual mandate and whether the Medicaid coverage expansion per ACA Section 2001 is "unconstitutionally coercive." *(Section 1506/10106/2001)*	**ACOs become operational under the Shared Savings Program:** first set of ACOs become operational under the Medicare Shared Savings Program on January 1, 2012. ACOs can also opt for a July 1, 2012 start date. All ACOs that start in 2012 will have agreement periods ending at the end of 2015. *(Section 3022)*		☆ **Supreme Court ruling on ACA expected**	**Medicaid payments prohibited for provider-preventable conditions:** Medicaid will no longer pay providers for preventable conditions. This provision was delayed by CMS which will delay enforcement until July 1, 2012. *(Section 2702)*	**MLR rebates:** plans that do not meet MLR requirements will have to pay consumers rebates by August 1 each year. *(Section 1001)*		**Hospital VBP program effective:** Medicare will start tying Medicare payments for inpatient hospitals to performance on quality measures for hospital discharges on or after October 1, 2012 (FY 2013). *(Section 3001)* **Medicare reduces payments for hospital readmissions:** CMS will reduce Medicare payments for inpatient hospitals for preventable hospital readmissions starting October 1, 2012. CMS plans to release requirements in the future regulations. *(Section 3025)*		

Major Legislation: Health Reform 2009-2010

Note: ACA creates other programs and initiatives effective in 2012, but HHS has not released any guidance or regulations on implementing them, therefore we do not know exactly when in 2012 they will be implemented. Programs include: the Pediatric ACO demonstration (Section 2706), the Medicaid hospital and physician state payment demonstration in up to eight states (Section 2704), and the Innovation Center's Medicaid bundled payment initiative (not under the law, but created under the Innovation Center's mandate per Section 3021).

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Constitutional challenge: Supreme Court and the ACA

The U.S. Supreme Court heard six hours of arguments March 26 – 28, 2012 and will issue an opinion in June 2012

- **Arguments were made by the NFIB, 26 states, the DOJ, and court appointed lawyers on four main issues:**

Issue	Highlights
March 26: Is *the Anti-Injunction Act applicable to ACA?*	Focused on whether the fine associated with the individual mandate is a tax versus a penalty
March 27: Is *the individual mandate Constitutional under Congress' power to regulate commerce?*	Focused on the limit of Congress' power if the mandate goes forward and the concept that mostly everyone goes into the health care market
March 28: Is *the law severable from the individual mandate? Does the Medicaid expansion coerce states into expansion?*	Debated how much of the ACA is severable without the mandate

Major Legislation: Health Reform 2009-2010

- **What to watch for:**
  - Impacts to the Presidential campaign
  - State implementation
  - Alternatives to the individual mandate
  - Employer activity
  - Industry reaction

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Industry impact: winners and losers in every sector

Major Delivery system elements of ACA

Major Elements	Providers			Health Plans			Biotech	Pharma	Medical Device	HIT	Retail Health	Employers
	Acute	Long Term Care	Ambulatory	Medicare Part C	Commercial	Medicaid						
Bundled Payments & ACOs	+	–	+	+	+		–	–	–			+
Physician Self- Referral Restrictions	+		+	+	+		–	–	–			
Transparency & Reporting	–	–	–	+	+	+	–	–	–			+
Data Driven Health Care	–	–	–		+		–	–	–			
Comparative Effectiveness	–		–				–	–	–			+
Medical Home	+		+	+		+					+	
HIT Adoption	–	–	–		+		–	–	–	+	+	+

+ Advantageous – Disadvantageous Nominal

18

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Industry impact: winners and losers in every sector

Major Health insurance & employer sponsored plan elements of ACA

Major Elements	Providers			Health Plans			Biotech	Pharma	Medical Device	HIT	Retail Health	Employers
	Acute	Long Term Care	Ambulatory	Medicare Part C	Commercial	Medicaid						
Health Insurance Exchanges	–	–	–	–	–	+					+	+
Transparency & Reporting	+		+		–		–	–	–	+	+	+
Employer Pay or Play	–	–	–		–		–	–	–	–	+	+
MLR, Premium Controls, et al	–		–	–	–	–						–
Individual Mandate	+	+	+		+						+	
Essential Health Benefits	+		+	–	–	–	+	+	+		+	–
Medicaid Expansion	+		+	+		+		+			+	

+ Advantageous Disadvantageous Nominal

19

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Industry impact: winners and losers in every sector

Funding mechanisms

Major Elements	Providers			Health Plans			Biotech	Pharma	Medical Device	HIT	Retail Health	Employers
	Acute	Long Term Care	Ambulatory	Medicare Part C	Commercial	Medicaid						
Industry Excise Taxes and Costs of Compliance	–				–			–	–			
Concessions	+			–			–	+	–	+		
Budget Cuts	–	–	–	–		–	–	–	–	+	+	+

+ Advantageous

Disadvantageous

Nominal

20

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The “Big Questions” in 2012 and Implications for Sectors

The "big questions" in 2012: what to watch

- How will the Supreme Court rule?
- How will the U.S. economy perform?
- How much will health care cost?
- How will the Budget Control Act of 2011 sync with ACA implementation, funding and the SGR?
- How will new rules and requirements impact the market especially regarding comparative effectiveness, meaningful use, health exchanges, essential benefits, accountable care, and bundled payments?
- How will physicians behave?
- How will delivery system integration and plan consolidation play out in cost containment?
- How will states comply with and fund ACA obligations?
- How will commercial insurers and employers respond to health insurance exchanges?
- And how will the Campaign 2012 impact implementation?

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Major implications for providers

• Radical cost reduction is key; additional Medicare cuts are inevitable and short-term increased insurance coverage not expected

• Plans will scramble; negotiations will be tougher

• Liquidity and sustainability may be stressed: accessing capital and effectively and strategically deploying it; HIT compliance, workforce re-design, clinical portfolio reviews—necessary starting points

• Physician-hospital alignment is essential to clinical integration and performance-based payments

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Major implications for plans

• Radical cost reduction is key; additional Medicare cuts are inevitable and short-term increased insurance coverage not expected

• Plans will scramble; negotiations with providers will be tougher

• Liquidity and sustainability will be stressed: accessing capital cost effectively and strategic deployment necessary; transparency in business operations, compliance key focus

• Physician-hospital alignment a potential threat

• Consolidation, diversification key strategies necessary

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Major implications for life sciences

• Evolving risk management strategies are key

• Impacts on the supply chain due to provider consolidation are likely

• Potential for gain-sharing models (participating with providers, health plans); new pricing models and bundled payments with providers/health plans

• Newly insured could lead to added revenue

• Increased need to employ a comparative effectiveness lens during all stages of drug development and marketing; technologies with high incremental value are likely to be rewarded

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Major implications for government

- Increased use of managed care and medical management programs/services in Medicaid is likely
- Will likely see improvements in IT infrastructure, provider screening, and enrollment process
- Set-up and operation of exchanges will have vast impacts
- Increased oversight responsibility of health plans
- Seamless transition between states and federal agencies for subsidies, individuals, and tax breaks to companies

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Key Takeaways

Key takeaways for health industry leaders

Cut costs …*innovation in supply chain, workforce innovation, doing more with less is "new normal"*

Go big….*increase revenues, partnerships, even those you don't control, bigger is better*

Connect the pieces…*leverage technology, integrate, diversify, integrate, and create new rules for operating*

Engage consumers…*branding, value, service delivery, transparency, costs*

Plan for multiple scenarios…*no one knows how this will play out, possible scenarios are wide and varied, flexibility is key*

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Deloitte Center for Health Solutions – Recent Publications and Contact Information

Center for Health Solutions recent publications

Health reform memos
On a weekly basis, DCHS publishes the Monday Memo: Health Reform Update, which highlights news from the previous week on various health care reform efforts and implications for stakeholders. Subscribe to the Memo at **www.deloitte.com/us/healthmemos/subscribe**

Physician perspectives about health information technology
With incentives now available to hospitals and physicians for adopting electronic health records (EHRs), and the 2013 deadline for ICD-10 conversion looming, this study sought to assess physicians' current use and overall views of health information technology, as well as specific actions surrounding EHRs, meaningful use, and ICD-10. **www.deloitte.com/us/physicianPerspectivesAboutHIT**

ACA Timeline
The ACA contains provisions to expand health care coverage, improve the delivery system and outcomes, and control costs. This ACA timeline highlights key health reform provisions taking effect from 2010 – 2018 including the establishment of key programs and new agencies, new requirements for industry, and changes to Medicare and Medicaid. **www.deloitte.com/us/acatimeline**

ACO Medicare Shared Saving Program Final Rule analysis and summary
ACOs are a key component of the ACA and have major implications for providers, health plans, the federal government, and consumers. This thoughtware provides background on ACOs (including required core competencies); CMS' estimated program savings, costs, and benefits; and ACO implications by stakeholder group. **www.deloitte.com/us/acofinalrulesummary**

Survey of health care consumers
Since 2008, DCHS has conducted an annual survey of health care consumers to assess behaviors, attitudes, and unmet needs, and to quantify year-to-year changes. The Survey offers health care industry leaders and policymakers a comprehensive and timely perspective about how consumers approach their health and health care. **www.deloitte.com/us/2011consumerism**

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Breakout 1: Art of Accounting for Contributions

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and
Scot E. Aurelius, CPA

Scot Aurelius, CPA, MSA

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Scot is a Shareholder with Moore Stephens Lovelace, P.A. and is the head of the Firm's Senior Housing Practice Group. Scot has more than 17 years of experience serving not-for-profit and healthcare organizations. He is also the President of the Central Florida Juvenile Diabetes Research Foundation. Scot obtained his Master of Accounting Degree from the University of Central Florida.

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Jeff is a shareholder with Moore Stephens Lovelace, P.A. and a member of the Healthcare Conference Committee. He has served over 50 not-for-profit and healthcare organizations in his career. Jeff is the co-author of the article, “Understanding the Florida Uniform Prudent Management of Institutional Funds Act” which will appear in the May / June issue of Florida CPA Today. Jeff obtained his Master of Accounting Degree from Florida State University.

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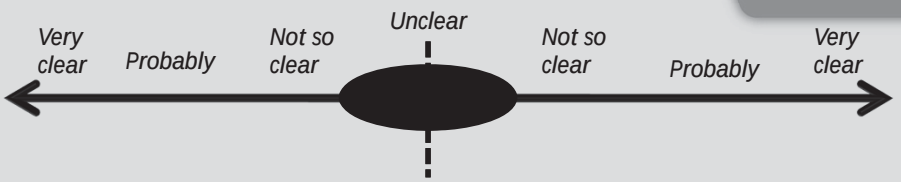
The Art of Accounting for Contributions

Jeff Goolsby, CPA
Scot Aurelius, CPA

So much more than an accounting firm...

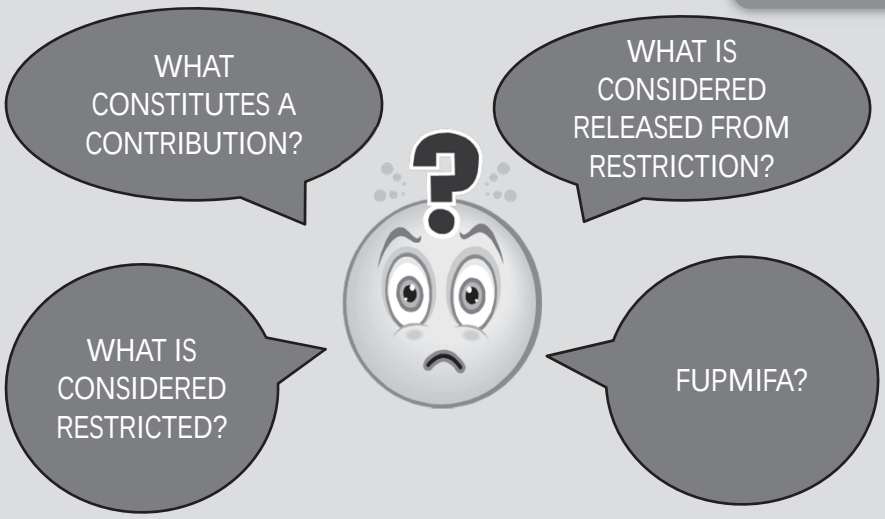
The Accounting Continuum



Contribution	vs.	Exchange transaction
Unrestricted	vs.	Restricted (by donor)
Intention to give	vs.	Promise to give
Conditional	vs.	Unconditional
Not a specialized skill	vs.	Specialized skill
Would not have to purchase	vs.	Would have to purchase

Adapted from "Financial Accounting Guide for Not-For-Profit Organizations", Seventh Edition

AREAS TO BE DISCUSSED



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CONTRIBUTIONS MADE EASY

CONTRIBUTION CHARACTER

A. It is an unconditional transfer of assets to the not-for-profit (NFP)

B. Transfer consists of:

– Cash or other assets or
– Settlement of cancellation of NFP liabilities

C. Transfer is from another entity or individual acting other than as an owner

D. The transfer is voluntary

E. Transfer is nonreciprocal

AUDIT GUIDE 5.02

PROMISES TO GIVE

- **A written or oral agreement to contribute cash or other assets to another entity**
- **Unconditional promises to give are recorded in financial statements as contributions**
  - However, to be recognized, there must be sufficient evidence in the form of verifiable documentation that a promise was made and received (e.g. pledge card)
  - Includes promises to give in future years

AUDIT GUIDE 5.78 – 5.80

CONDITIONAL PROMISES TO GIVE AND INTENTIONS TO GIVE

- **Donor imposed conditions**
  - Represent future or uncertain events whose occurrence or failure to occur permits the donor to receive the return of assets, or alleviates the donor of the obligation to make the donation
- **Conditional promises to give are not recognized until all conditions are satisfied**
- **A conditional promise to give would be considered unconditional, if the likelihood of not meeting the condition is deemed remote**

AUDIT GUIDE 5.51; 5.54 - 5.55

CONDITIONAL PROMISES TO GIVE AND INTENTIONS TO GIVE
(Continued)

- **Wills are considered intentions to give because the individual retains the ability to change the beneficiaries**
  - Once a probate court determines will is valid, the amount is recognized as a contribution
- **Disclosure of amounts expected from wills permitted per ASC 958-310-50-4**

AUDIT GUIDE 5.88

HOW MUCH TO RECORD

- **Contributions are recorded at fair value (e.g. net realizable value)**
  - Contribution revenue recorded at the fair value of assets "expected" to be received or liabilities expected to be forgiven
  - Includes promises to give expected to be received within one year
- **Promises to give over multiple years are discounted using a present value technique**
  - The discount rate should reflect current conditions and is not subsequently updated

AUDIT GUIDE 5.104; 5.110; 5.113

DONOR RESTRICTIONS

DONOR RESTRICTIONS

- **Contributions are classified as restricted when there is a donor imposed stipulation on the use of donation**
- **Restrictions do not impact recognition, but, rather the classification of the donation**
  - When the contribution is to remain unspent in perpetuity the restriction is considered permanent
  - All other donor restrictions are considered temporary

AUDIT GUIDE 5.53; 5.67

TEMPORARY RESTRICTIONS

- **Temporary restrictions result from stipulations that resources may be used:**
  - Only after a specified date
  - For a particular program or service
  - To acquire buildings or equipment
- **Promises to give in future periods are considered restricted support unless specific donor stipulation that donation supports current period activities**
  - Use clear language on pledge cards

AUDIT GUIDE 5.53; 5.82

DONOR IMPLIED RESTRICTIONS

- **Donor stipulations do not have to be explicit**
- **Donor restrictions are also created if circumstances surrounding the receipt of the contribution make clear the donor's implicit restriction on use**
- **Examples:**
  - Contribution to a capital campaign that has a stated purpose to build an expansion
  - Contribution at a themed event (e.g. event to support cancer research)

AUDIT GUIDE 5.63 – 5.64

CONTRIBUTION SOLICITATIONS

- **Be mindful of language used in solicitations and signage at special events which would imply restrictions**
- **Be clear with language to avoid discrepancies with interpretations**
  - Example: Signage at an event that the proceeds of the event will benefit cancer research

    Question – Did the NFP intend that *all* receipts (i.e., gross proceeds) or *net* receipts after event expenses (i.e., net proceeds) will benefit cancer research?

HONORING DONOR INTENT

- **NFPs may occasionally receive donations with stipulations that it may not be able to honor**
  - Examples:
    - A $100,000 contribution to be held until $1,000,000 is raised. What happens if the NFP is unable to raise the full $1,000,000?
    - An NFP receives a $100,000 donation to build a garden center. The donor stipulates that $25,000 must be used to erect a 10 foot statue of the donor. What happens if the NFP objects to erecting a statue?

HONORING DONOR INTENT

(Continued)

- **When an NFP is not able to honor the donor's wishes, the following remedies are available:**
  - Contact donor (or executor) and request the stipulation be revised
  - Decline or return the donation
  - Modifications of endowments now permissible (to be discussed later)
- **NFPs should avoid ignoring portions of the donor's stipulations or making unilateral decisions to redirect the contributions**

GARTH BROOKS vs. INTEGRIS C.V. REGIONAL HOSPITAL

- **Hospital solicited singer, Garth Brooks, and his father about possibly designating a women's center after Brooks' mother**
- **Mock drawings included mother's name on Women's Center**
- **In December 2005, Hospital received anonymous $500,000 gift with no stipulations attached**
- **Brooks later identified as donor**

GARTH BROOKS vs. INTEGRIS C.V. REGIONAL HOSPITAL *(Continued)*

- **Hospital officials claim that no written terms were entered into and no commitments were made**
- **Hospital policy stated that naming rights required at least 50% of the estimated costs**
  - In this case, total project cost was $2 million
- **Hospital completed expansion in 2008, without Garth's mother being named**
- **In February 2012, Garth Brooks awarded $500,000 refund, along with $500,000 punitive damages**

RAY CHARLES FOUNDATION vs. ALBANY STATE UNIVERSITY

- Singer, Ray Charles, made gifts totaling $3 million in 2001
- The Ray Charles Foundation claims the donations are for naming rights on a $23 million Performing Arts Center that has not been built as of 2012
- The University claims gifts were unrestricted. They have already used $2 million for 125 scholarships named in honor of Ray Charles

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SATISFACTION OF RESTRICTIONS

RELEASE OF RESTRICTION

- **A restriction expires when:**
  - The stipulated time has elapsed
  - The stipulated purpose for which the resource was restricted has been fulfilled
  - Both
- **If two or more temporary restrictions are imposed on a contribution, when all of the restrictions have been satisfied**

AUDIT GUIDE 5.70

REPORTING OF RELEASE

- **The expiration of donor-imposed restrictions should be reported in the period or periods in which the restriction is met**
  - Time restrictions have lapsed
  - Required purchases or expenditures have been made
- **Expirations are reported in a statement of activities as reclassifications**
  - Decreasing temporarily restricted net assets and
  - Increasing unrestricted net assets

AUDIT GUIDE 5.71

EXAMPLE ONE

- **An NFP annually spends $5,000 on educational scholarships**
- **The NFP receives a donation of $10,000 to be utilized exclusively for educational scholarships**
- **The $10,000 is placed into a separate scholarship bank account and is recognized as a restricted contribution**

EXAMPLE ONE

- **The NFP spends a total of $7,000 on educational scholarships, of which $2,000 was paid from the new bank account**
- **The balance in the educational scholarship account was $8,000 at the end of the year**
- **How much should be released from restriction?**
  - ANSWER: $7,000. The balance of temporary restricted net assets would be $3,000 ($10,000 less the $7,000)

ALL APPLICABLE EXPENSES

- **If an expense is incurred for a purpose for which both unrestricted and temporarily restricted net assets are available, a donor-imposed restriction is fulfilled to the extent of the expense incurred**
- **Hence, recognition of a release of restriction does not always require additional unbudgeted monies to be spent or that the expenditure be incurred with the intent of specifically meeting the restriction**

AUDIT GUIDE 5.72

EXCEPTION FOR SPECIFIC REVENUE SOURCE

- **If the expense is for a purpose that is directly attributable to another specific external source of revenue, the expenditures would not be eligible to offset an unrelated temporary restriction**
  - Example. A hospital receives a restricted donation for cancer treatment. The Hospital has an employed cancer physician whose salary is paid directly from a separate grant agreement. The costs of the physician's salary are not eligible for meeting the satisfaction of the restriction

AUDIT GUIDE 5.72 - 5.73

DIVERSITY IN PRACTICE

- **NFPs are overly conservative on recognizing that restrictions have been met**
- **NFPs often establish formal protocols to utilize restricted funds**
  - This is especially true when new bank accounts are established for the donated funds
- **As a result, temporarily restricted net assets tend to accumulate**
  - This may lead to a decline in future donations if restricted assets continue to accumulate

EXAMPLE TWO

- **An NFP receives a $1,000,000 gift to be held in perpetuity and the investment results are to be utilized for the general purposes of the NFP**
- **The NFP recognizes the $1,000,000 as a permanent restriction**
- **A separate investment account is created. The fair value at the end of the year was $980,000**
- **What is the value of permanent restricted net assets at year-end?**

  Answer: $1,000,000

NET ASSET ACCOUNTING

- Accounting for contributions as unrestricted versus restricted (temporary or permanently) is a net asset (i.e., equity) accounting and not a physical asset accounting
- Commingling of assets received is permitted
- The segregation of restricted assets into separate bank or investment accounts generally has no impact on accounting

APPLICABLE EXCEPTIONS

- If the donor stipulates the application of gains or losses on investments held
- The donor specifies the investments that must be held (limiting the ability of the NFP to manage against gains or losses)

SAME PERIOD RECOGNITION

- An NFP may meet donor-imposed restrictions on all or a portion of the amount contributed in the same reporting period in which the contribution is received
- The NFP may adopt a policy to report these as unrestricted support provided that the NFP has a similar policy for reporting investment gains and income, and discloses its accounting policy in notes to financial statements

AUDIT GUIDE 5.68

BENEFITS OF ADOPTING POLICY

- Many healthcare providers have debt covenants which are tied to a performance indicator
- The performance indicator is based on unrestricted net assets, which includes all expenses. However, the reclassification of the release of restrictions generally is shown below the performance indicator
- Thus, restrictions of expenses can result in a reduction in performance indicator

AUDIT GUIDE 5.68

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FLORIDA UNIFORM PRUDENT MANAGEMENT OF INSTITUTIONAL FUNDS ACT "FUPMIFA"

FUPMIFA

- **Florida Statutes 617.2104**
- **Effective July 1, 2012**
- **For all Florida 501(c)3 organizations:**
  - Provides regulation for all investments
  - Provides a spending policy requirement related to donor endowments
  - Permits modification of endowments
- **Application of GAAP as a result of passage will change**

INVESTMENTS

- **FUPMIFA applies to "institutional funds," which represents investment securities held. FUPMIFA requires the following:**
  - Good faith ("prudent person")
  - Consideration of eight factors in managing
  - Diversification of investments, unless the governing Board deems it not to be prudent
  - Duty to exercise expertise by those who are selected to manage funds based on expertise
  - Prudent person monitoring of external agents

The Eight Prudence Factors

- General economic conditions;
- Possible effect of inflation or deflation;
- Expected tax consequences, if any, of decisions or strategies;
- Role of each investment or course of action within the overall investment portfolio;
- Expected return from income and appreciation of investments;
- The other resources of the NFP;
- Needs of the NFP and the fund to make distributions and to preserve capital; and
- An asset's special relationship or special value, if any, to the charitable purposes of the NFP.

RECOMMENDATIONS

- **Modify written investment policy to include:**
  - Adoption of FUPMIFA
  - Adoption of eight prudence factors to be considered by governing board
  - Address reserve funds (e.g., bond funds) that do not permit diversification
- **Expect to see language in minutes at least annually regarding investment performance**

ENDOWMENTS

- **Established by donor** (does not include "quasi" endowments internally established)
- **Principal (corpus) to be maintained for a specific period of time (e.g., perpetuity)**
- **Permits NFP to expend or accumulate as much of endowment fund as determined prudent (subject to donor requirements)**
- **Requires adoption of spending policy that includes consideration of seven factors**

SPENDING POLICY FACTORS

- General economic conditions;
- Possible effect of inflation or deflation;
- The duration and preservation of the endowment fund;
- The purposes of the institution and the endowment fund;
- Expected return from income and appreciation of investments;
- Other resources of the NFP; and
- The investment policy of the NFP.

GAAP FOR ENDOWMENTS AND FUPMIFA

CURRENT GAAP (ASC 958-205)	AFTER FUPMIFA
• In the absence of **explicit** donor restriction, both investment income and related gains (losses) are classified as **unrestricted**. • When an expense is incurred that **would** satisfy a donor-imposed restriction, the donor-imposed restriction is considered **met** (regardless of intent to satisfy the restriction).	• Unless **"appropriated for expenditure"** any portion of an endowment fund that is not considered permanently restricted will be considered **temporarily restricted.** • Required reclassification of any amounts not "appropriated for expenditure." • Reclassification **subject to original restriction.**

SPENDING POLICY

- **A written spending policy should be in place**
- **Organizations will need to address "appropriated for expenditure" issues with any releases that occurred prior to July 2012**
- **Expect formal means of addressing future appropriated for expenditure issues**
- **Consider preemptive language**

Example: "The organization deems that the funding for applicable expenditures will first come from endowment funds with the remainder of the expenditures covered from other available sources."

MODIFICATION PERMITTED

- **Modification of endowment fund best achieved with written donor consent**
- **When donor consent cannot be obtained (i.e., death or inability to identify) the Board has authority to:**
  - Release or modify endowment funds less than $100,000
  - Release or modify endowment funds between $100,000 and $250,000 with written notice to Attorney General (and fund is older than 20 years)
  - Local circuit court has authority to release restrictions upon application and written notice

38 Years of Excellent Client Service

QUESTIONS?

Breakout 2: Optimizing Value Based Purchasing Payment through Hospital Process Integration

Sandra Sieck

Sandra Sieck

Chief Operating Officer

Society of Chest Pain Centers

Sandra Sieck is the *Chief Operating Officer* for the **Society of Chest Pain Centers**. Ms. Sieck presents nationally as a HealthCare Reform Business Analyst. She has her RN degree as well as a degree in Business Administration. She was a selected committee member of the National Institute for Health (NIH) National Heart, Lung, Blood Institute (NHBLI) to address the nations HealthCare Initiative Cardiovascular Disease and Women (Healthy People Initiative 2010), and CMS-APC Observation Reimbursement Committee (one of the original team members who challenged CMS regarding the new observation code implemented April 1, 2002).

Ms. Sieck worked with CMS/NCHS in updating ICD-9 Codes to meet the Cardiology National Guidelines and Medical Necessity Standards. Ms. Sieck continues to work with the Federal government in monitoring and updating Health policy. Since 1998, she has visited and presented to nearly 2,000 hospitals across the United States. In addition to developing unique healthcare concepts, Ms. Sieck has developed a one of its kind, nationally recognized program, “A New Generation of Hospital Operations - The industry leader in the alliance of clinical and financial strategies.” Ms. Sieck developed a New Re-engineering Model for the US Healthcare Delivery System known as the Provider Excellence Program (PEP™). She also has numerous publications. Most recently Ms. Sieck is a member of the 9th National Forum with a focus on the Million Hearts Campaign.

Optimizing Value Based Purchasing Payment through Hospital Process Integration

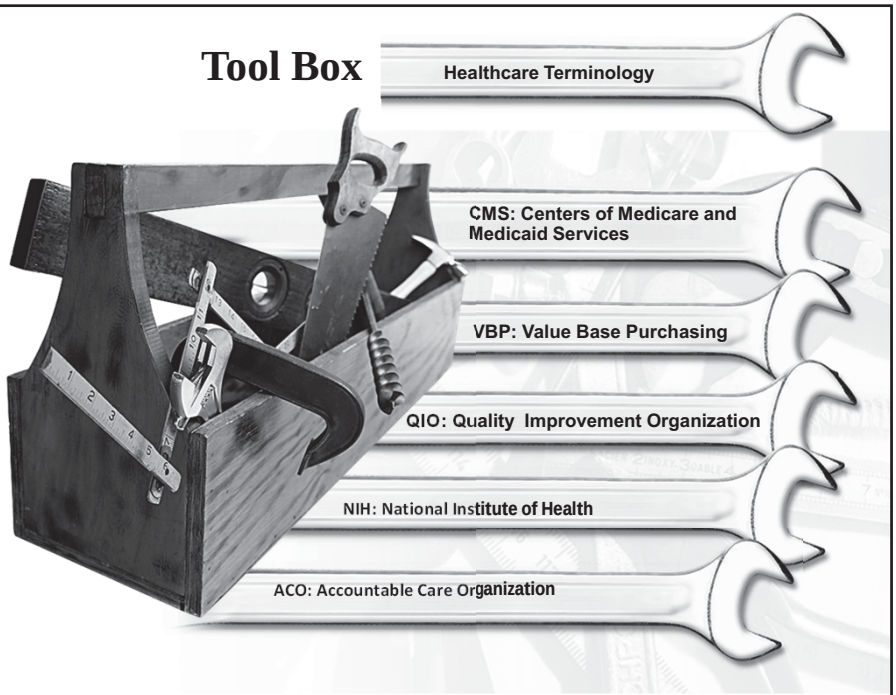
Because Every Heart Matters

April 26, 2012
11:10-12:00 pm

SOCIETY OF CHEST PAIN CENTERS

Sandra Sieck
Chief Operating Officer
Society of Chest Pain Centers
Dublin, OH

Tool Box



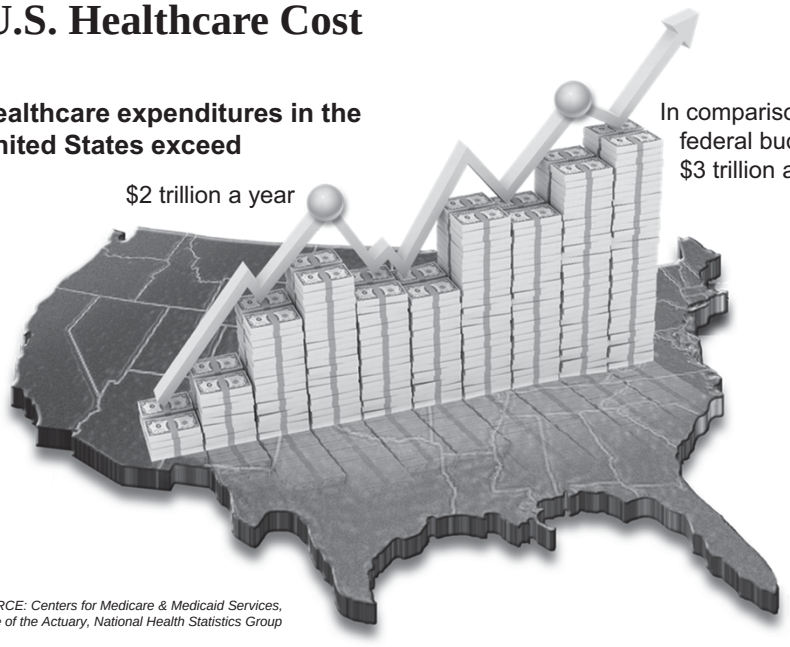
Healthcare Environment

U.S. Healthcare Cost

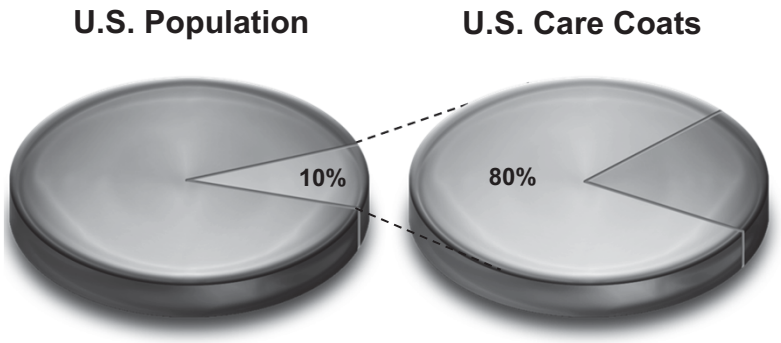
Healthcare expenditures in the United States exceed

$2 trillion a year

In comparison, the federal budget is $3 trillion a year.



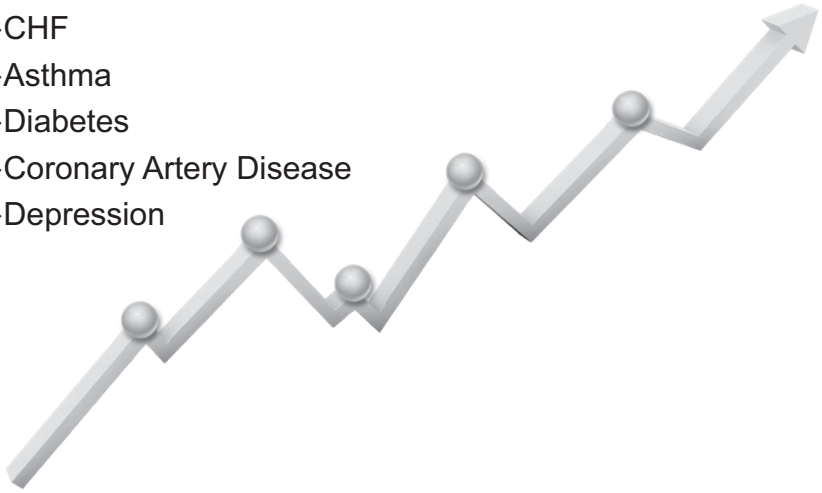
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group



Cost Drivers

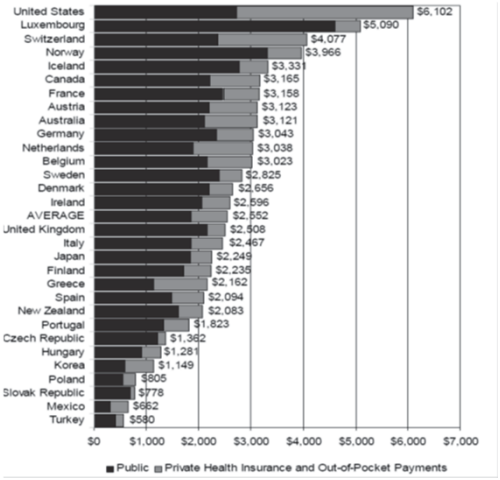
Five conditions drive over 50% of all costs

- CHF
- Asthma
- Diabetes
- Coronary Artery Disease
- Depression



Healthcare System in the United States

- In the United States, the debate regarding healthcare reform includes questions of a right to health care, access, fairness, sustainability, quality and amounts spent by government.
- *The mixed public-private health care system in the United States is the most expensive in the world, with* ***health care costing more per person than in any other nation.***



Source: Congressional Research Service. Washington, DC. Pub No. RL34175

The Healthcare Industry is in Crisis

- The $2.2 trillion healthcare sector is now mired in deep crisis related to safety, quality, cost, and access that pose serious threats to the health and welfare of many Americans [1,2]
  - As many as 98,000 Americans die each year as a result of faulty health care processes and system failures[3]
  - Only half of adult US patients receive known "best practice" treatments for their illnesses[4]
  - Less than half of physician practices use recommended processes for care[5]
  - An estimated 30 to 40 cents of every dollar spent on health care, or roughly three quarters of a trillion dollars per year is spent on costs associated with "overuse, underuse, misuse, duplication, system failures, unnecessary repetition, poor communication, and inefficiency"[2]

1. Centers for Medicare & Medicaid Services. National Health Expenditure Projections, 2006-2016. http:\www.coms.hhs.gov/NationalHealthExpendData/Downloads/proj2006.pdf. Accessed March 15, 2007.
2. Lawrence D. Bridging the quality chasm. In: Reid PP, Compton WD, Grossman JH, Fanjiang G, eds. Buiilding a Better Delivery System: A New Engineering/Health Care Partnership. Washington, DC: National Academy Press; 2005.
3. Kohn, et al, eds, for the Committee on Quality of Health Care in America at the Institute of Medicine. To Err Is Himan. 5th ed. Washington, DC: National Academy Press; January 2006: 26-48.
4. McGlynn EA, et al. The quality of health care delivered to adults in the United States. *N Engl J Med.* 2003;348:2635-2645.
5. Casalino L, et al. External incentives, information technology, and organized processes to improve health care quality for patients with chronic diseases. *JAMA.* 2003;289:434-441.

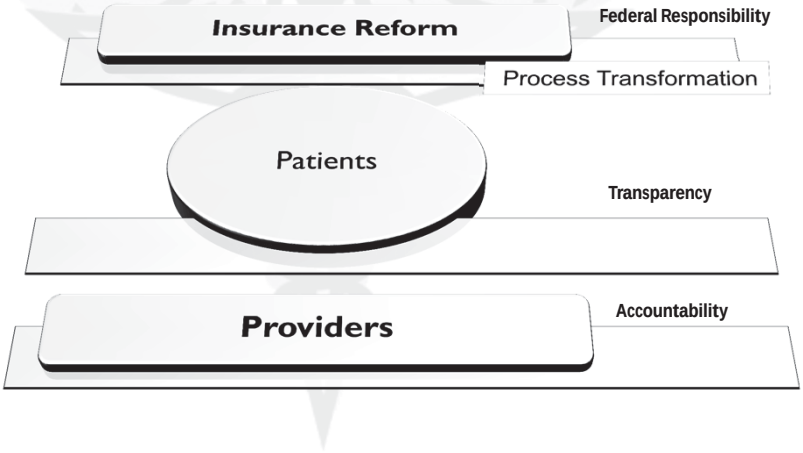
System Breakdown Impacts Operations

Hospital Statistics

- 32% of all hospitals are operating at a loss
- Total Number of Emergency Departments decreasing
- 24% increase in ED presentations and usage
- 30% Reduction of inpatient beds
- External Pressures to meet demanding clinical and financial targets (VBP< RAC< MAC< MIC<etc.)
- Most facilities are looking for ways to increase Quality, Cost, and Patient Satisfaction

Healthcare Changes Direction

Levels of Transformation



Current External Pressures to Eliminated Waste

Improper payments-to the wrong person, in the wrong amount, or for the wrong reason—cost Medicare $48 billion last year, or nearly 10 percent of the $516 billion spent on care for seniors, according to federal estimates.

www.thefiscaltimes.com
09-27-11

Define: Healthcare Reform

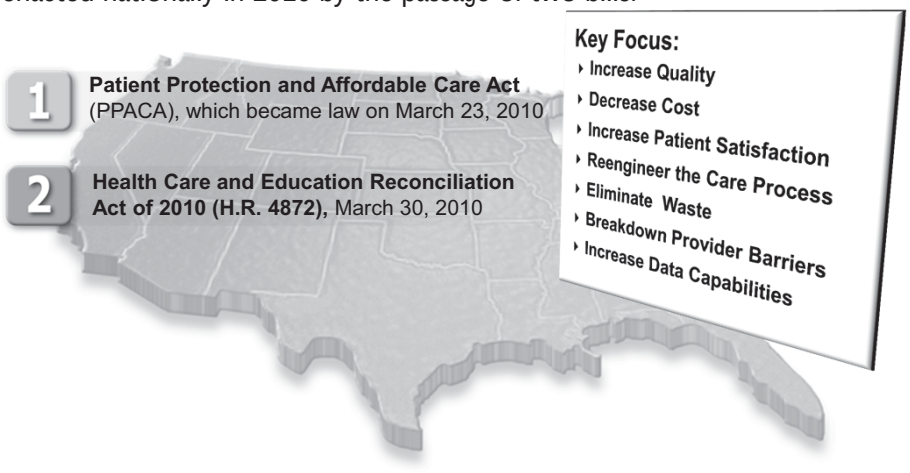
Wikipedia, encyclopedia

Health care reform is a general rubric used for discussing major health policy creation or changes—for the most part, governmental policy that affects health care delivery in a given place. Health care reform typically attempts to:

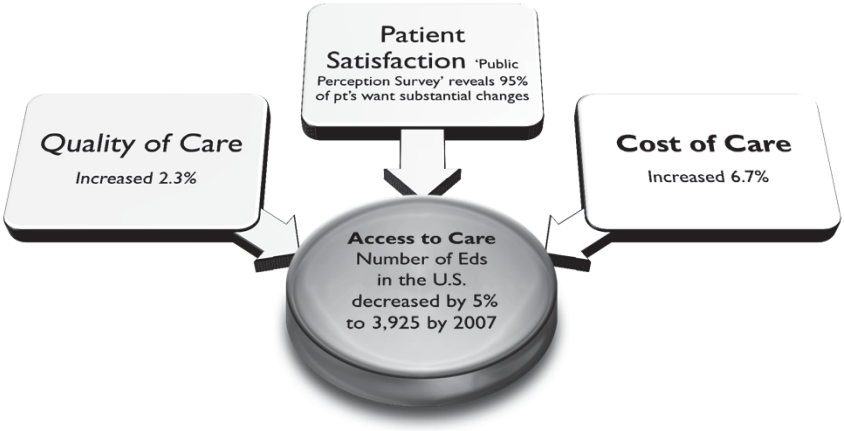
- Broaden the population that receives health care coverage through either public sector insurance programs or private sector insurance companies
- Expand the array of health care providers consumers may choose among
- Improve the access to health care specialists
- Improve the quality of health care
- Give more care to citizens
- Decrease the cost of health care

Healthcare Reform in the United States

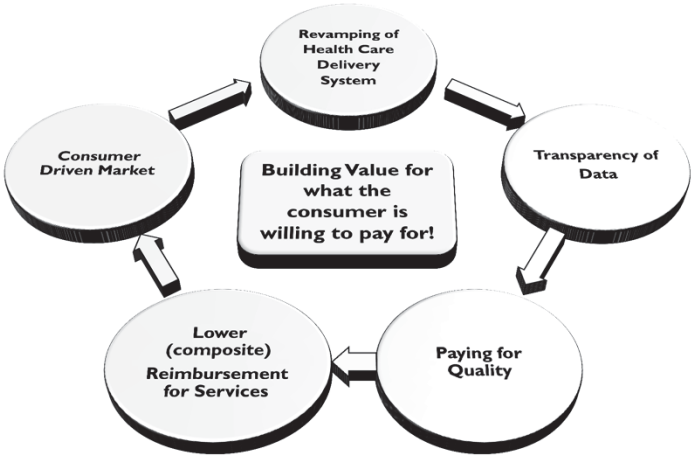
Health care reform in the United States was most recently enacted nationally in 2010 by the passage of two bills:



Major Health Care Delivery Issues



Reaction to Current Crisis



2010 Patient Protection & Affordable Care Act

Within one year of enactment (2010–2011)

- Insurance companies barred from dropping people from coverage when they get sick, ending the practice of rescission. Lifetime coverage limits eliminated and annual limits restricted.
- Young adults able to stay on their parents' health plans until age 26. Many health plans previously dropped dependents from coverage when they turned 19 or finished college.

Effective during 2011

- Medicare provides 10% bonus payments to primary care physicians and general surgeons.
- Medicare will cover the full cost of annual wellness visits and personalized prevention plan services for beneficiaries. New health plans will be required to cover preventive services with little or no direct cost to patients

Effective as of 2012 (Oct. 1, 2012, Medicare institutes the national hospital value-based purchasing (VBP) program)

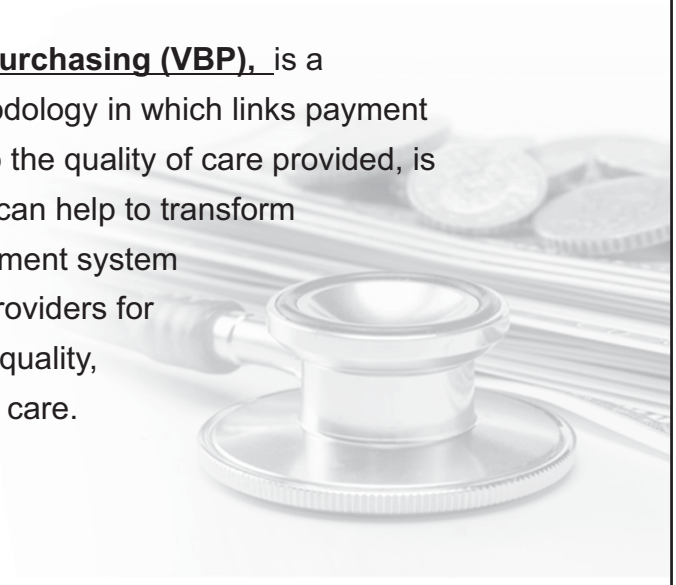
- Physician payment reforms are implemented in Medicare to enhance primary care services and encourage doctors to form "accountable care organizations" to improve quality and efficiency of care.
- An incentive program is established in Medicare for acute care hospitals to improve quality outcomes.
- The Centers for Medicare and Medicaid Services, which oversees the government programs, begins tracking hospital readmission rates and puts in place financial incentives to reduce preventable readmissions.

Effective as of 2013

- A national pilot program is established for Medicare on payment bundling to encourage doctors, hospitals and other care providers to better coordinate patient care.

What is Value Based Purchasing?

- **Value-based purchasing (VBP),** is a payment methodology in which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care.



Value Based Purchasing, Transitioning U.S. healthcare from a Volume-based system to a Value-based system

- Effective Oct. 1, 2012, many inpatient acute-care hospitals that meet or exceed certain performance standards will be eligible for incentive payments (i.e., higher Medicare payments) from a pooled hospital-derived fund.

- **The program will initially cover at least these five conditions or procedures:**
  1. Acute myocardial infarction (AMI)
  2. Heart failure
  3. Pneumonia
  4. Certain surgeries
  5. Certain healthcare-associated infections.

- **Transition to additional measures**
  1. Medicare spending per beneficiary
  2. Readmissions
     1. AMI, heart failure and pneumonia readmissions.

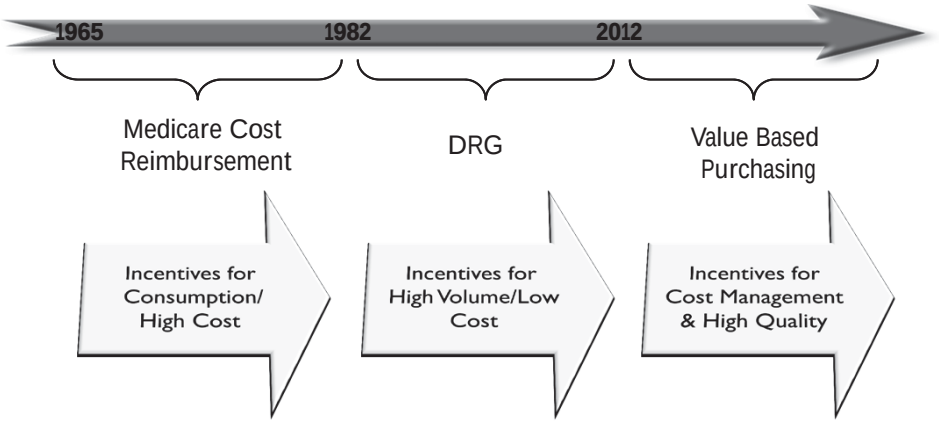
2013 Expansion

1. Chronic obstructive pulmonary disease,
2. Coronary artery bypass graft,
3. Percutaneous transluminal coronary angioplasty
4. Other vascular procedures.

CMS Defines Goals

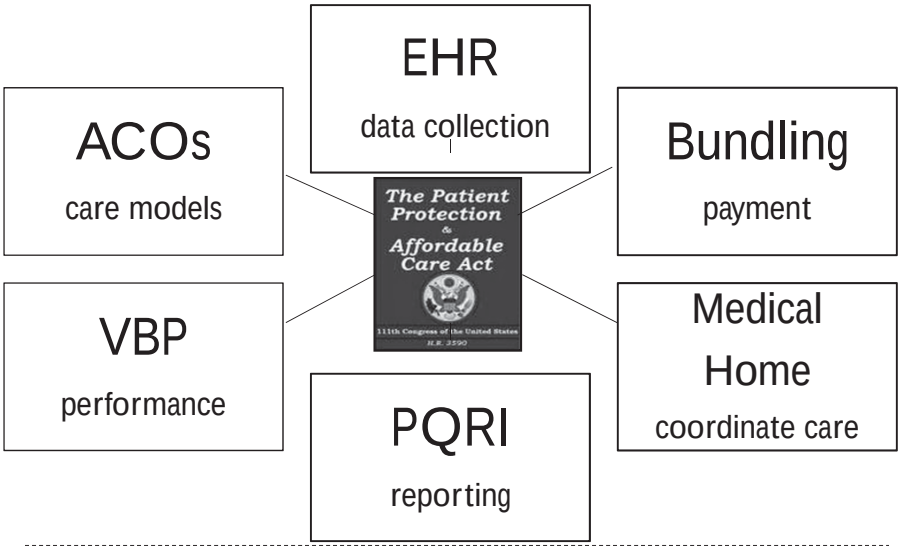
CMS Defines Goals for a Value Based Purchasing Program (VBP)	
Improve Clinical Quality	
Reduce Adverse Events	
Improve Patient Safety	
Encourage Patient Centeredness	
Avoid Unnecessary Costs in Delivery of Care	
Stimulate Investments in Structural or System Components IT Capability, Care Management Tools and Processes	
Improve Performance Results and Transparency Consumer Driven System	

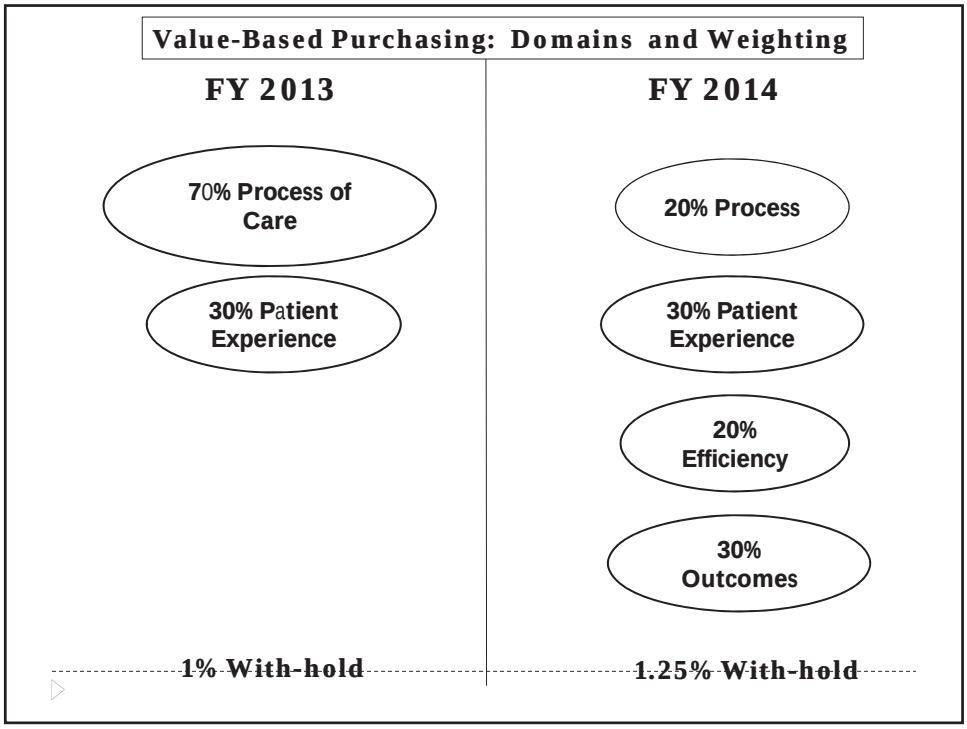
Medicare Inpatient Hospital Payments

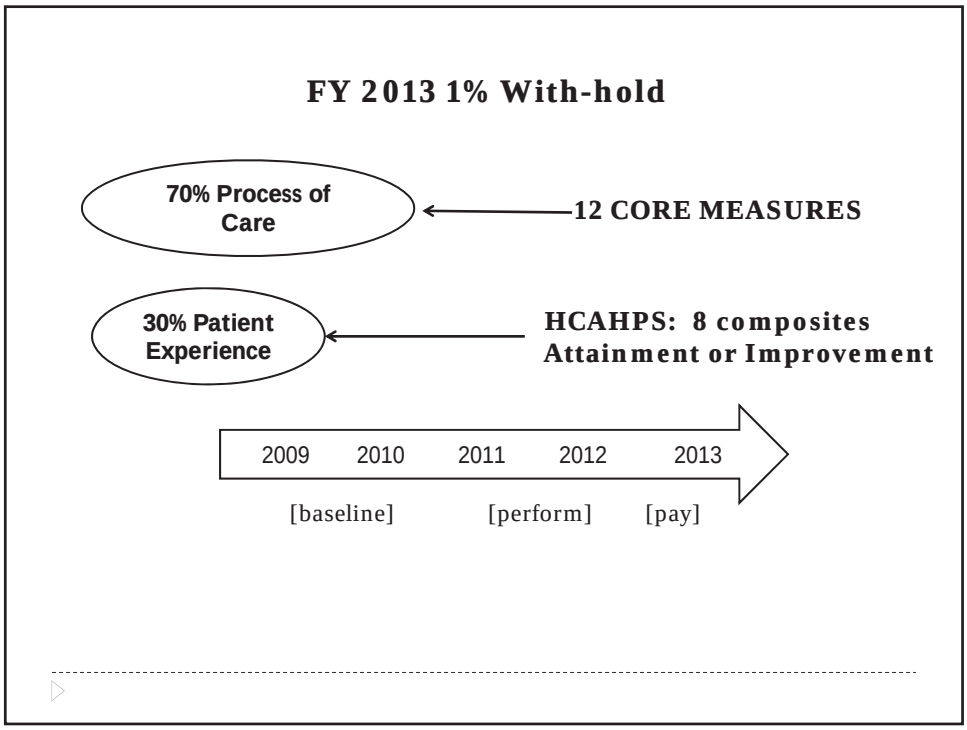


Sieck HealthCare Consulting, LLC

"Improving the Quality and Efficiency of Health Care"



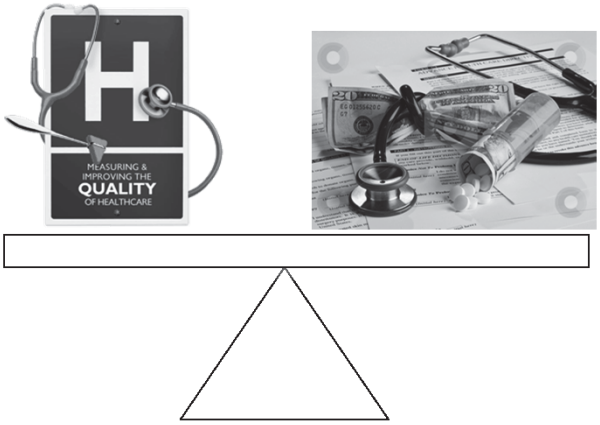

Value-Based Purchasing: Domains and Weighting
FY 2013
FY 2014
70% Process of Care
30% Patient Experience
20% Process
30% Patient Experience
20% Efficiency
30% Outcomes
1% With-hold
1.25% With-hold


FY 2013 1% With-hold
70% Process of Care
12 CORE MEASURES
30% Patient Experience
HCAHPS: 8 composites
Attainment or Improvement
2009
2010
2011
2012
2013
[baseline]
[perform]
[pay]

VBP Performance Measures

The VBP Equation

Value = Quality / Cost



What is Quality – to CMS?

	FFY 2013 Program		Proposed FFY 2014 Program *	
VBP Domain	Measure Count	Domain Weight	Measure Count	Domain Weight
Process of Care	12	70%	**13**	**20%**
HCAHPS (Patient Experience of Care)	1 (using 8 HCAHPS dimensions)	30%	**1 (using 8 HCAHPS dimensions)**	**30%**
Outcomes (mortality/ARHQ/HACs)	N/A	N/A	**13**	**30%**
Efficiency	N/A	N/A	**1**	**20%**
Totals	13 (2 domains)	100%	**28 (4 domains)**	**100%**

* Only some aspects of 2014 program are final

12 Clinical Process of Care Measures

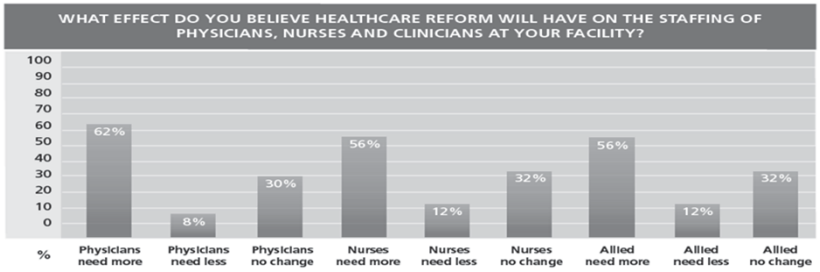
Measure ID	Measure Description	Achievement Threshold 50th Percentile	Benchmark Mean of Top Decile
	Acute Myocardial Infarction (Heart Attack)		
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.6548	0.9191
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	0.9186	1.0000
	Heart Failure		
HF-1	Discharge Instructions	0.9077	1.0000
	Pneumonia		
PN-3b	Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital	0.9643	1.0000
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	0.9277	0.9958
	Healthcare-Associated Infections		
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	0.9735	0.9998
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	0.9766	1.0000
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	0.9507	0.9968
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	0.9428	0.9963
	Surgical Care Improvement		
SCIP-Card-2	Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period	0.9399	1.0000
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	0.95	1.0000
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	0.9307	0.9985

StuderGroup

2010 Survey of Healthcare Executives:
Initial Responnse of Healthcare Reform on Cost, Quality

What is Your Initial response to the Passage of the Healthcare Reform Bill?	
Greatly pleased	8.8%
Moderately pleased	12.9%
Unsure/Neutral	6.3%
Somewhat concerned	17.0%
Very concerned	55.0%

What Effect do You Think healthcare Reform Will have on the Quality of Care Your Facility is Able to Provide?	
Very beneficial	8.8%
Somewhat beneficial	14.1%
No Effect	14.1%
Somewhat detrimental	34.7
Very detrimental	28.3%



AMN Healthcare 12400 High Bluff Drive Sab Diego, CA 92130 (866) 756-6635 www.amnhealthcare.com

HCAHPs Domain Measures – FFY 2013 Program

Patient Satisfaction Survey	
HCAHPS	Eight Dimensions (using the most positive responses, "top box" responses for each question used within the HCAHPS dimension): • Communication with Nurses • Communication with Doctors • Responsiveness of Hospital Staff • Pain Management • Communication About Medicines • Cleanliness and Quietness of Hospital Environment • Discharge Information • Overall Rating of Hospital

Modifications to HCAHPS on Hospital Compare:
•"cleanliness and quietness" – combined
•"would you recommend this hospital?" - not included

HCAHPS: Reporting and Payment

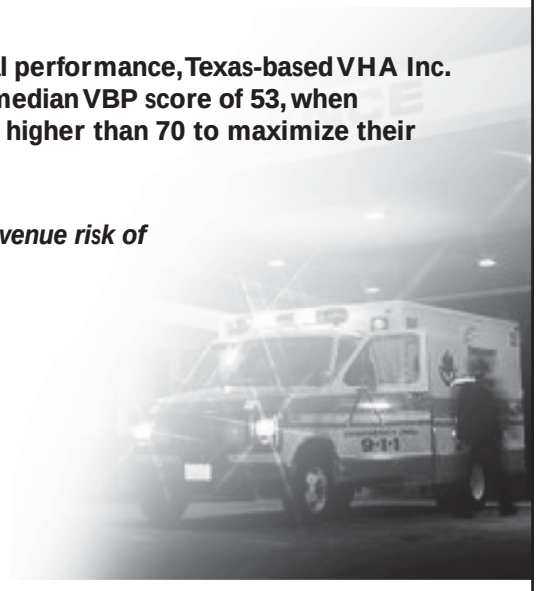
Evaluation of Care	**Communication with nurses (3)** **Communication with doctors (3)** **Responsiveness of hospital staff (2)** **Pain management (2)** **Communication about medicines (2)** **Discharge information (2)**
Environment	Cleanliness of hospital environment Quietness of hospital environment
Global items	**Overall rating of hospital (0-10)** Willingness to recommend hospital (y/n)

Current State:
VBP Impact Seventy-five Percent Of Hospitals Face Losses

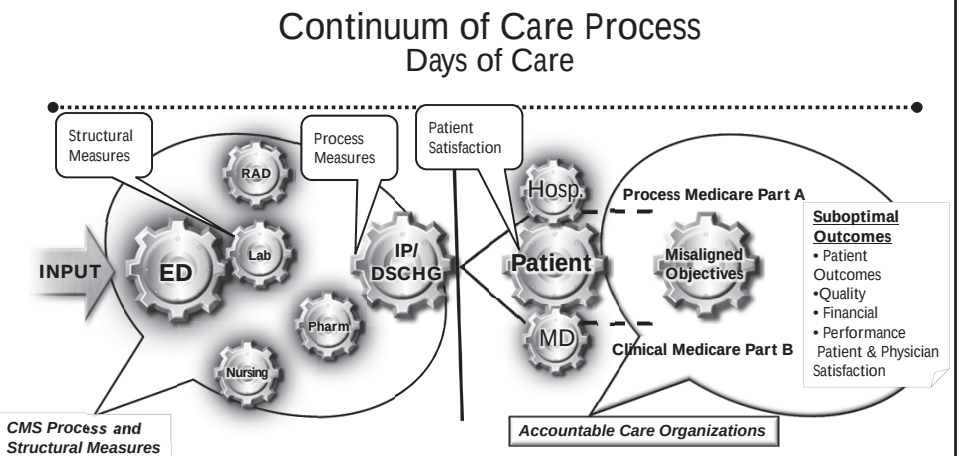
In a national analysis of hospital performance, Texas-based VHA Inc. recently calculated a national median VBP score of 53, when hospitals likely will need scores higher than 70 to maximize their Medicare reimbursements.

Hospitals face an average VBP revenue risk of

- $888,812 in 2012
- $6.67 million over five years.



Lack of an Integration Impacting Outcomes



Think Globally, Long Term, and with Accountability

33

Administrators Learning Opportunity "Change the Way they do Business"

Past Business Structure: Endpoints: Volume, Supply Cost, LOS, and FTE's

Current Business Structure: Endpoints: Quality, Cost, and Patient Satisfaction

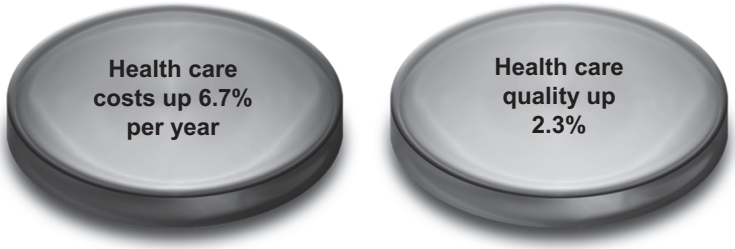
- Hospitals to examine their data at granular level and build a business plan based on Disease Management "NOT" payment structure.
- Hospitals to start benchmarking from a national perspective. "Don't look at the guys across the street.
- Hospitals have significant amounts of unknown variance because their dashboards aren't set up to indicate variance. Process Drilldown.
- Build accountability teams. Shared Responsibility across departmental lines.
- Integrated health IT solutions designed to make it easy for physicians, nurses and hospital administrators to gain insights from data aggregated from multiple clinical and financial systems across the hospital.

"Every Step in the Process offers Value"

Find Equilibrium: Quality and Cost

What Is Quality?

A Quality Disconnect



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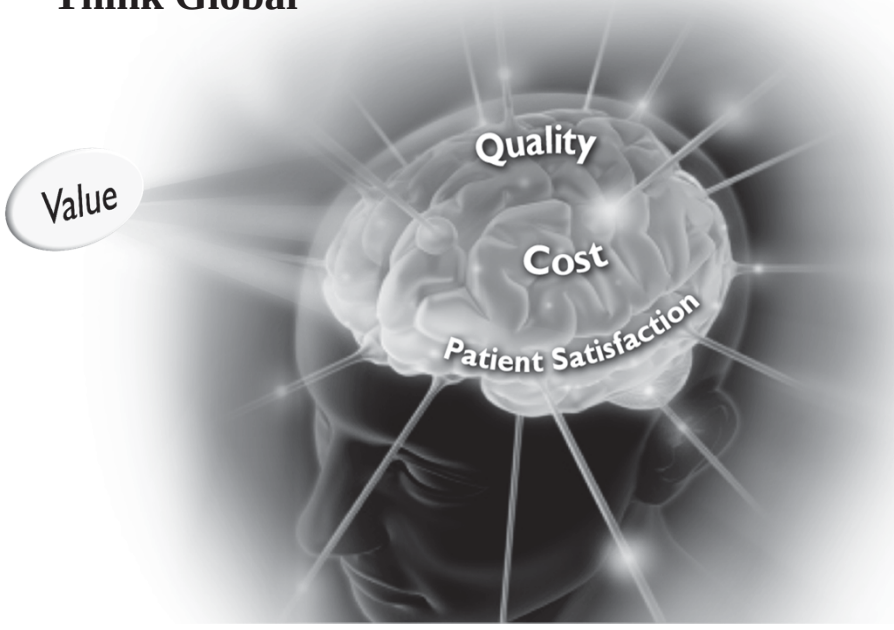
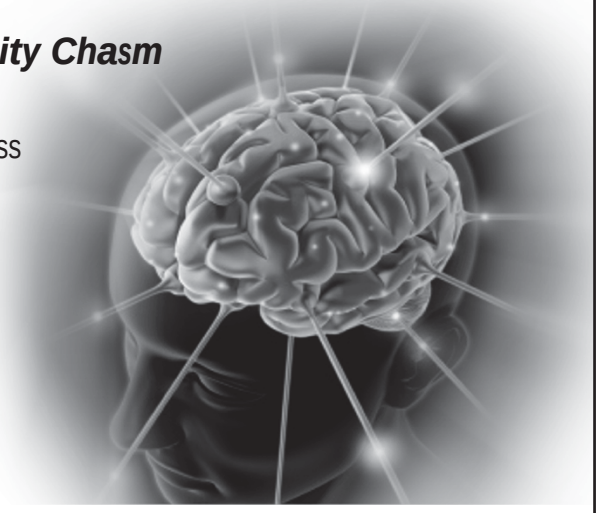
Think Global



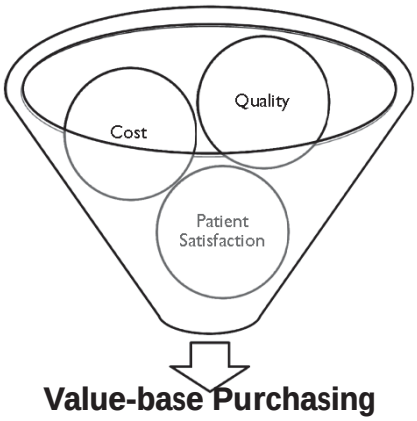
3 Primary Outcomes and 7 Acquisition Decision Points

Quality + Cost + Patient Satisfaction= VBP

- ***Crossing the Quality Chasm***
  1. Effectiveness
  2. Patient centeredness
  3. Timeliness
  4. Efficiency
  5. Equity
  6. Safety
  7. Flow



Bundles Outcomes

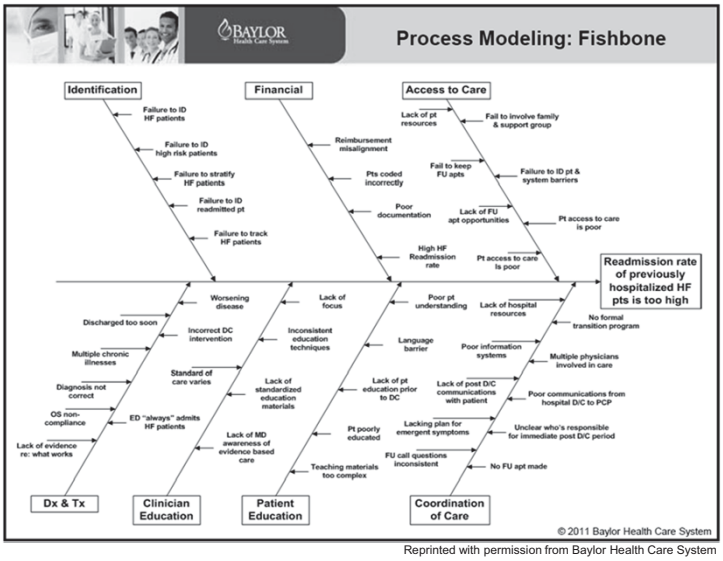


Value-base Purchasing
Patient Centric Model

Baylor System

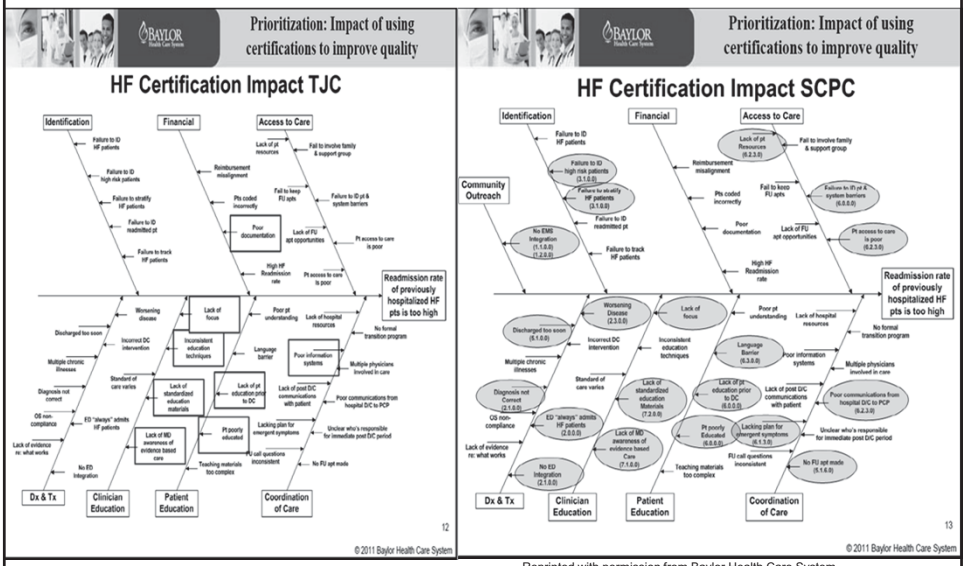
Customer Identifies Needs

Process Modeling at Baylor Health Care System



Reprinted with permission from Baylor Health Care System

Process Modeling at Baylor Health Care System



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Future of Healthcare

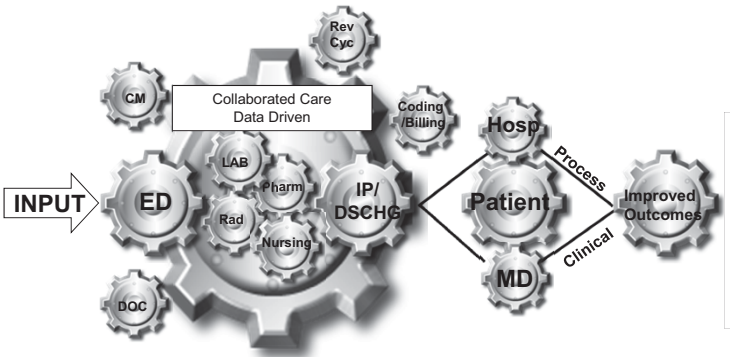
Where is the market going?

- Congressional Budget Office estimates that in the absence of any changes, total spending on health care would rise from
  - 16% of gross domestic product (GDP) in 2007 to
  - 25% in 2025 and
  - 37% in 2050.
- Federal spending on Medicare and Medicaid would rise from
  - 4% of GDP in 2007 to
  - 7% in 2025 and
  - 12% in 2050.
- Americans will be faced with increasingly difficult choices between health care and other priorities
- Advances in medical science will allow providers to diagnose and treat illnesses earlier and more effectively than were previously possible.

Excellence

Total Integrated Patient Care Model

Continuum of Care Process
Hours of Care



Outcome Measures
•Improved Patient Outcomes
•Improved Quality
•Improved Financial Performance
•Improved Patient & Physician Satisfaction
•Increased Accreditations

Think Globally, Long Term, and with Accountability

4/12/2012

44

Example Survey Key Points

HCAHPS measures

- Patients respond based on their perceptions and impressions of the experience.

The overarching goal is to give effective clinical care and a great patient experience, exceeding expectations.

What Influences Patient Responses

First and Last Encounters: ED and Discharge

In Between: attention/communication/physical needs

- Nursing Communication
- Pain Management
- Physician Interaction

What is the patient's experience?

FEAR

LOSS OF CONTROL

Poor sleep

Pain

Disparate communication

Waiting

Lack of information

Hospital Operations

Public reporting and direct financial accountability are driving changes in hospital performance

Public Reporting: market

Value-Based Purchasing: money

HealthCare Transformation

Just the tip of the iceberg!

Medicare VBP Payment

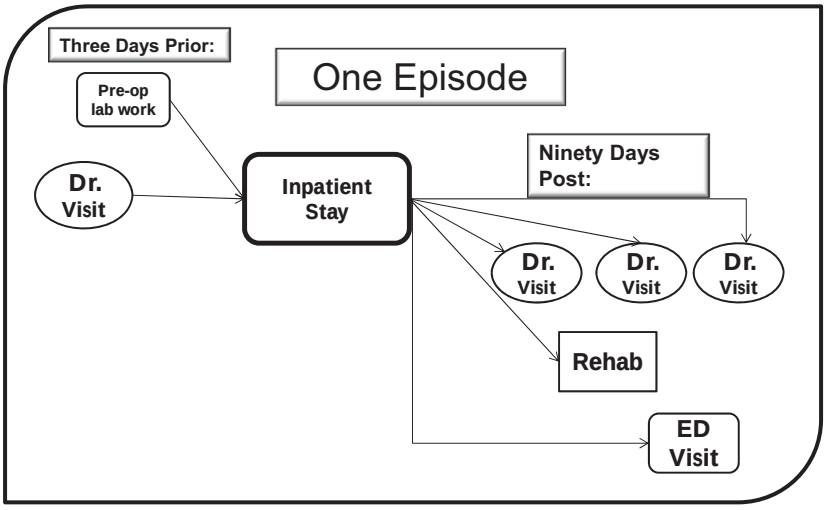
Payment Reductions

2013: - 1.00%
2014: - 1.25%
2015: - 1.50%
2016: - 1.75%
2017: - 2.00%

- Technology and analytics that assist Hospitals to “earn back” based on “Quality Scores”

Best Performers win; others break even or lose

Episodes of Care



VBP in Context – Affordable Care Act's Mandatory Delivery System Reforms for Hospitals

FFY 2013 → FFY 2015

VBP	Readmissions	HACs	EHR Meaningful Use (ARRA)
• Begins October 1, 2012 (FFY 2013) • Redistributes inpatient payments • Budget neutral	• Begins October 1, 2012 (FFY 2013) • Cuts Medicare inpatient payments 1% (13) to 3 % (15) • $7 billion cut /10 years nationwide	• Begins October 1, 2014 (FFY 2015) • Cuts Medicare inpatient payments 1% for top quartile • $1.4 billion cut / 10 years nationwide.	• Incentives for qualifying hospitals now • Cuts Medicare inpatient payments in FFY 2015 for hospitals that do not meet "meaningful use" standard

No one is quite sure where we will land but it is certain that politics and legislation will continue to evolve and shape the landscape

- **To thrive in future health care delivery, hospitals will need to transform to a patient-centered, information-rich organization. This means building proficiency in technology, health analytics to deliver evidence-based outcomes, that translates into a cost-effective coordinated and accountable care delivery model.**

"The best way to predict the future is to create it."

- Peter F. Drucker

Thank You!

Questions???

Breakout 3: ACO's Practical Applications

David A. Schuh, CPA

CliftonLarsonAllen Health Care

Accountable Care and Risk Based Contract Impacts

Practical Concepts for Modeling the Financial Impacts of ACO and Risk Based Contracting Scenarios

April 2012

Session Objectives

At the end of this session, you should…

1. Understand the basic financial structures and effects of Medicare's proposed Accountable Care Organization (ACO) rule,
2. Understand the basic economic implications of ACO and other value-/risk-based payment models from an Integrated Health System perspective, and
3. Understand the critical success factors of moving to ACO and value-based payment arrangements.

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Modeling Highlights of the Medicare ACO Rule

- Two Tracks of Payment Models
- Attribution (Beneficiary Assignment)
- Global Target Setting (Benchmark)
- Gain & Loss Sharing
- Another Way to Quality with Score Based on Deciles and 65 Separate "Domains"
- Significant Governance and Operating Implications
- Significant Potential Capital Requirements

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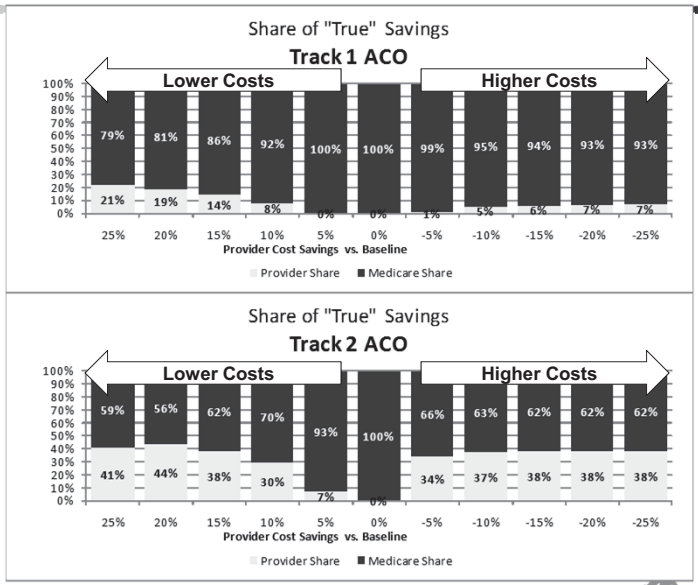
Provider vs. Medicare Share of "True" Savings

The BEST You Can Do➔ 90th + Percentile in ALL 65 Domains!!!!



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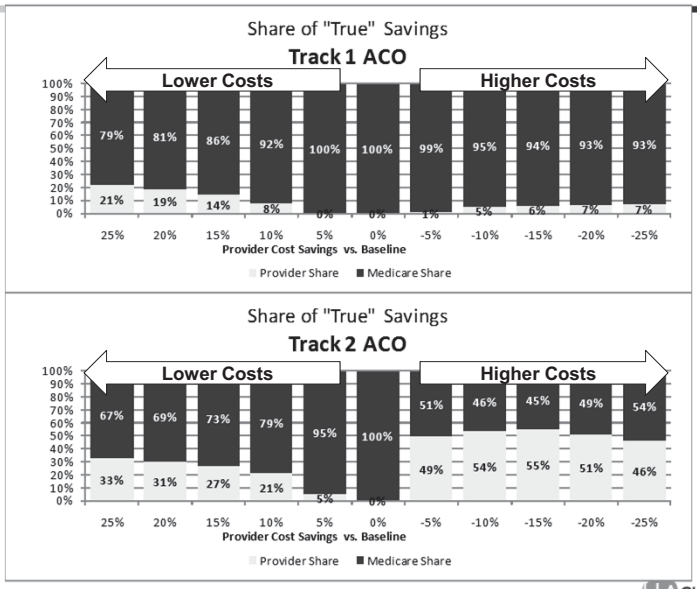
Provider vs. Medicare Share of "True" Savings

50th Percentile in ALL 65 Quality Domains!!!!



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OUR APPROACH TO MODELING RISK BASED CONTRACTS

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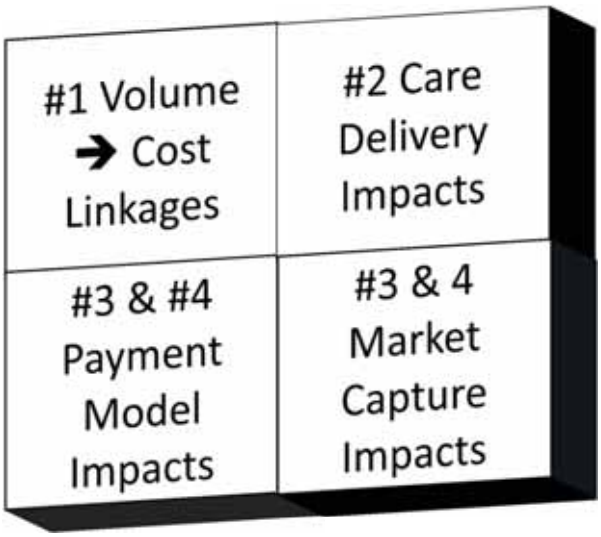
Accountable Care: Performance Cubes



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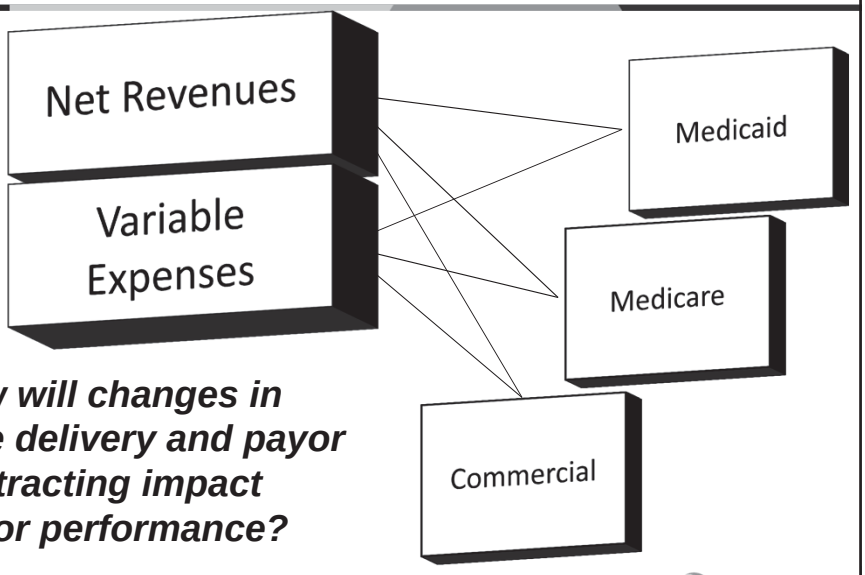
Accountable Care: Performance Cube #1



How will changes in care delivery and payor contracting impact payor performance?

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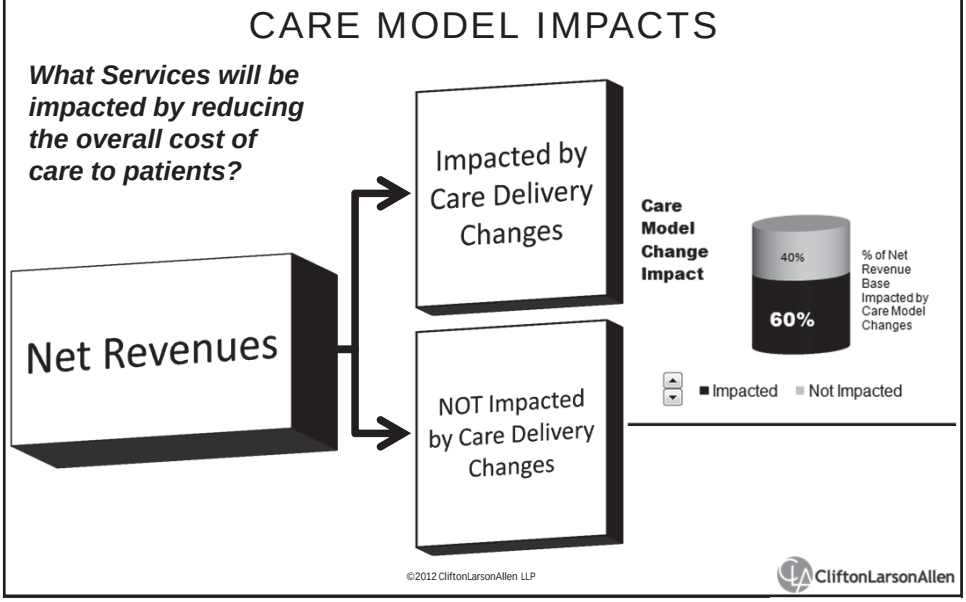
Accountable Care: Performance Cube #2



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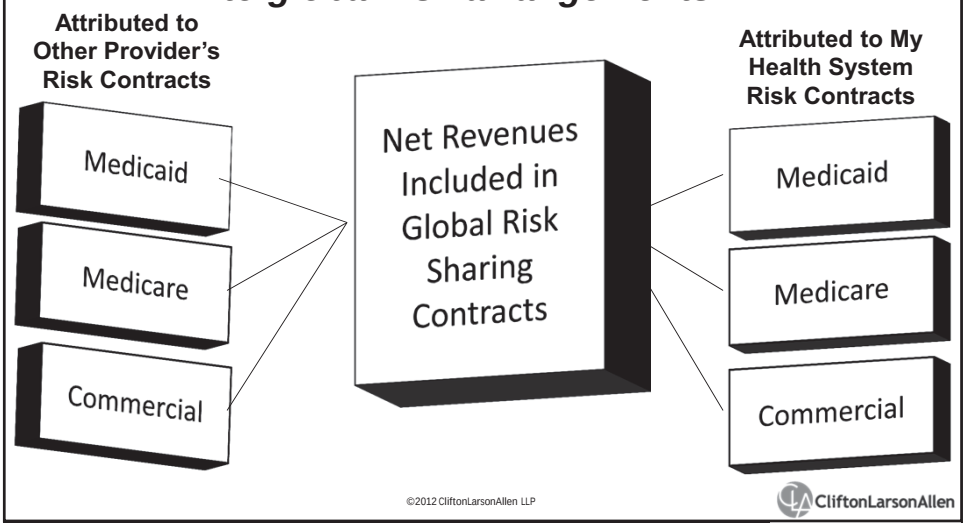
Accountable Care: Performance Cube #3



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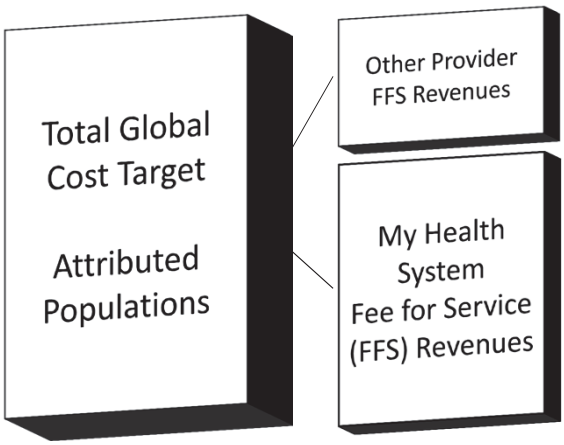
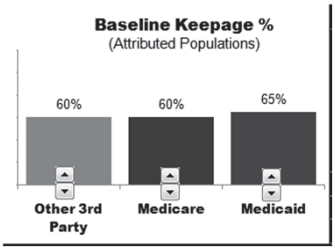
Accountable Care: Performance Cube #4

What Costs are Included in a Global Total Cost of Care Contract?





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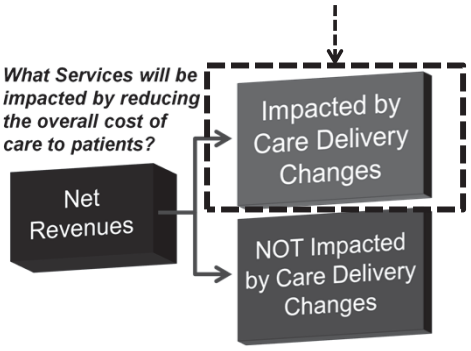
Key Opportunity and Risk

1. **Care Delivery Changes = Reduced FFS Revenues** and **"Savings" in a Global Cost Model**

We need to impact these costs to produce "gains" in a global risk based payment model



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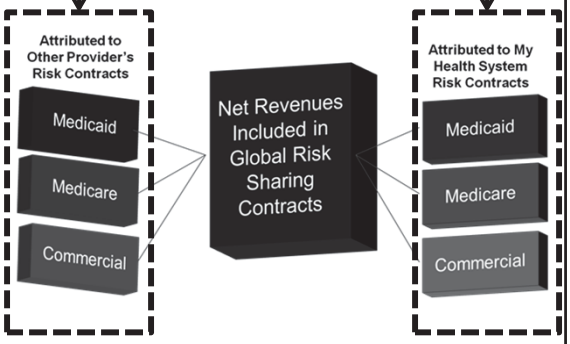
Key Opportunity

2. Global Risk Contacts = Opportunity to Increase Revenue

Due to Sharing of Gains from managing population costs

Global Risk Contracts allow us to share in gains (and losses) of changes in care delivery to manage population cost



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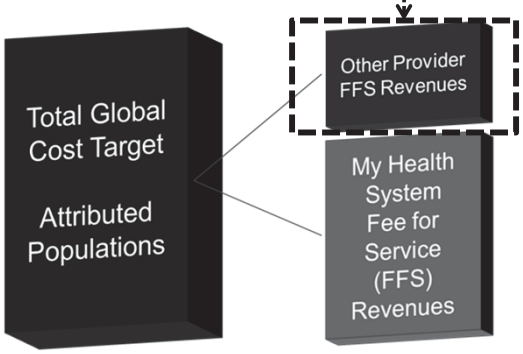
Key Opportunity

3. Keepage = Higher FFS Volumes

Due to Increase in Attributed Revenues going to My Health System

***Keepage** = more capture of attributed patient volumes in our Health System*



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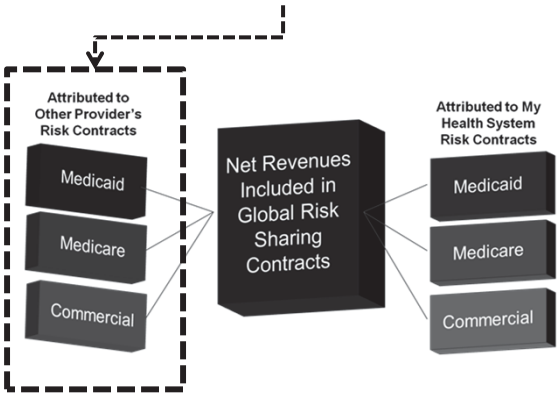
Key Risk

4. Leakage = Lower FFS Volumes

Due to changes driven by other Provider's care delivery changes and keepage

Leakage *= reductions in our FFS revenues due to volumes changes driven by other provider's care delivery changes and keepage*



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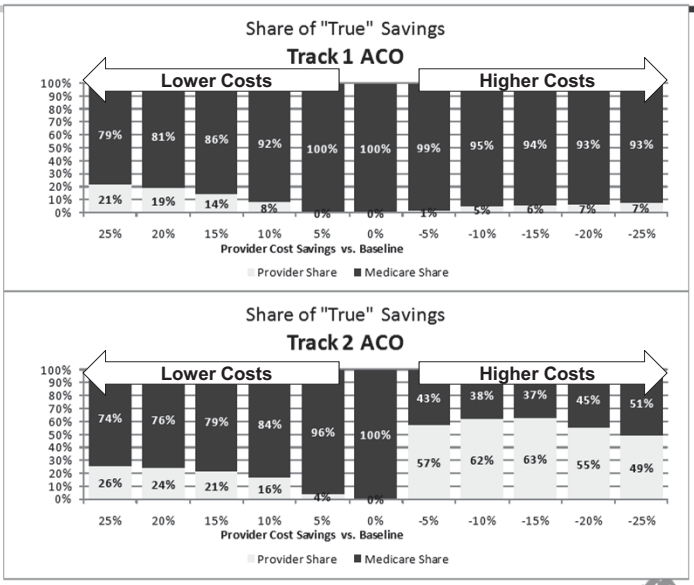
Provider vs. Medicare Share of "True" Savings

The WORST You Can Do➔ 30th Percentile in ALL 65 Domains!!!!



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Changing the Business Model

CASE STUDY: MODELING POTENTIAL IMPACTS OF ACO AND RISK BASED PAYMENT MODELS

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Key Financial Modeling Concepts: ACO and Risk Based Payment Arrangements

- Environment
  - Care Model Impacts
  - Baseline Keepage
  - Conversion of Payor Mix to Risk Based Contracts (RBC)
  - Timing of Impacts – Care Model vs. Revenue Model
  - Impacts of Other Providers ACO/RBC Arrangements
- Performance
  - Care Model Savings
  - Global Risk Sharing Parameters
  - Keepage
  - Leakage

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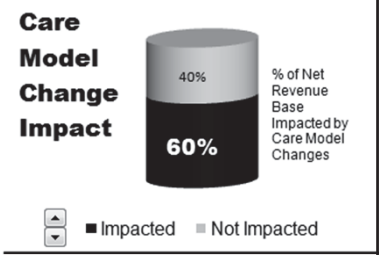
Key Concept: Care Model Impacts

- **Key Question:** What portion of my current revenue stream is impacted by the Care Model changes that will drive "savings" in a ACO or other total cost of care arrangement?
- **Remember → Your Revenue = Cost in a Total Cost of Care Model**



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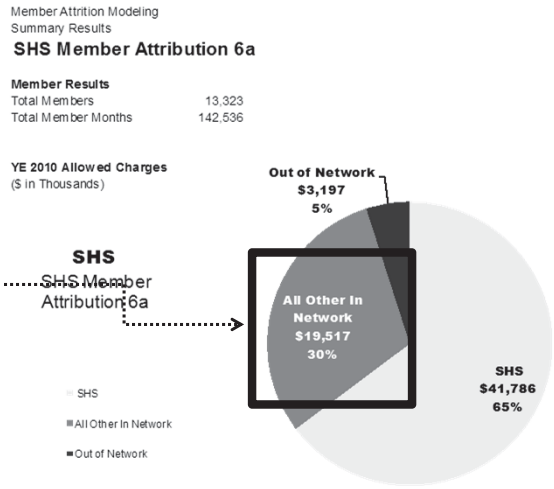
Key Concept: Keepage

- **Key Question:** What portion of services to "attributed" populations could I capture in my delivery system?



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Key Concept: % ACO / Risk Based

- **Key Question:** What portion of my total payor book of business is covered under ACO or risk based arrangements?
- **Key Question:** How can you capture gains provided to the self insured lives of a payor (not captured in typical risk based arrangements)?
- **Remember** → By default, 100% of care model savings pass to payors

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Key Concept: Timing Impacts

- **Key Question:** How aligned are my care model changes compared to my revenue model changes?

What are the financial implications if my care model impacts start 2 years before my contracting / revenue model changes?

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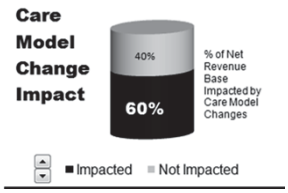
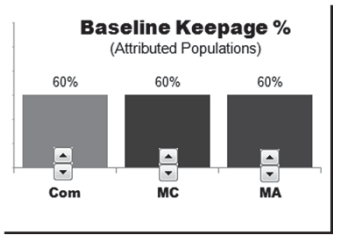
CLA Language of ACO and RBC Modeling

Environment Variables

ACO Environment Dashboard Elements





Variables Defined

Care Model Impact
% of Total Net Patient Revenues impacted by changes in care models

Example: If Our Care System has $500M of net patient revenues, then the setting at left imply that 60% ($300M) of that revenue is impacted by changes in care model.

Baseline Keepage %
For current attributed populations to Our Care System, was % of the total global cost of care is provided by Our Care System (and is Net Revenue to us)

Example: The settings at left imply that 55% of total patient revenues for attributed patients to Our Care System in Commercial, Medicare & Medicaid are captured by Our Care System. So, if we have $100M of attributed Commercial Revenue in our revenue base, then the total Global patient revenues ("Global Total Cost of Care") of that population would be $167M ($100/60%).

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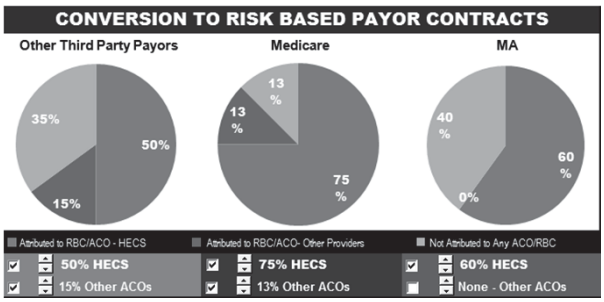
CLA Language of ACO and RBC Modeling

Environment Variables

ACO Environment Dashboard Elements



Variables Defined

Conversion to Risk Based Contracts
Define what % of our total net revenues by payor for Year 5 are…

- included in RBC / ACO payment arrangements (attributed to Our Care System)
- attached to other provider's ACO/RBC payment arrangement (attributed to other systems)
- not included in ACO/RBC payment arrangements

Example: Assuming we had total commercial payor net revenues of $100M, we've assumed $50M (50%) is with payors through risk based contracts, $15M (15%) are for patients attributed to other providers RBC/ACO arrangements, and $35M (35%) are included in more traditional "fee for volume" contacts.

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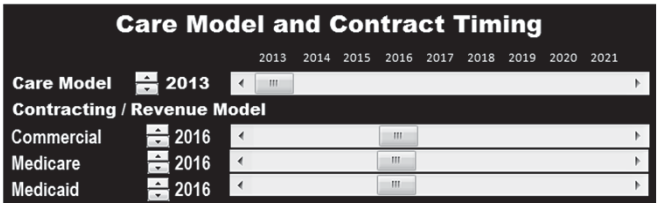
CLA Language of ACO and RBC Modeling

Environment Variables

ACO Environment Dashboard Elements



Variables Defined

Care Model and Contract Timing
Define the year in which care model and contracting model impacts are to begin to take effect.

Example: Based on the above settings, it is assumed that the care model changes begin in 2013 while the revenue contracts for Commercial, Medicare and Medicaid are not converted to risk based (global cost of care) contracts until 2016.

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Key Performance Considerations

- Care Model Impacts
  - "My Cost"
  - Downstream Costs to Other Providers
- ACO and RBC Gain/Loss Share %
- **How do I impact payors not covered under ACO or RBC?**
- Keepage Impacts
- Leakage Impacts

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CLA Language of ACO and RBC Modeling

Performance Variables

ACO Performance Dashboard Elements	Variables Defined
☑ Include Risk Based Contracts	Variable Defined
CARE MODEL IMPACTS ON GLOBAL COSTS	
50% of Baseline Growth Included in Global Target	% of our baseline growth that is attributed to higher "per patient" costs (i.e reduces our future gain share or increases our future loss share)
Our Care System Care Model Savings	Savings in Global Health Costs due to reductions in utilization of services provided by Our Care System (i.e. reductions in OUR Net Patient Service Revenues)
☑ 10.0% Care Model Savings	
Other In / Out Network Care Model Savings	Savings in Global Health Costs due to reduction or elimination services provided by other providers to our attributed patients (note - this does NOT include impacts of services we keep "Keepage")
☑ 5.0% Care Model Savings	
GLOBAL RISK SHARE PARAMETERS	
☑ Commercial: 60.0% Provider Gain Share	Our overall share of gains and losses on global risk contracts
☑ Non RBC = FFS RBC + 2.0% /Yr for 3 Yrs	Our increased pricing (over baseline) for payors that we don't have risk based contracts with in the future
☑ Medicare: 2 Sided *51% Provider Gain Share* 70-80th ACO Quality Achievment	Our overall share of gains and losses on global risk contracts as part of Medicare ACO arrangements
KEEPAGE (by HECS) ☑ Com ☑ MC ☑ MA MA 55% 62% MC 55% 62% Com 55% 62% ■ Base ■ Increase Target ☑ IP 25% ☑ OP 30% ☑ MD 20%	Volumes currently provided to our attributed patients by outside providers that is "captured" by Our Care System
LEAKAGE (Keepage by Other Systems)	Volumes current provided by Our Care System that are either captured or reduced by other ACO / RBC providers
☐ *All Payors: No Net Loss*	

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Example Impact: Changes in Care Model + Changes in Revenue Model

Margin Impact: Risk Based Contracts

	2012	2013	2014	2015	2016
Population Cost Mgmt	$0.0M	($6.2M)	($19.0M)	($26.1M)	($26.7M)
Gain (Loss) Share	$0.0M	$0.0M	$1.4M	$7.6M	$12.9M
Higher Non RBC Rates	$0.0M	$8.7M	$18.3M	$29.0M	$30.3M
Keepage	$0.0M	$2.0M	$8.1M	$16.6M	$21.6M
Leakage	$0.0M	$0.0M	$0.0M	$0.0M	$0.0M
TOTAL NET	$0.0M	$4.5M	$8.8M	$27.1M	$38.1M

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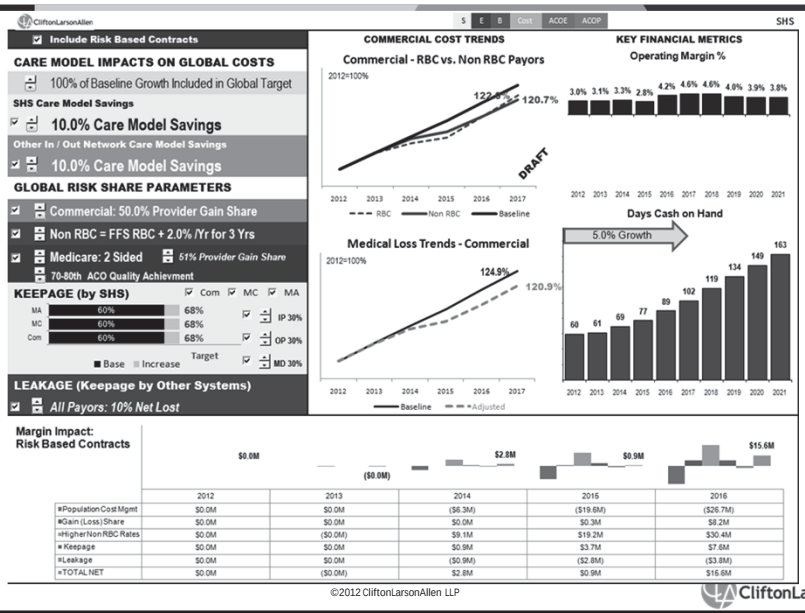
Alternative A:
Aggressive Care Model / Aggressive RB Payor Contracts/Capture and Keepage



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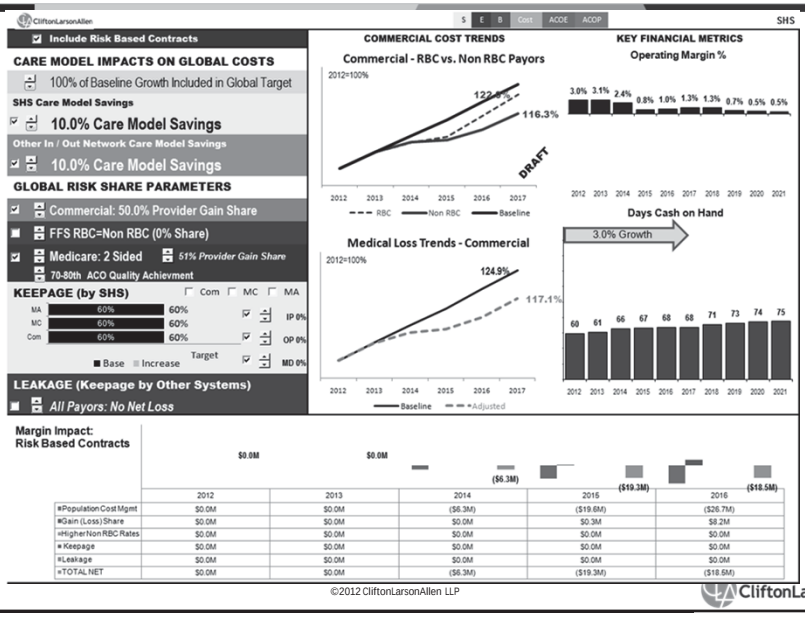
Alternative B:
Aggressive Care Model / Limited RB Payor Contracts and Keepage



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Discussion and Questions

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Lunch Presentation: The New Health Age: The Future of Health Care in America

Jonathan D. Fleece

Jonathan Fleece

Attorney and Advisor

Blalock Walters

Jonathan Fleece is a leading health care attorney and advisor, located in Tampa Bay Florida. Mr. Fleece regularly manages health care transactions, such as sales, purchases and other types of integration. He is also an expert in Health Care Reform Laws and the Patient Protection and Affordable Care Act (PPACA). His consulting services include advising health care companies how to strategically plan for success during the sweeping changes that are coming in health care over the next decade. Mr. Fleece engages with clients to optimize their performance in the areas of operations, legal compliance, and reimbursements.

He received his Law Degree and Certificate in Health Law Studies from St. Louis University School of Law. Mr. Fleece, a shareholder of his law firm, is a Florida Board Certified Health Care attorney, and has years of experience in various health care settings, including a non-profit academic medical center with a large physician group practice and hospital. Mr. Fleece has extensive experience providing strategic counsel to numerous companies in the health care space, including physician medical groups, hospitals, hospice providers, physical therapy companies, health care management companies, and ancillary health care providers.

Mr. Fleece is a member of the American Bar Association, the Florida Bar, the Florida Bar Health Law Certification Committee, the Missouri Bar, the Illinois Bar, American Health Lawyers Association, the Manatee County Bar Association and the Sarasota County Bar Association. He serves as special counsel to the Manatee and Hernando County Medical Societies. Jonathan currently serves on the Board of Directors of Tidewell Hospice, Inc. He is Committee Chair for the Manatee Chamber of Commerce Health Care Committee and serves as Treasurer for the Chamber. He was recently elected to Chair the board of the newly formed, Manatee County Healthcare Alliance, Inc., which will bring regional leaders together to improve health care in Manatee County. Mr. Fleece regularly speaks at Florida Medical Association events. Mr. Fleece is Past-Chair of the Manatee County Economic Development Council and a current EDC Trustee. He is a prior Ear Research Foundation Director, and is a former Vice Chair of We Care Manatee, Inc. Mr. Fleece is also a graduate of the Tampa Bay Partnership's CEO Direct Program.

Mr. Fleece is the co-author of a recently published book, The New Health Age: the Future of Healthcare and Medicine in America, with the acclaimed futurist, author, and speaker, David Houle. www.thenewhealthage.com

The New Health Age:
The Future of Health Care in America

Jonathan Fleece
Co-Author
Advisor
Health Care Attorney

Inflection Point in History

- New Century
- New Age → The Shift Age
- New Decade → The Transformation Decade
- New Millennium

THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW
WE MAKE A DIFFERENCE

Four Ages of Modern Man

- Agricultural Age 10,000 years ago
- Industrial Age 300 years ago
- Information Age 30 years ago
- Shift Age 2006 →

THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW WE MAKE A DIFFERENCE

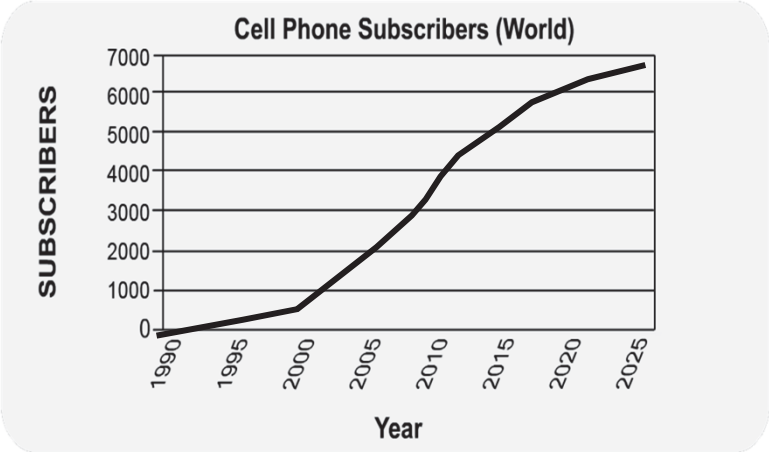
Three Fundamental Forces of the

- The Flow to Global
- The Flow to the Individual
- Accelerated Connectedness

THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW WE MAKE A DIFFERENCE

Cell Phone Growth



THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW WE MAKE A DIFFERENCE

The Transformation Decade: 2010-2020

- Transformation: “A change in nature, shape, character or form”
- Humanity and most of its institutions will be transformed
- First decade of 21st century thought

THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW WE MAKE A DIFFERENCE

80% Accepted/ 20% to Go

- Health Care is about 18% of America's GDP
- All the technological, connectivity, productivity and communications transformations we have accepted in the 80% of our economy are now coming to the 20% that is health care

THE NEW HEALTH AGE ADVISORS

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The Current Landscape of Health Care in America

"America's state of health, the economic models driving health care choices and costs, and America's health care delivery systems do not adequately foster the right ***incentives*** *for American Stakeholders to* ***(1) increase the quality of their health, (2) improve health care service to everyone, or (3) control health care costs.*** *This reality is contributing to the rapid decline of America's pride, financial strength, and competitive advantage in a global marketplace. It is, therefore, essential for America to acknowledge, embrace, and foster The New Health Age."*

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Who Are America's Health Care Stakeholders?

- American companies of all sizes
- Individuals of every age - young, old and in between
- Public and private sectors
- Workers and employers
- Unemployed and employed
- Patients and health care providers, including physicians, nurses, hospitals, and long term care providers
- Payers and their beneficiaries
- Teachers and students
- Governments and citizens

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The Dynamic Flows of the New Health Age

- There are nine dynamic flows that are and will reshape health care in the New Health Age
- They are grouped into three categories:
  - How we THINK about health care
  - How we DELIVER health care
  - The ECONOMICS of health care

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The Dynamic Flows About How We THINK About Health Care

Sickness → Wellness

Ignorance → Awareness/Understanding

Opposition → Alignment

The Dynamic Flows About How We DELIVER Health Care

Treatment → Prevention

Reactive → Proactive

Episodic → Wholistic

The Dynamic Flows of the ECONOMICS of Health Care

Procedures → Performance

Isolation → Integration

Non-Efficient → Efficient

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The New Structure of Health Care

1. Medical Homes
2. Integrated Delivery Systems (IDS)
3. Accountable Care Organizations (ACOs)
4. Employer ACOs (EACOs)
5. Health Insurance Exchanges

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Medical Homes

"Medical homes will function at the center of health care and be the catalyst for community-based collaborative care networks, expanding access to primary care and general health care services."

- David Houle and Jonathan Fleece
"The New Health Age: The Future of Health Care in America"

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Medical Homes

- Not physical structures
- Physician driven
- Patient centered
- Coordinated care
- Appropriate care

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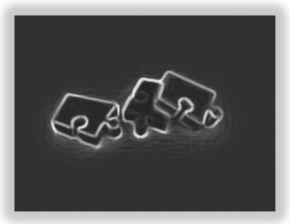
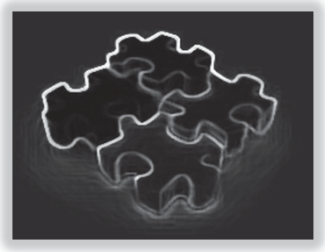
Integrated Delivery Systems





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Accountable Care Organizations

- Think of top health care players coming together to collaborate in a board room
- Agree on sharing bundled, capitated, and performance bonus payments
- Contract with payers (government and private)
- Appropriate care
- Performance based

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Employer Accountable Care Organizations (EACOs)

- Employer funded health care benefit plans
- New world around health management
- Health care network design and partnering
- Absenteeism management
- Workforce productivity oriented

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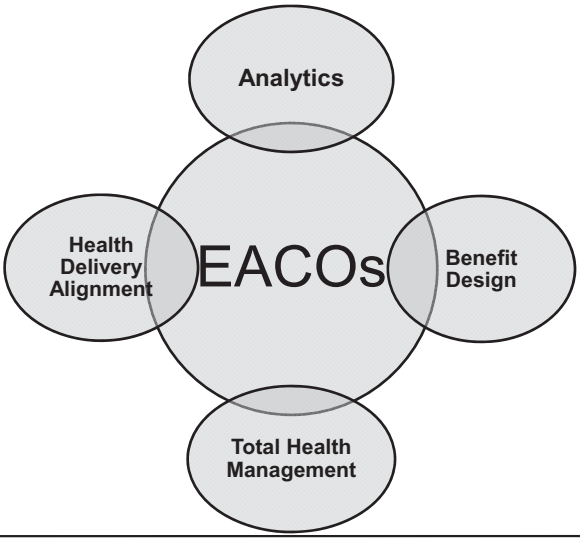
EACOs



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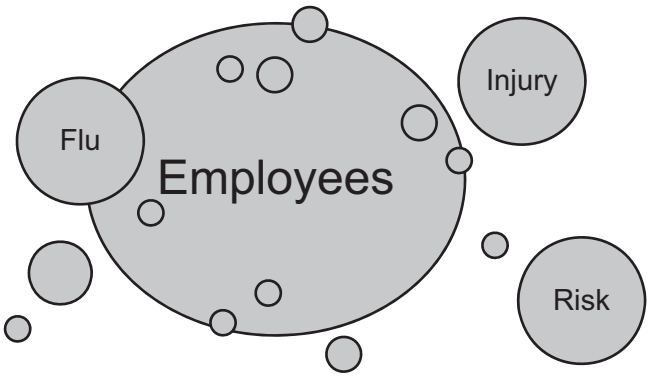
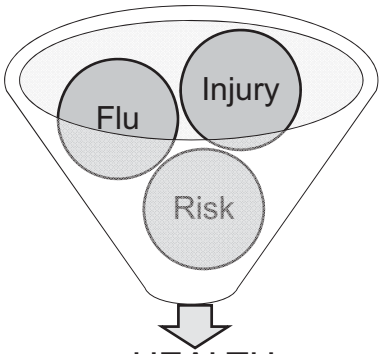
Workforce Health Management Today



THE NEW HEALTH AGE ADVISORS

BLALOCK WALTERS ATTORNEYS AT LAW WE MAKE A DIFFERENCE

Workforce Health Management Tomorrow



HEALTH MANAGEMENT

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Health Insurance Exchanges

- Travelocity, Expedia, Orbitz for health care insurance
- Shopping place for small business and "free riders"
- Must address health management
- State supported or Fed supported

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THE RACE to a HEALTHY AMERICA SM

- **The New Health Age version of the Race to the Moon**
- **Goal: to make America the healthiest country in the world by 2025**

www.theracetoahealthyamerica.org

THE NEW HEALTH AGE ADVISORS
Welcome to
The New Health Age!
Thank you!
jonathan@newhealthageadvisors.com
@JonathanFleece
941.920.0404

Breakout 4: The New AICPA Audit and Accounting Guide for Health Care Entities is Here!

C. Cline Comer, CPA

C. Cline Comer, CPA

Partner

LarsonAllen

Cline Comer serves as a Partner with LarsonAllen, specializing in business consulting and audit and accounting engagements for health care organizations.

Cline has over 30 years in public accounting, substantially all of which have been concentrated in the health care industry. He has been responsible for hundreds of engagements with hospitals, health systems, senior service organizations and other health care clients including both engagement responsibility and concurring review responsibility. He serves as the Accounting and Auditing Quality Principal for LarsonAllen's national hospital audit and accounting practice and is a member of the firm's Accounting and Auditing Quality Committee. In addition to engagement responsibility, he has consulted with a number of health care clients served by other LarsonAllen offices on a wide range of issues.

In addition to hospital and health system audit engagements, Cline has considerable experience serving senior health providers, performing feasibility studies and preparing forecasts and projections, working with bond counsel and underwriters on bond issues and refinancings, and tax issues of not-for-profit organizations.

Cline has a Bachelor of Science in business administration with a concentration in accounting from the University of North Carolina at Chapel Hill. His professional affiliations include membership in the American Institute of Certified Public Accountants (AICPA), the North Carolina Association of Certified Public Accountants (NCACPA), the Health Care Financial Management Association, the North Carolina Hospital Association and the American Hospital Association. He is currently serving a second term as a member of the AICPA Health Care Expert Panel and Audit Guide Task Force and also serves as a reviewer for the annual revisions to the AICPA Health Care Audit Guide and the annual AICPA publication, Health Care Industry Developments. He served on the AICPA Alternative Investments Task Force, the Private Companies Practice Section (PCPS) Technical Issues Committee, was a member of the Task Force that developed SOP 98-3, "Audits of States, Local Governments and Non-Profit Organizations Receiving Federal Awards," and served as a member of the Governmental Accounting and Auditing Committee. In addition, he is currently serving as a member of the Governmental Accounting Standards Advisory Council (GASAC). As a member of the NCACPA, Cline is further involved by participating on their Health Care Committee, the Governmental Accounting and Auditing Committee and as Chair of the Professional Ethics Committee.

Breakout 5: Hospital and Physician Alignment

George C. Batalis, CPA
and
Jeff Whitcomb

George Batalis, CPA

Director, Health Industries Advisory

PricewaterhouseCoopers LLP

Mr. Batalis is a Director with PricewaterhouseCoopers LLP ("PwC") in the Health Industries Advisory practice at PwC. George's experiences are focused in strategy and planning for Health Care providers.

Mr. Batalis has successfully managed and facilitated hospital and physician relationship deals for various specialties including but not limited to anaesthesiology, cardiovascular, emergency medicine, inpatient medical management, gastroenterology, orthopaedics, oncology and urology. Partnering relationships include traditional joint ventures, management contracts, management companies, employment arrangements, directorships and leasing arrangements.

In addition, George has overall Health Care strategy planning experience in identifying and implementing market expansion projects for hospitals and physician practices, analyzing hospitals and physician practice operations from a financial and operational perspective and providing recommendations around improving profitability thru full service line assessments.

George earned a full athletic football scholarship from Indiana University and holds his Bachelor's degree in Accounting and Finance from Indiana.

George is currently a licensed CPA in the States of Florida and Indiana.

Associations: AICPA, FICPA and HFMA.

Advisory April 26th, 2012

FICPA Health Care Industry Conference
Hospital & Physician Alignment

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Private and Confidential

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Table of Contents

Section		Page
1	Why Hospitals and Physicians are Aligning	3
2	Co-Management Model	6
3	Physician Employment	15
4	Trends for Hospital/Physician Alignment	23
5	Questions	27

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Section 1

Why Hospitals and Physicians are Aligning

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Factors Driving Hospitals to Collaborate With Physicians

Better Alignment between hospitals and physicians through the vehicles discussed today will better prepare physicians and hospitals/health systems to address potential changes in the delivery of healthcare such as:

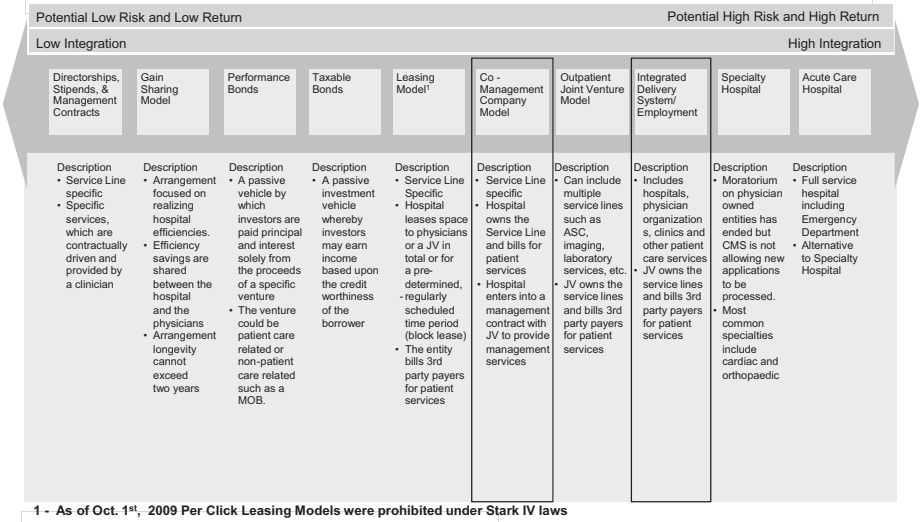
Factors driving hospitals to collaborate with physicians:

- Readiness for Health Reform Changes (i.e. Accountable Care Organizations, Bundled Payments, Readmission Rates, etc.)
- Improves a hospital's ability to compete for admissions
- Secure loyalty from physicians
- Improve quality of care
- Control the cost of care
- Gain leverage with health plans in rate negotiations

Factors driving physicians to partner with hospitals:

- Potential to stabilize (or increase) their income beyond their professional fees
- Readiness for Health Reform Changes (i.e. Accountable Care Organizations, Bundled Payments, Readmission Rates, etc.)
- Increase productivity
- Improve leverage in gaining entry to private insurers' provider networks and negotiating better payment rates

Model Options for Hospital/Physician Alignment



1 - As of Oct. 1st, 2009 Per Click Leasing Models were prohibited under Stark IV laws

Section 2

Co-Management Model

What is the Co-Management Model?

A co-management agreement is a type of arrangement in which a contract is put in place between the hospital and physicians for the management of a service line, development of new programs and the improvement of quality and operational metrics at a hospital or health system. Two types of co-management arrangements are typically utilized:

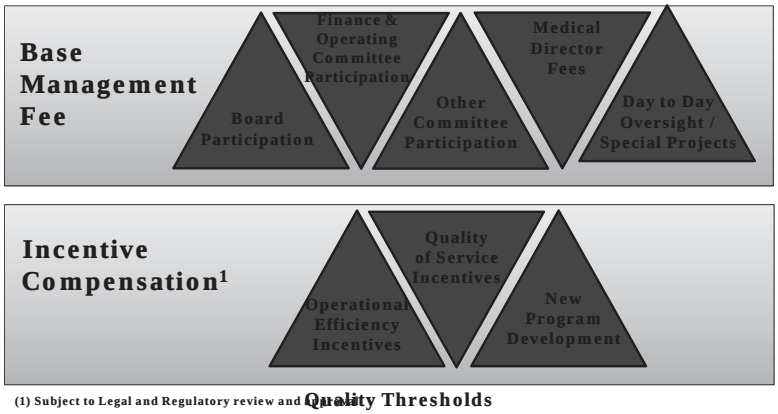
- Co-Management Contract

  A co-management contract is an agreement where the hospital directly contracts with a physician group (or an LLC formed by various physicians) for the physicians to manage a hospital service line

- Co-Management Company

  A co-management company is a type of joint venture where the hospital and physicians together form an LLC and share in the day to day management of a hospital service line

Co-Management Compensation Components

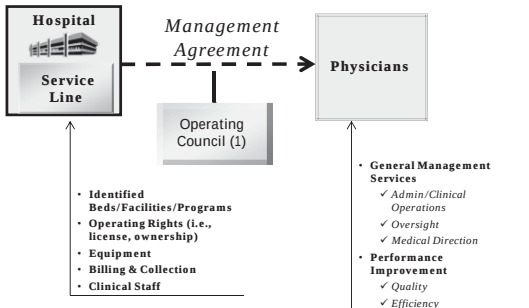


(1) Subject to Legal and Regulatory review and Quality

What is the Co-Management Model?

	Co-Management Company	Co-Management Contract
New Entity Formed With The Hospital	Yes	No
Ownership	Both the hospital and physicians	Physicians only
Governance	Shared between the hospital and physicians	Primarily physicians
Committee Structure	Committees formed in order to appropriately manage the program (i.e. Finance & Operations Committee, Quality Committee, etc)	A joint operating committee would be formed to ensure hospital and physician collaboration. In addition, committees similar to the co-management company can be utilized
Physicians Play a Direct & Active Role in Daily Management of the Service Line	Yes	Yes
Initial Capital Investment Required by Physicians	Yes - a minimal physician investment is required	No
Management Agreement Compensation	Base management fee + incentive compensation	Base management fee + incentive compensation

Management Contract Example Organizational Structure

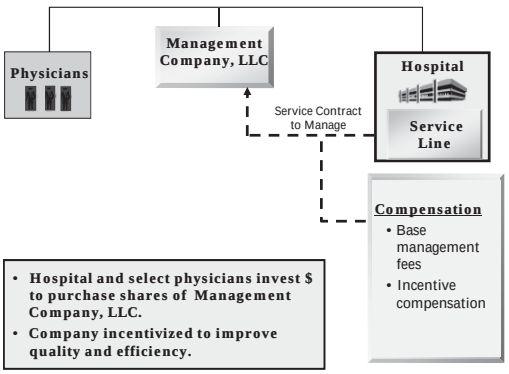


1 – Comprised of both physicians and hospital representatives

Benefits

- Allows for direct compensation to physicians to manage the service line.
- Allows for direct compensation to physicians for improved operational efficiencies and needed cost.
- Potential to increase physician productivity, through improved operational and clinical outcomes.
- Creates framework for service line and physician practice succession planning.
- Limited capital investment requirements, limits physicians 'at risk' investment.

Management Company Example Organizational Structure



Benefits

- Allows for direct compensation to physicians to manage the service line.
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- Potential to increase physician productivity, through improved operational and clinical outcomes.
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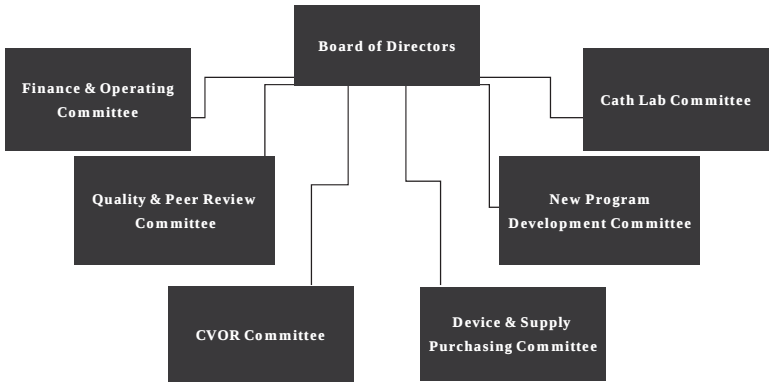
Potential Co-Management Company Governance Structure (Cardiovascular) Example



Co-Management Example Incentive Compensation

Quality Performance Elements	Operational Efficiency Elements	New Program Development
• Complication rates • Timeout and Patient Identification • Infection rates • Demand matching • Mortality rates • Patient satisfaction • Readmission rates • Pharmacy formulary & protocol development • SCIP measures • Core measures	• OR Room utilization • Turnover rate • Throughput • Length of stay (commercial patients only) • First morning start times • Protocol and care pathway standardization • Block utilization • On time start rate • Staff hours per case • Patient prep time • Wait time • Medical record compliance • Cancellation rates • On-call coverage schedule maintenance and compliance • Utilization of block schedules • Cost/Case (commercial patients only) • Staff turnover • Cost/Discharge (commercial patients only)	• Completed business plans • Development of community partners • Community outreach • Marketing programs • Research trial participation • Develop other programs

Co-Management – Pros & Cons

PROS	CONS
• Structure is the foundation/beginning of a long term relationship between the hospital & physicians • Provides "flexibility" to Hospital and Physicians for future collaborative initiatives • Structure positions the hospital and physicians to address Health Reform together • Not a passive investment, requires active participation by the physician • Quick to execute, no construction • Improved communication between Hospital & Physicians • Provides a mechanism for Physicians to play an active role in managing the service line • Lower capital investment requirements than other models like "traditional" joint ventures	• Not a passive investment, requires active participation by the physicians • Lack of familiarity with the co-management company concept • May not be enough of a monetary return to satisfy the physicians

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Section 3
Physician Employment

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Physician Employment

Physician employment has become an attractive model due to the reimbursement climate, regulatory environment and dependencies between hospitals and physicians:

Physician Drivers:

- Declining reimbursement
- Sky-rocketing cost of malpractice insurance
- Increase physicians' productivity
- Better leverage in gaining entry to private insurers' provider networks and negotiating better payment rates

Hospital Drivers:

- Reimbursement under Provider Based Status
- Hospitals desire to fundamentally improve patient care and clinical outcomes (currently a portion of hospitals revenues at risk for quality measures with an increase portion in the near future)
- Proactively gain long-term relationship with key physicians in the community (physician loyalty)
- Improve quality of care
- Control cost of care
- Gain leverage with health plans in rate negotiations

Drivers for Both:

- Begin to build some income security
- Secure and improve the relationship between hospitals and physicians
- Prepare for future health reform (i.e. Accountable Care Organizations, Bundled Payments etc...)

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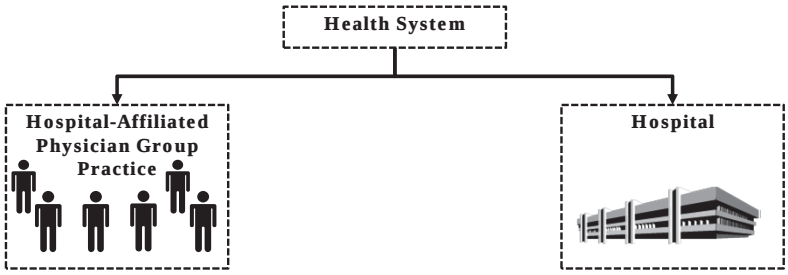
Types of Physician Employment

- Full Employment*- Acquire Assets and Staff
- Full Employment*- Lease Assets and Staff
- Professional Services Agreement*- Acquire Assets and Staff
- Professional Services Agreement*- Lease Assets and Staff

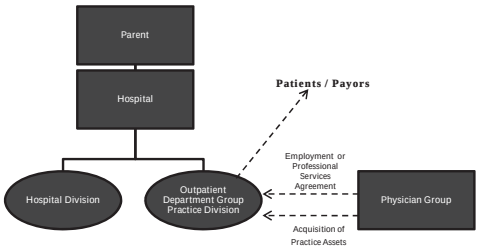
** Along with physician employment, there are also Provider Based Designation Considerations – Convert the entire practice or ancillaries only*

Physician Employment Example Organizational Structure



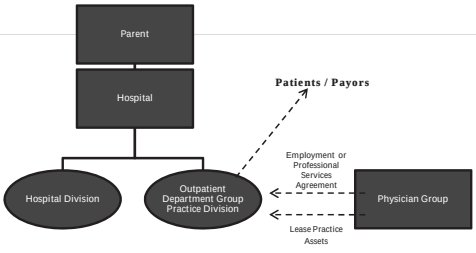
- Employs primary care physicians and specialists
- Physician is paid market (private practice competitive) compensation
- Can be set-up as Provider Based Clinic or as a Free Standing practice

Provider Based Clinics: Hospital Outpatient Department's Acquisition of Physician Group



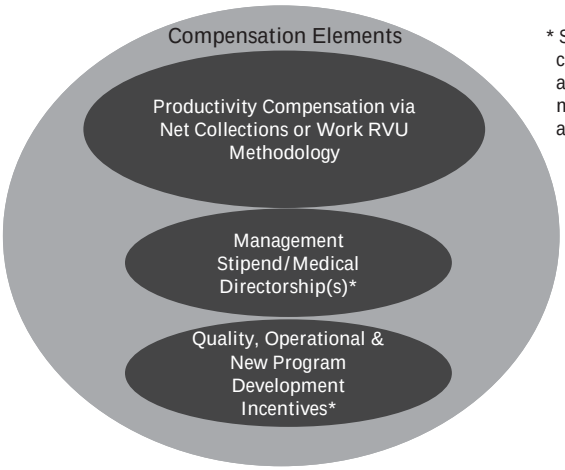
- Group Practice Program operated as outpatient department and division of Hospital.
- Hospital receives facility fee for outpatient department "clinic" services. Physician fees subject to site of service differential.
- Hospital acquires practice assets from the Physician Group for its outpatient department. Note: Physician building and land would not be acquired; just the hard assets of the practice.
- Outpatient Group Practice Division obtains physician coverage through Employment Agreement with the Physicians or professional service agreement.
- Subject to hospital licensing and TJC requirements.
- Subject to medical staff oversight.
- Employment of non-physician staff may be required to achieve provider based status

Provider Based Clinics: Hospital Outpatient Department Leases Physician Group Practice Assets



- Group Practice Program operated as outpatient department and division of Hospital.
- Hospital receives facility fee for outpatient department "clinic" services. Physician fees subject to site of service differential.
- Hospital leases practice assets from the Physician Group for its outpatient department.
- Outpatient Group Practice Division obtains physician coverage through Employment or Professional Services Agreement with Physician Group.
- Subject to hospital licensing and TJC requirements.
- Subject to medical staff oversight.
- Employment of non-physician staff may be required to achieve Provider Based Status

Potential Physician Employment Compensation Structure



* Structured through employment contract or professional services agreement and consistent with a co-management company/contract with a hospital.

Physician Employment – Pros & Cons

PROS	CONS
• Provides greater control of physicians' practice and referrals • Structure positions the hospital and physicians to address Health Reform together • Reduces areas of hospital and physician conflict and competition • Fundamentally improve patient care and clinical outcomes • Create operational efficiencies and drive high costs out of the health system • Rapidly attract new services and technology to the market • Possible conversion to provider based status	• Operational costs can be significant • Difficult to include certain specialists in income opportunities from ancillary services • Developing compliant productivity compensation models can be difficult • Hospital is liable for physician malpractice • Physicians may view employment as reducing their autonomy and control of their practice • Possible disadvantages of provider based status (higher co-pays, patient confusion, etc)

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Section 4

Trends for Hospital/Physician Alignment

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Bundled Payment Models

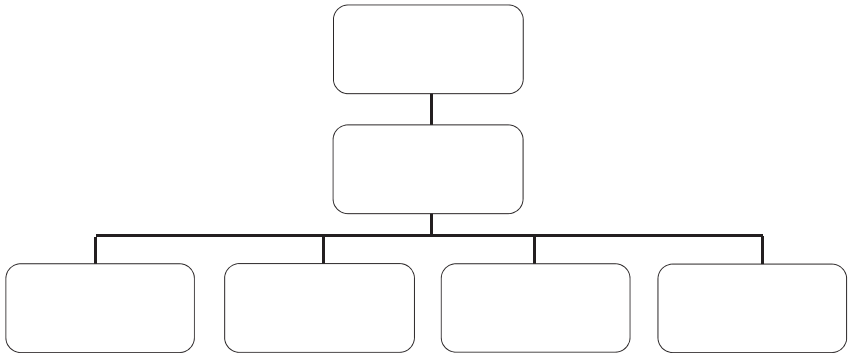
- Medicare pays a single provider entity composed of a hospital and its affiliated physicians an amount intended to cover the costs of providing the full range of care needed over the episode.
- Providers not only are motivated to contain their own costs but also have a financial incentive to collaborate with their partners to improve their collective performance.
- Providers involved in the episode could develop new ways to allocate this payment among themselves. This flexibility gives providers a greater incentive to work together and to be mindful of the impact their service use has on the overall quality of care, the volume of services provided, and the cost of providing each service.
- Encourages doctors, hospitals and other health care providers to work together to better coordinate Medicare patients care.
- Gainsharing allowed during duration of the bundled project (Estimated 3-5 years)
- Four Models
  - Model I – Pertains to care during the hospital inpatient stay
  - Model II – Both inpatient admission and post discharge
  - Model III – Post discharge care only
  - Model IV – Pertains to care during the hospital inpatient stay

Accountable Care Organizations (ACO's)

- Intended to promote accountability for a population of Medicare beneficiaries, improve coordination of fee for service care, and encourage investment in infrastructure and redesign care
- A combination of a hospital, primary care physicians, and possibly specialists. Potential ACOs include:
  - Integrated Delivery Systems (IDS)
  - Physician Hospital Organizations (PHO)
  - Hospital plus multispecialty groups
  - Hospital and independent practices
- Associated with a defined population of patients
- Accountable for total Medicare spending and quality of care for that patient population
- CMS Pilot Program - 32 awarded

Physician Division

A hospital will need to develop and manage the physician division like any other part of the health system to address future health reform legislation and increased physician integration. The time is now to prepare.



** Includes Billing & Collections, Operations, Human Resource, Financial Management and Information Technology*

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Section 5
Questions

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Jeff Whitcomb, Manager, PwC; **(813) 222-6258; jeff.whitcomb@us.pwc.com**

Breakout 6: The Calm Before the Next Malpractice Storm

Matt Gracey

Matt Gracey

Malpractice Insurance Specialist

Danna-Gracey

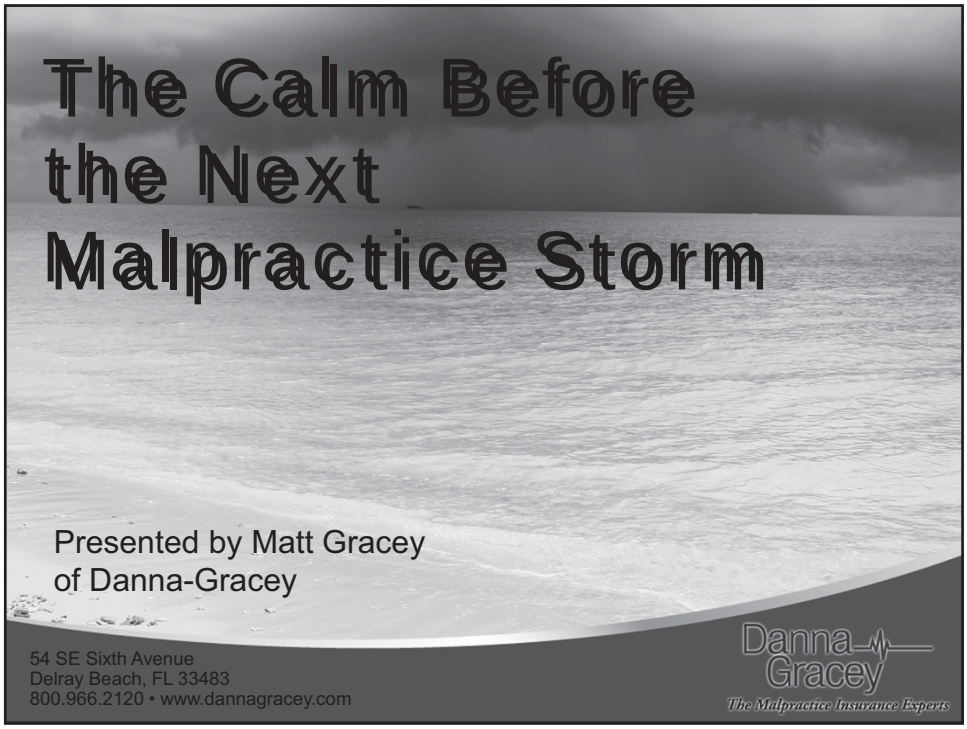
Medical Defense Solutions, MDS

Matt Gracey is CEO of Danna-Gracey, an independent boutique insurance agency specializing in medical malpractice and workers' compensation insurance coverage for Florida's doctors.

Having held an insurance license for over thirty years in Florida. Mr. Gracey is dedicated to serving the medical community on many fronts, including matching the most appropriate insurer for each client's particular specialty, practice profile, and claims history.

Matt has created a number of insurance purchasing alliances for Florida physicians. These include programs for three county medical societies and numerous regional medical associations, single specialty networks including a 250 doctor ENT group, The Network of Florida Otolaryngologists, plus a number statewide medical associations including the Florida Orthopaedic Society and Florida Gastroenterologic Society.

As a speaker and writer, Matt is actively involved, both locally and statewide, in seeking solutions to some of healthcare's most pressing issues. He appears regularly at medical conferences and writes a regular column for South Florida Hospital News, as well as regularly contributing to a number of other publications. He is very active politically and financially in local, regional, and statewide tort reform efforts. He continues to strongly encourage physicians to unite behind organized medicine and has become a loud voice for political and judicial change.



Let the Good Times Roll!

- Low rates: Up to 60% lower than in 2005
- More choices of insurers; much more competitive climate
- Loose underwriting
- Expanded coverage; bells and whistles!

Danna Gracey
The Malpractice Insurance Experts

Even Turkeys Fly in a Stiff Wind!

- New, unrated, undercapitalized insurers enjoying the flight
- Market differences difficult for buyers
- Marketing messages becoming more “creative”

Danna Gracey
The Malpractice Insurance Experts

Reality Will Strike

- Loss ratios increasing as pricing decreases
- Reserve takedowns dwindling
- Market shrinking as doctors retire, sell out to hospitals, go bare, or retire

Danna Gracey
The Malpractice Insurance Experts

Hospital Employment Med Mal Issues

- Tail purchase considerations
- Hospitals take over defense of their doctors; not always favorable
- Hospitals' outside-referral-system issues

Danna Gracey
The Malpractice Insurance Experts

EHR Med Mal Issues

- Hospital EHR evaluations vs. doctors' clinical approach
- Level of tort oversight going skyward!
- Communications issues at the core of many med mal cases

Danna Gracey
The Malpractice Insurance Experts

Inevitable Next Med Mal Crisis

- When, not if
- The herd runs off the cliff, then…
- Things get ugly
- Last-crisis highlights

Danna Gracey
The Malpractice Insurance Experts

Recommendations

- Move to high ground!
- Plan now to avoid being uninsurable, or unable to afford coverage
- Coverage options
- Bare options
- Counterintuitive acts

Danna Gracey
The Malpractice Insurance Experts

Enjoy the Party While it Lasts!

- Historically low rates
- Buyer's market!

Danna Gracey
The Malpractice Insurance Experts

Danna Gracey
The Malpractice Insurance Experts

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Breakout 7: The New AICPA Audit and Accounting Guide for Health Care Entities is Here! (Part II)

C. Cline Comer, CPA

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Partner

LarsonAllen

Cline Comer serves as a Partner with LarsonAllen, specializing in business consulting and audit and accounting engagements for health care organizations.

Cline has over 30 years in public accounting, substantially all of which have been concentrated in the health care industry. He has been responsible for hundreds of engagements with hospitals, health systems, senior service organizations and other health care clients including both engagement responsibility and concurring review responsibility. He serves as the Accounting and Auditing Quality Principal for LarsonAllen's national hospital audit and accounting practice and is a member of the firm's Accounting and Auditing Quality Committee. In addition to engagement responsibility, he has consulted with a number of health care clients served by other LarsonAllen offices on a wide range of issues.

In addition to hospital and health system audit engagements, Cline has considerable experience serving senior health providers, performing feasibility studies and preparing forecasts and projections, working with bond counsel and underwriters on bond issues and refinancings, and tax issues of not-for-profit organizations.

Cline has a Bachelor of Science in business administration with a concentration in accounting from the University of North Carolina at Chapel Hill. His professional affiliations include membership in the American Institute of Certified Public Accountants (AICPA), the North Carolina Association of Certified Public Accountants (NCACPA), the Health Care Financial Management Association, the North Carolina Hospital Association and the American Hospital Association. He is currently serving a second term as a member of the AICPA Health Care Expert Panel and Audit Guide Task Force and also serves as a reviewer for the annual revisions to the AICPA Health Care Audit Guide and the annual AICPA publication, Health Care Industry Developments. He served on the AICPA Alternative Investments Task Force, the Private Companies Practice Section (PCPS) Technical Issues Committee, was a member of the Task Force that developed SOP 98-3, "Audits of States, Local Governments and Non-Profit Organizations Receiving Federal Awards," and served as a member of the Governmental Accounting and Auditing Committee. In addition, he is currently serving as a member of the Governmental Accounting Standards Advisory Council (GASAC). As a member of the NCACPA, Cline is further involved by participating on their Health Care Committee, the Governmental Accounting and Auditing Committee and as Chair of the Professional Ethics Committee.

Breakout 8: Maintaining Cash Flow During ICD-10 and HIT Conversions

Simon Hughes

Presentation Will Be Available
On-line After the Conference

Breakout 9: CIO Panel Discussion

Mary C. Ford, FHIMSS
and
Rick Schooler, FACHE, FCHIME

Rick Schooler, FACHE, FCHIME, MBA

Vice President & CIO

Orlando Health

Rick Schooler joined Orlando Health in October, 2001 as Vice President/Chief Information Officer. His current areas of responsibility include Information Technology, Telecommunications, Clinical Informatics, BioMedical Engineering, Supply Chain, Retail Pharmacy and a Group Purchasing Organization. Prior to joining Orlando Health, he was the Vice President and CIO for Central Georgia Health System. From 1991 to 1994, Rick served as Director of Systems Integration for the Methodist Hospital of Indiana. His previous employers also include Ameritech, General Dynamics, and Computer Systems Corporation.

Rick earned his Masters degree in Business Administration from the University of Indianapolis and his Bachelor of Science degree in Computer Technology from Purdue University.

Rick is a member of the following professional organizations: American College of Healthcare Executives (Fellow), College of Healthcare Information Management Executives (Fellow and former Board Member) and the Healthcare Information Management and Systems Society (Senior Member.)

Rick serves on the Board of Directors of the Central Florida Regional Health Information Organization (co-Founder and Vice Chairman) and recently served on the Board of Directors for the Health Care Center for the Homeless (Chairman – Orlando). He is also a member of the Industrial Advisory Board for the Purdue University College of Technology (department of Computer and Information Technology,) the KLAS CIO Advisory Board, the Healthcare Informatics magazine Editorial Board and the University of Central Florida Regional Extension Center (REC) advisory board.

There is no PowerPoint presentation for this session.

Breakout 10: IFRS: Prepare Your Organization for Adoption

Richard Stuart

Richard K. Stuart

Partner, National Professional Standards Group

McGladrey & Pullen, LLP

Summary of Experience

Richard Stuart is a partner in the National Accounting Standards Group of McGladrey & Pullen, LLP, where he develops Firm guidance and consults on a variety of complex accounting issues. His areas of expertise include revenue recognition (general and software), leasing transactions, asset impairments, fair value measurements, and International Financial Reporting Standards. Rich's responsibilities include consulting with clients and engagement teams on complex accounting issues associated with these subject matters, as well as facilitating related internal training. He also is responsible for monitoring standard setting by the Financial Accounting Standards Board (FASB) and International Accounting Standards Board. Rich is a member of the FASB's Valuation Resource Group (VRG) and also a former member of the AICPA's Financial Reporting Executive Committee (FINREC). He has also served on a number of task forces of the American Institute of Certified Public Accountants (AICPA), and working groups of the Emerging Issues Task Force (EITF).

Before joining the Firm, Rich worked for two major international companies in roles in which he was responsible for the development of accounting policies and establishing company positions on complex accounting matters.

Rich has experience as a project manager on the staff of the FASB, where he served on the Financial Instruments Team. In that role, Rich was responsible for the development and drafting of a number of financial accounting standards. Prior to joining the FASB staff, Rich served in a similar role as a Technical Manager in the Accounting Standards Division of the AICPA.

Rich also worked for Coopers & Lybrand, with his last position there being a manager in the National Accounting Office. His responsibilities in that role included researching complex accounting issues, developing guidance, and training staff and clients on new accounting standards.

In these positions, Rich has gained significant speaking experience at both internal training and external education sessions.

Professional Affiliations and Credentials

- Certified Public Accountant licensed in Connecticut
- Member of FASB's Valuation Resource Group
- Member of the AICPA
- Member of the Connecticut Society of Certified Public Accountants

Education

Bachelor of Science degree in accounting from Lehigh University in Pennsylvania

International Financial Reporting Standards

Florida Institute of Certified Public Accountants
Health Care Industry Conference
April 26, 2012

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McGladrey overview

- 5th largest accounting firm in the U.S.
- Provide assurance, tax and consulting services
- Nearly 6,500 professionals and associates in more than 70 offices nationwide
- US member of RSM International (RSMI) – 6th largest network of independent accounting, tax and consulting firms worldwide
  - 714 offices in 86 countries with more than 32,000 people

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Today's presenter

Richard Stuart, Partner
McGladrey & Pullen
National Accounting Standards Group

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Agenda

- Status of IFRS in U.S. 10 min
- Joint projects 35 min.
- Other issues/questions 5 min.

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Status of IFRS in U.S.

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May 2011—Exploring a Possible Method of Incorporation

- Various ways of incorporating
  - Full adoption of IFRSs as issued by the IASB (without review)
  - Full adoption after a transition period
  - Provide US companies with an option to adopt
  - Convergence approach
    - Gradual convergence of local accounting standards with IFRSs over time
  - Endorsement approach
    - Individual IFRS standards are incorporated into local GAAP using endorsement criteria

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May 2011—Exploring a Possible Method of Incorporation

- Convergence aspects
  - Address existing differences between U.S. GAAP and IFRS
  - Approach IFRS on an individual-standard basis
- Endorsement aspects
  - Newly issued IFRS
  - Modify IFRS as necessary
    - Public interest
    - Investor protection

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FASB and SEC Roles

- SEC Role
  - Continue statutory oversight role over FASB
  - Actively share standard-setting perspectives with IASB
  - Maintain authority to establish accounting standards
- FASB Role
  - Continue as U.S. national standard setter
  - Provide input and support to IASB
  - Develop transition plan to address existing differences

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Feedback Received

- Largely supportive of SEC's approach
- Retain a strong FASB role and US GAAP reference (contractual/regulatory burdens)
- Final decision in 2011
- Divergence on big bang vs. staggered
- Divergence on retrospective/prospective

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Recent Developments

- December 2011 AICPA and PCAOB conference
- February 2012 SEC Chief Accountant comments
- February 2012 SEC Chair comments

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Joint Projects

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Joint Projects—Estimated Timeline

Project	Pre-2012	First Half 2012	Second Half
Financial instruments			
Classification	U.S. ED IASB IFRS 9		ED
Impairment	FASB ED Joint Supplement		ED
Hedging	EDs	IASB Staff Draft	Final
Revenue	EDs	Roundtables	
Leases	ED		Revised ED
Insurance	FASB DP IASB ED		Revised ED
Consolidation	FASB ED IASB Final	IASB roundtable	FASB Final

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Revenue Recognition

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Revenue Recognition

- Exposure draft issued in June 2010
- Revised exposure draft issued in Nov. 2011 with comments due in March
- Final standard expected in early 2013

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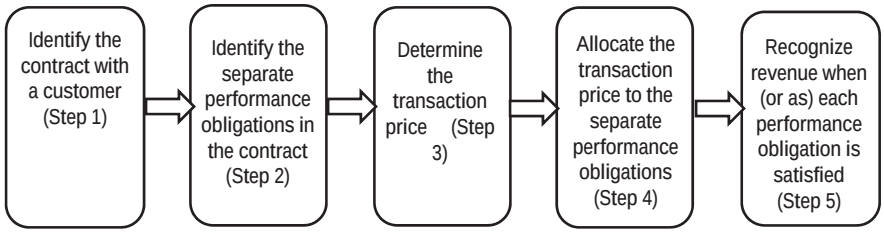
Revenue Recognition

- Scope
- Steps in applying the model



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1. Identify the contract with a customer

- Enforceable agreement between parties
- Can be written, oral or implied
- Combination
  - Required for contracts entered into at or near the same time if certain criteria are met
- Modifications
  - Treat separately if separate performance obligation is added and the consideration is consistent with its standalone selling price
  - Otherwise combine with remaining goods or services

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2. Identify separate performance obligations

- Promise in a contract to transfer a good or service
- Account for separately if distinct because either of the following criteria are met
  - Good or service is regularly sold separately by the entity; or
  - Customer can benefit from good or service on its own or together with other readily available resources
- However, bundle of promised goods or services is accounted for as one performance obligation if both of the following criteria are met:
  - Highly interrelated and require significant integration service; and
  - Significantly modified or customized to fulfill contract

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3. Determine the transaction price

- Amount of consideration to which an entity expects to be entitled from a customer
  - Variable consideration (e.g.; contingencies, rebates, royalties), estimate based on probability-weighted or most-likely amount
  - Time value of money
  - Noncash consideration
  - Consideration payable to a customer
- Collectibility not considered in transaction price
  - Record uncollectible amounts adjacent to revenue

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4. Allocate the transaction price

- Generally based on relative standalone selling prices of separate performance obligations
- Standalone selling price
  - Observable price when sold separately (best)
  - Otherwise, estimate based on:
    - Cost plus margin
    - Adjusted market assessment
    - Residual technique allowed if highly variable or uncertain
    - Others?
- Subsequent changes in the transaction price are allocated on a relative standalone selling price basis unless certain criteria are met

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5. Recognize revenue

- Recognize revenue as performance obligations are satisfied based on transfer of control
- Determine if satisfied (and revenue recognized) over time, based on whether entity's performance:
  - Creates or enhances an asset the customer controls; or
  - Does not create an asset with an alternative use and one of following criteria is met:
    - Customer receives a benefit as entity performs
    - Another entity would not need to reperform work completed to date
    - Vendor has right to payment for performance to date
- Select method of progress toward completion (output or input)

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5. Recognize revenue

- If prior criteria not met, then satisfied at a point in time
- Recognize revenue when customer obtains control based on following indicators:
  - Entity has right to payment
  - Entity has transferred physical possession
  - Customer has legal title and risks and rewards of ownership
  - Customer has accepted goods or services
- Recognize amount allocated to performance obligation except for certain variable consideration, which is limited to reasonably assured amount based on:
  - Experience with similar performance obligations
  - Whether that experience is predictive of outcome

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Health Care Specific Impacts

- Collectibility
  - Proposed presentation similar to ASU 2011-07
  - However, more than just patient service revenue
  - Also may accelerate recognition for transactions with uninsured patients (for those now on cash basis)
- Contract acquisition costs
  - Capitalization vs. present practice of expensing
- Onerous performance obligations
  - More frequent “onerous assessments”
  - Would be done on a contract-by-contract basis
- Disclosures

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Financial Instruments

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Classification and Measurement

- IASB issued IFRS 9 in November 2009
- Amended IFRS 9 in October 2010
- In November 2011, decided to make targeted improvements
- January 2012—decision to jointly redeliberate selected aspects
  - Contractual cash flows characteristics
  - The need, and basis for, bifurcating financial assets
  - Basis for (and scope of) a possible category to measure debt instruments at FVOCI
  - Interrelated issues
- Boards will continue discussions over next several months
- Potential ED in second half of 2012

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Classification and Measurement

- IFRS 9 Summary
  - Reduced categories to amortized cost or fair value
  - Debt instruments
    - Trading: FVNI
    - Hold: Amortized cost
  - Equity securities
    - Measured at FV
    - If not held for trading, option to record G/L in OCI
- In general, IFRS allows for greater use of amortized cost than U.S. GAAP

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Impairment

- Began joint deliberations in September 2010
- "Three bucket" approach
  - Bucket 1: Losses expected over next 12 months
  - Bucket 2: Lifetime losses evaluated collectively
  - Bucket 3: Lifetime losses evaluated individually
- Assets start in bucket 1 unless purchased w/explicit expectation of credit loss
- Move to bucket 2 (if evaluated collectively) and bucket 3 (if evaluated individually) if more than insignificant deterioration in credit quality occurs such that its reasonably possible contractual cash flows may not be fully recovered

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Hedging

- Hedge accounting requirements in IAS 39 are considered complex and rules-based
- Exposure draft issued December 2010
- Plan to issue a “review draft” in first half of 2012
- Began deliberations on macro hedging
  - Discussion Paper or ED expected in second half of 2012

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Leases

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Leases

- Exposure draft August 2010
- Nearly all leases to be recorded on balance sheet
- Lessees:
  - Asset representing “right of use”
  - Liability for obligation to make payments
- Lessors:
  - Performance obligation approach vs. derecognition approach
  - Asset for receivable under either approach
  - Liability under performance obligation approach
  - Derecognize a portion of asset under derecognition approach

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Leases

- Responses to ED
  - Concerns about “front loading” of expenses for lessees (compared to straight line)
  - Lease term
  - Variable lease payments
  - Lessor accounting

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Leases redeliberations

- Retain position that leases within scope should be reflected on balance sheet
- Concerned about “front loading” if expense recognition under ED approach
- Discussed 3 approaches in late February
  - ED approach (accelerated recognition)
  - Interest-based amortization approach
  - Underlying asset approach
- Divergence in preferences
- To be discussed in April
  - Leads to delay in project: re-exposure in 2H 2012

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Leases Current Status

- Scope
  - Intangibles (other than RoU assets) excluded
  - Non-regenerative resources and biological assets excluded
- Short-term leases
  - Maximum possible term of 12 months
  - Lessees can elect not to recognize assets and liabilities under RoU model (S/L recognition)
  - Lessors can elect not to apply receivable and residual approach (S/L recognition)

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Leases Current Status (cont.)

- All initial measurements will be based on information existing at lease commencement
- Lessees will separate lease and non-lease components if observable prices exist
- Lease term = noncancelable period plus optional periods with "significant economic incentive" to extend (or not terminate)
  - Contract factors
  - Asset factors
  - Market factors
  - Entity-specific factors

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Current Lessee Accounting

- Still will have most leases reflected on balance sheet
- Boards currently redeliberating expense recognition
  - Concerned about "front loading" if expense recognition under ED approach
  - Discussed 3 approaches in late February
    - ED approach (accelerated recognition)
    - Interest-based amortization approach
    - Underlying asset approach
- Divergence in preferences

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Current Lessor Accounting

- Subject to change based on lessee redeliberations
- Receivable and residual approach
  - Recognize receivable at PV of estimated lease payments
  - Derecognize a portion of asset for cost of RoU asset transferred to lessee
  - Reclassify remaining portion of underlying asset
  - Might recognize profit at lease commencement
  - Investment property would not fall under this approach

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Insurance

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Insurance Project

- IASB Exposure draft July 2010
- FASB Discussion Paper September 2010
- Joint redeliberations started in January 2011
- To date, a number of differences persist

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Questions

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Breakout 11: Accountants & Attorney's: A Team Approach to Health Care Audit Defense

Michael A. Igel

Mike Igel

Attorney

Trenam Kemker

Mike Igel joined Trenam Kemker as an Associate in the Business Transactions Group in July 2008. Mike is a member of the Trenam Kemker Health Care Team, and concentrates his practice on the representation of hospitals and health systems, physician groups, pharmacies, home health agencies and other health care companies in a variety of regulatory, compliance and health care business matters. As the leader of Trenam Kemker's Health Care Audit Defense Team, Mike has extensive experience in representing health care providers in defense of claims for overpayment by Medicare, Medicaid, and other third party payors.

Practice Areas Include:

☐ State and Federal Regulation of Health Care Industries
☐ Physician-Hospital Joint Ventures
☐ Health Care Provider Overpayment Audit Defense
☐ Hospital Operations
☐ Mergers and Acquisitions
☐ Medical Staff Bylaws
☐ HIPAA Compliance
☐ Clinical Research
☐ Managed Care Contracts
☐ Electronic Medical Records

Education:

☐ University of Houston Law Center (LL.M. in Health Law), 2007

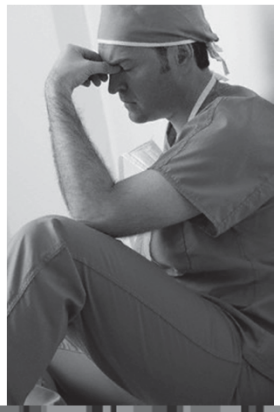
– University of Houston Law Center is consistently ranked as one of the top health law LL.M. programs in the country
– Golden Key Honor Society, Graduate Student Member

☐ Nova Southeastern University Shepard Broad Law Center (J.D.), 2006

– Dean's List
– *Journal of International and Comparative Law*, Staff member

☐ American University (B.A.), 2002

Accountants and Attorneys:
A Team Approach to Health Care Audit Defense



Michael A. Igel, Esq.

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The 3:00 AM Phone Call

- Dr. Jones calls your office
- "I received a records request from Medicare. It's been sitting around the office for a few weeks. My office staff didn't give it to me right when it came in, and this is the first chance I've had to call you about it. It's due on Friday. Can you help?"
- When this happens, how can we team up to assist the client?

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Lots of $$$$$ at Stake

- Overview
  - Medicare is among the **top 3 Federal programs with Improper Payments** totaling **$34.3 billion** in 2010 alone
  - Government health care fraud prevention recovered nearly $4.1 billion in 2011
  - RAC Audits are thought to be not only a means to recoup these improper overpayments, but also an attempt to extend the life of Medicare
    - Medicare has approximately $34 billion unfunded liabilities
  - Bottom Line: State and Federal governments need $$$, and auditors are getting it for them

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Medicare Audits

- Who is auditing?
  - An alphabet soup
    - RACs, ZPICs, FIs, PSCs, MACs, DOJ
  - Some auditors paid on contingency, some paid via contract

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What Is The "Audit?"

- Claims reviewed on a post-payment basis
- Typically use same Medicare policies as FIs and Carriers
- Can only review claims made ***after*** a given period
  - Permitted to look back three years from the date the claim was paid
  - Beware of "car salesman math"
- What are auditors really doing?
  - Between 2007 and 2010:
    - 96% of claims reviewed were overpayments
    - $900 million in overpayments
    - $38 million in underpayments

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What Else Can They Do To The Provider?

- Loss of Medicare billing privileges
- Pre-payment review
  - Typically saved for high error rates
  - Based upon specific codes
  - Can be electronic or in writing
  - Fiscal intermediary has discretion to remove pre-payment review
- Corrective Action Plan
  - Required action to achieve compliance
- Corporate Integrity Agreement
  - Can include required compliance plans, communications hotlines, fines, etc.

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Proper Response Is Essential

- Auditor sends Medical Record Request Letters for Complex Reviews
- Provider has time (typically 45 days) to submit copied charts
- Auditor must notify provider of decision within specified time period of receipt of records (typically 60 days)
- "Demand Letters" are sent when an overpayment is identified
- Provider can pay by check, opt for recoupment, appeal or declare bankruptcy

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Defending The Audit Together

- Level 1: Request for Redetermination
  - Made to Fiscal Intermediary
  - 30 days from receipt of demand to freeze money!
- Level 2: Request for Reconsideration
  - Made to Qualified Independent Contractor
  - 60 days from receipt of redetermination to freeze money!
- Level 3: Administrative Law Judge (ALJ)
  - 60 days from receipt of reconsideration
- Level 4: Medicare Appeals Council (MAC)
  - 60 days from receipt of ALJ decision
- Level 5: Federal District Court
  - 60 days from MAC decision

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What's The Good News?

- Audits are increasing at an alarming rate
  - New kinds of auditors, new kinds of audits
  - New penalties if errors found
  - Auditors know that appeals are stressful and expensive
- **Not limited to Medicare audits**
  - Medicaid
  - Third party payors

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Medicaid Audits

- Who is the Enemy?
  - AHCA
  - MICs
  - RACs (as of January 1, 2012)
  - Other third party reviewers
    - Another alphabet soup

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Medicaid Audit Process

- Formal Records Request
- Preliminary Audit Report
  - "What we think you owe us"
  - You can provide additional information…but beware of Section 409, Florida Statutes
- Final Audit Report
- Appeal in front of ALJ

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Sanctions

- AHCA now adding sanctions to most Final Audit Reports
- 59G-9.070, Florida Administrative Code permits AHCA to impose sanctions for "failure to comply with the provisions of the Medicaid laws"
- Money comes and goes, sanctions stay forever

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To Appeal Or Not To Appeal?

- Contradictory AHCA positions
  - Negotiate or force a hearing?
  - Section 409.913(23), Florida Statutes permits AHCA to recover investigative, legal and other costs in certain circumstances should you appeal
- Offsets
  - Section 409.913(27), Florida Statutes permits AHCA to offset amounts allegedly owed against future payments beginning 30 days after Final Audit Report
    - Offsets can begin regardless of whether you appeal
    - Is this constitutional?

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Working Together To Attack An Audit

- Anatomy of the Appeal
  - Coding issues
    - Do the codes match the medical record?
  - Regulatory issues
    - Does auditor have authority to do what it did?
    - Did auditor conduct audit within the rules?
    - Did provider comply with the law?
  - Accounting issues
    - Was statistical sampling accurate?
    - *Can the provider handle an audit financially?*

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Dealing With Offsets

- Medicare and Medicaid commence offsets at different times
- Cash flow can completely cease while offsets are being made
- Practice goes from “money in\money out” to “money out”
- In order to keep operating, practice requires extra money in reserve

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Here Comes Trouble…

- Dr. Jones receives a records request
  - Accountant
    - Notify attorney
    - Begin assessment of practice’s cash flow to assess presence of deviation
    - Examine practice’s cash flow to prepare for cash reserve
  - Attorney
    - Review request
    - Ensure records submitted are appropriate

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Frustration Begins…

- Dr. Jones receives Preliminary Audit Report (Medicaid) or
  - Accountant
    - Scrutinize auditor's statistical analysis to determine whether "car salesman math" has been appropriately applied
    - Review coding expert's shadow audit results to calculate appropriate rebuttal amount
  - Attorney
    - Evaluate whether auditor has complied with applicable law
    - Evaluate whether provider has complied with applicable law
    - Prepare initial response for timely filing
      - Early appeal filing essential to freeze Medicare offset

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The Battle Continues…

- Dr. Jones receives the Final Audit Report (Medicaid) or Redetermination (Medicare)
  - Accountant
    - Reassess statistical sampling to determine whether it has been properly applied
    - Confirm that practice has adjusted its cash reserve as offsets likely begin
  - Attorney
    - Continue negotiations with auditor
    - Prepare Request for Reconsideration (Medicare)
    - File for formal ALJ hearing (Medicaid)

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When A Lawyer Needs An Accountant

- The accountant keeps the provider financially afloat during the audit
- Thorough analysis of practice cash flow
  - Does revenue look strange this year?
  - Can the provider handle an appeal?
  - Will provider go out of business if appeal not attempted?
- Statistical analysis for purposes of appeal
  - Audits are overturned based upon incorrect statistical analysis
- Adjustments to amount that practice keeps in reserve
  - Audits can take years, with offsets taking place during the entire appeal period

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Reporting and Returning Overpayments

- Part of health care reform law
- An overpayment must be reported and returned within 60 days after the date the overpayment was identified
- Examples
  - Payments for non-covered services
  - Payments in excess of the allowable amount
  - Duplicate payments

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How To Make A Voluntary Refund

- To be reported using a form on the First Coast website
- Must be done per claim
  - Includes
    - How the error was discovered
    - Description of corrective action plan
    - Reason for refund
    - Whether there is a Corporate Integrity Agreement
    - Timeframe of refund
    - NPI Number
    - The refund payment
    - A description of the statistical sampling used to identify the refund amount (if applicable)

Trenam Kemker ATTORNEYS

How Do I "Know" If An Overpayment Exists?

- "A person has identified an overpayment if the person has actual knowledge of the existence of an overpayment or acts in reckless disregard or ignorance of the overpayment"
- 10 year look-back period!!
- 60 day requirement runs from the date on which the overpayment was identified
  - Includes receiving information that creates an obligation to investigate
    - Ex. Results of a self-audit, anonymous compliance hotline complaint
    - Ex. Unexplainable increase in revenue

Trenam Kemker ATTORNEYS

What If The Overpayment Is Not Returned Within 60 Days?

- Risk violation of False Claims Act
  - A crime
  - Could lose Medicare billing privileges

Trenam Kemker ATTORNEYS

And You Thought April 15 Was Bad

- Essential to determine amount owed as early as possible
- Little time to make lots of determinations
  - Clients *always* notify us early so we have ample time to prepare
- If more time is needed to calculate amount owed, must apply for an extension using Medicare's Extended Repayment Schedule
- Not automatically granted
  - Need to submit "significant documentation" to show that timely payment would be "true financial hardship"
- Note: No extension granted for more time to discover amount to be refunded

Trenam Kemker ATTORNEYS

Compliance Plans

- Of significant importance in minimizing risk for audit, and in positioning your practice if an audit takes place
- Required for nursing homes beginning this year
  - Government strongly recommends all providers implement
- Having a compliance plan and not adhering to it is worse than not having one
- Government looks very favorably upon compliance plans
- New overpayment refund law requires you to refund money if you should have known there was an overpayment
  - How would you know there was an overpayment? By adhering to your compliance plan

Trenam Kemker ATTORNEYS

Questions?

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Trenam Kemker ATTORNEYS

Breakout 12: Rebuilding the Revenue Cycle @ 50,000 Feet

Patrick McDermott

Presentation Will Be Available
On-line After the Conference

Breakout 13: New Accounting for Healthcare

David A. Rood, CPA

David Rood, CPA

Audit Partner

KPMG LLP

Mr. Rood is an audit Partner in KPMG's Tampa office. He has more than 21 years of experience in serving the healthcare provider industry. David also serves as the Managing Partner of KPMG's Tampa office.

Mr. Rood has experience in managing audits of large, integrated delivery health systems, hospitals, long-term care and assisted-living organizations, physician practice management companies, continuing care retirement communities, foundations, and home health agencies.

David also has experience in public offerings of equity and debt securities, Securities and Exchange Commission (SEC) registrations under the 1933 and 1934 Acts, tax-exempt financings, and providing such services as due diligence reviews and internal control reviews.

David earned his Bachelor's degree in Accounting and Business Administration from the University of Kansas.

David is currently a licensed CPA in the States of Florida, South Carolina and Missouri.

Associations: AICPA, FICPA, and HFMA.

KPMG
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Healthcare Provider Accounting Update

April 26, 2012

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Agenda

- Recently issued accounting standards updates
  - ASU 2010-23 Measuring charity care for disclosure
  - ASU 2010-24 Presentation of insurance claims and related insurance recoveries
  - ASU 2011-07 Presentation and disclosure of net revenue, provision of bad debts, and the allowance for doubtful accounts
- Accounting considerations for electronic health record incentive payments
- SEC concerns on reporting of conduit debt obligors

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Recently issued accounting standards updates

ASU 2010-23, *Measuring charity care for disclosure* (EITF 09-L)

ASU 2010-23, *Measuring charity care for disclosure* (EITF 09-L)

Background

- Disclosure of the level of charity care provided is required
- The level of charity care provided has historically been measured based on the provider's rates, costs, units of service, or other statistical measure
- Diversity existed in the health care industry regarding the measurement used to disclose the level of charity care
- The majority of health care organizations (HCOs) used the provider's rates (charges forgone) to measure charity care

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ASU 2010-23, *Measuring charity care for disclosure* (EITF 09-L) (continued)

EITF Assessment and Conclusions

- Issue addressed by the Task Force:
  - How should the disclosure of the level of charity care provided by HCOs be measured?
- Final Consensus
  - Charity care should be measured based on the cost (both direct and indirect) of charity care provided
  - Amounts received for reimbursement related to charity care should be disclosed separately
- Effective Date
  - Fiscal years beginning after December 15, 2010
- Transition
  - Retrospective basis
  - Early adoption was permitted

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ASU 2010-23, *Measuring charity care for disclosure* (EITF 09-L) (continued)

Determination of Direct and Indirect Costs

- Based on specific identification of costs or estimate
- Estimates should be based on reasonable techniques
  - Cost to charge ratios obtained from cost reports
  - Amounts determined from cost accounting systems
  - Other reasonable techniques

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ASU 2010-23, *Measuring charity care for disclosure* (EITF 09-L) (continued)

Revised Disclosure Requirement

- Policy for providing charity care
- Level of charity care provided measured based on direct and indirect costs
- The method used to identify or estimate costs
- Separate disclosure of funds received to subsidize charity care services (i.e. grants or uncompensated care funds)

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ASU 2010-24, *Presentation of claims and related insurance recoveries* (EITF 09-K)

ASU 2010-24, *Presentation of claims and related insurance recoveries* (EITF 09-K)

Background

- Health care industry had a practice of netting receivables for expected insurance recoveries against liabilities accrued for medical malpractice or other similar claims
- ASC Topic 720-20 (EITF 03-8) indicates that offsetting receivables for expected insurance recoveries against a recognized incurred-but-not-reported liability is not permitted, unless certain criteria of ASC Topic 210 (FIN 39) are met
- Right of Setoff Conditions:
  - Each of two parties owes the other determinable amounts
  - The reporting party has the right to set off the amount owed with the amount owed by the other party
  - The reporting party intends to set off
  - The right of set off is enforceable by law
- These conditions are not met in typical health care medical malpractice and other claim insurance arrangements

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ASU 2010-24, *Presentation of claims and related insurance recoveries* (EITF 09-K) (continued)

EITF Assessment and Conclusions

- Issue addressed by the Task Force:
  - How should HCOs record liabilities for medical malpractice and other similar claims and related insurance recoveries?
- Final Consensus
  - Net presentation is not permitted
  - Applies to malpractice claims and similar contingent liabilities
- Effective Date
  - Fiscal years beginning after December 15, 2010, and interim periods within those years
- Transition
  - Either prospective or retrospective adoption is allowed
  - Cumulative-effect adjustment to retained earnings upon adoption
  - Early adoption was permitted

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ASU 2010-24, *Presentation of claims and related insurance recoveries* (EITF 09-K) (continued)

Accounting Considerations

- Record gross liability and gross insurance receivable separately
- Measure gross insurance receivable on the same basis as the liability
- If necessary, record a valuation allowance for uncollectible amounts associated with the insurance receivable
- Cumulative-effect adjustment is recognized in opening retained earnings in the period of adoption if:
  - A difference exists between any liabilities and insurance receivable resulting from applying the ASU
- Verify that actuary will be able to provide you with gross liability and gross receivable information

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ASU 2010-24, *Presentation of claims and related insurance recoveries* (EITF 09-K) (continued)

- Example
  - ABC Hospital has $2,000 in estimated malpractice claims and anticipates $1,500 in insurance recoveries associated with those claims

	Current Practice Presentation	Proposed Presentation
Insurance Recoveries	$0	$1,500
Total Assets	$0	$1,500
Medical Malpractice Reserves	$500	$2,000
Total Liabilities	$500	$2,000

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ASU 2011-07, *Presentation and disclosure of patient service revenue, provision for bad debts, and the allowance for doubtful accounts for certain health care entities* (EITF 09-H)

ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H)

Background

- Diversity in practice among health care entities regarding when revenue is recognized, either:
  - When services are provided, net of contractual allowance and discounts (predominant); or
  - After collectability is assured
- Concern: there is a gross-up of revenue for amounts that are not expected to be ultimately collected
- The FASB's objective is to provide financial statement users with greater transparency about a health care entity's net revenue and allowance for doubtful accounts.

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ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H) (continued)

EITF Assessment and Conclusion

- Applies to health care entities that recognize patient service revenue at the time services are rendered even though the patient's ability to pay is not assessed
- Health care providers within the scope of this ASU record bad debt expense for ALL patient service revenue as a deduction from patient service revenue. They do not bifurcate certain patient service revenue bad debts to reflect as an operating expense.
- What is a " significant amount of patient service revenue which is not assessed for collectability"?
- Separately present
  - Patient service revenue (net of contractual allowance and discounts)
  - Provision for bad debt as a deduction from patient service revenue
  - Resulting net patient service revenue less the provision for bad debts
- Bad debts shall continue to be an operating expense for:
  - Receivables from other than patient service revenue
  - Entities that only recognize patient service revenue to the extent it expects to collect such amounts

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ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H) (continued)

Interim and Annual Disclosures

Patient Service Revenue Disclosures:

- Policy for assessing collectability in determining the timing and amount of patient service revenue (net of contractual allowances and discounts) to be recognized by major payor source
- Patient service revenue (net of contractual allowances and discounts) before the provision for bad debts by major payor source
- Major payor sources should be consistent with how the hospital manages its business

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ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H) (continued)

Allowance for Doubtful Accounts Disclosures

- Policy for assessing the timing and amount of uncollectible patient service revenue recognized as bed debts by major payor source
- Quantitative and qualitative information about significant changes in the allowance for doubtful accounts related to patient accounts receivable
- Quantitative and qualitative information may include:
  - Changes in estimates and underlying assumptions
  - Amount of self-pay write-offs
  - Amount of third-party payor write-offs
  - Other unusual transactions impacting the allowance for doubtful accounts

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ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H) (continued)

Effective Date & Transition

- Effective for interim and annual period beginning after December 15, 2011 for public companies
  - Includes conduit debt obligors for conduit debt securities traded in a public market
- Effective for annual reporting periods ending after December 15, 2012 for nonpublic companies
  - Early adoption permitted
  - Retrospective application for presenting bad debt expense as a reduction of revenue
  - Prospective application required for expanded disclosures

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ASU 2011-07, *Patient service revenue bad debts* (EITF 09-H) (continued)

Application of ASU 2011-07 in consolidated entity financial statements when financial statements are also issued at the subsidiary level

- View A : Retain treatment determined at the subsidiary level
- View B : Determine treatment at the consolidated entity level
- View C : Adopt A or B and disclose approach in footnotes
- This issue is not addressed by the ASU

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EHR Incentive payment – Accounting models for hospital providers

Hospital income recognition models for EHR payments

- HFMA Issue Analysis – Published December 2011
  - Medicare Incentive Payments For Meaningful Use of Electronic Health Records: Accounting and Reporting Developments
- Hospitals not registered with the SEC have two options
  - Grant Accounting Model
  - Contingency Model
- Hospitals that are SEC registrants apply the contingency model
- Conduit debt obligors with conduit debt securities that trade in the public market are NOT considered SEC registrants for this purpose and can apply either the grant model or the contingency model.

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Grant accounting model

- Proponents of the grant accounting model believe this model is consistent with the definition of government grants under IAS 20 – *Accounting for Government Grants and Disclosures of Government Assistance*.
  - ***IAS 20 Definition*** : *Government grants are assistance by government in the form* of transfers of resources to an entity in return for past or future compliance with certain conditions relating to the operating activities of the entity. They exclude those forms of government assistance which cannot reasonably have a value placed upon them and transactions with government which cannot be distinguished from the normal trading transactions of the entity
  - **The goal of the ARRA meaningful use payments**: Incent hospitals to become meaningful users of certified EHR technology is to:
    - Improve quality, safety, efficiency, and reduce health disparities
    - Engage patients and families in their health care
    - Improve coordination of care
    - Improve public and population health
    - Maintain privacy and security

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Grant accounting model – Income recognition

- IAS 20 – Government grants should be recognized only when there is reasonable assurance that BOTH
  - The grant will be received (i.e., the funding will be available through ARRA) and
  - The entity will comply with the conditions attached to the grant (i.e. meet meaningful use criteria during the compliance period)
- If management is reasonably assured of meeting meaningful use objectives for the entire EHR reporting period at the outset of the EHR reporting period
  - Recognize grant income ratably over the entire EHR reporting period (90 days or 365 days, as appropriate)
  - In year 1 it may be difficult for hospitals to be reasonably assured of meeting meaningful use objectives at the outset of the EHR reporting period given the complexities of implementing the systems and meeting compliance requirements
- If management is not reasonably assured of meeting meaningful use objectives for the entire EHR reporting period at the outset, but at some point during the reporting period becomes reasonably assured of meeting the objectives, then
  - An adjustment would be recorded to recognize the income earned through that date. The remainder would be recognized over the remaining compliance period.

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Contingency model – Income recognition

- Proponents of the contingency model believe that significant conditions must actually be met before meaningful use payments can be recognized as income.
- Preliminary view: contingency considerations that must be satisfied prior to recognizing revenue:
  - Hospital must comply with meaningful use criteria during the entire compliance period (90 consecutive days in year 1 and 365 days during years 2 through 4).
    - The earliest this contingency could be satisfied is on the 90th or 365th day, respectively.
  - Discharges used in the final payment calculation must have occurred.
    - Final payments are based on discharges occurring during a hospital cost report year that begins in the EHR reporting period (i.e. 9/30 Federal fiscal year end). Unless Hospital year end is 9/30, such discharges will typically not occur until after the EHR reporting period.
  - Similar contingency considerations could apply to other final settlement calculation data such as total charges, patient days and charity care charges.
- Submission of the cost report and subsequent desk reviews and audits would not likely be viewed as a contingency.
- Healthcare providers adopting the contingency model should give consideration to all potential contingencies and monitor current accounting and reporting developments as they occur.

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Differences – Grant accounting model vs. contingency model

- In order to recognize income:
  - Grant accounting model requires reasonable assurance that meaningful use criteria will be met during the compliance period and permits a reasonable estimate of the final payment amount.
  - Contingency model requires that meaningful use criteria have actually been met and discharges used in final payment amount must have occurred.
- Timing of income recognition:
  - Income would typically be recognized under the grant accounting model before it is recognized under the contingency model.
  - Income would typically be accrued uniformly over the compliance period under the grant accounting model.
  - Income will likely be recognized entirely in a single quarter under the contingency model (i.e. the last quarter of the hospital's fiscal year end with discharges used in the final payment calculation).

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Figure 1: Juxtaposition of EHR reporting period and ABC hospital's fiscal year

- Source: HFMA Issue Analysis – Published December 2011
  - *Medicare Incentive Payments For Meaningful Use of Electronic Health Records: Accounting and Reporting Developments*

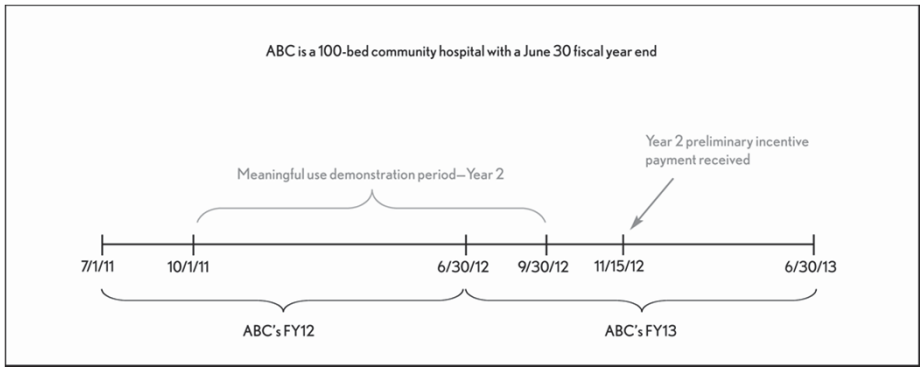

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Figure 2: Illustration of application of contingency model – ABC hospital

- Source: HFMA Issue Analysis – Published December 2011
  - *Medicare Incentive Payments For Meaningful Use of Electronic Health Records: Accounting and Reporting Developments*

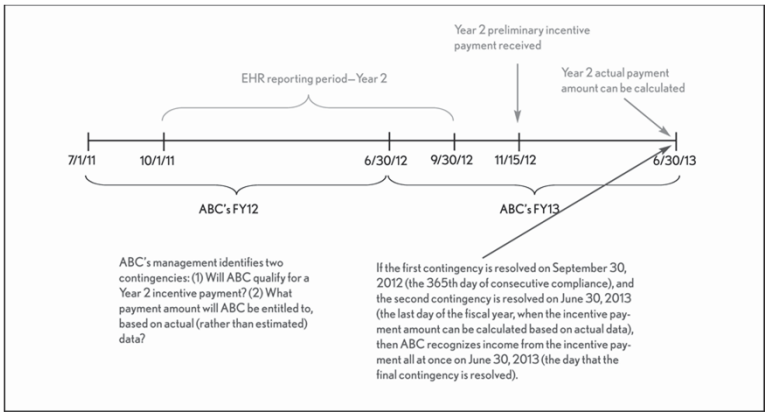

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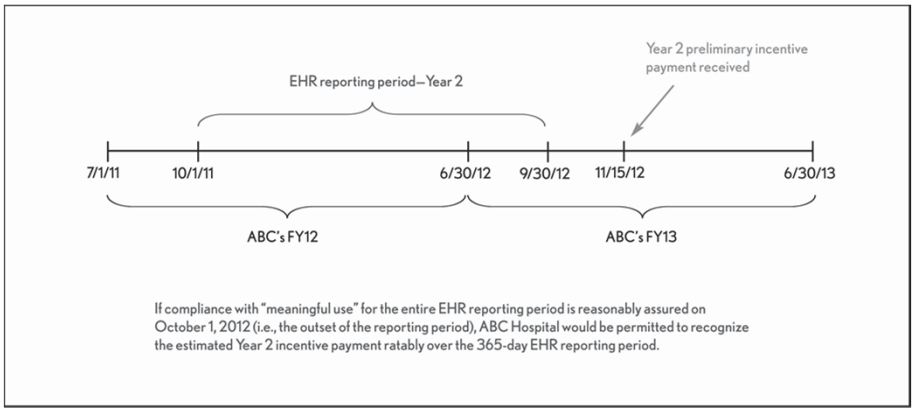
Figure 3: Illustration of application of IAS 20 grant accounting model – ABC hospital

- Source: HFMA Issue Analysis – Published December 2011
  - *Medicare Incentive Payments For Meaningful Use of Electronic Health Records: Accounting and Reporting Developments*



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Presentation

- Meaningful use payments are included in the performance indicator as part of "other income" or disclosed separately depending on facts and circumstances.
- It is not appropriate to record meaningful use payments as an offset to expense since they are not reimbursement for specific expenses incurred over the reporting period.

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Other considerations related to EHR incentive payments for hospital providers

Other considerations – Meaningful use compliance reports

- Develop a system of processes and controls to comply with meaningful use criteria
  - How is management assured that meaningful use compliance has been achieved?
- In developing processes and controls, consider the following:
  - Process for implementing new operational policies necessary to meet meaningful use criteria
  - Documentation of the policies and procedures designed to meet meaningful use objectives
  - Process to monitor compliance with such policies and procedures
  - Internal controls surrounding the quality of inputs into the EHR system
  - Procedures to assure that results submitted to CMS are consistent with what was produced by the EHR system.
- Determine to what extent others such as internal audit or compliance auditors in your organization can assist in testing the quality of inputs or outputs of the EHR system
- Ensure other IT systems have been appropriately configured and controlled around EHR technology

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Other considerations – Meaningful use compliance reports (continued)

- Estimates and judgment will be necessary and critical
- Ensure users have “bought-in”, e.g. medical professionals
- Meeting the minimum?
- Ensure contingencies identified are complete and reasonable
- Many providers not attesting for Medicare until 2012
  - Want to be sure they can maintain compliance each consecutive year
  - Stage 2 criteria not yet developed

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SEC Concerns on Reporting of Conduit Debt Obligors

Municipal Bonds

- Municipal bonds are debt securities issued by states, cities, counties and other governmental entities to finance capital projects
- Interest on Municipal Bonds is generally tax exempt
- Two most common types of Municipal Bonds
  - General obligation bonds
  - Revenue bonds
- Municipal borrowers sometimes issue bonds on behalf of private entities, such as a hospital
- Conduit borrowers

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Municipal Bonds

- **Today's investors hold about $2.8 trillion of municipal debt**
- **According to SEC Chairman Mary Schapiro "This is a critical market that touches every aspect of our lives, from the water we drink to the roads upon which we drive. But for the market to continue to serve our communities, investors in municipal securities must be confident that they are getting the information necessary for knowledgeable decisions, at the time and in a form that they need it."**

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Municipal Bonds

Risk of investing in Municipal bonds

- Historically were fixed rate debt issuances supported by bond insurance
- Today there are greater risks associated with complexity of bonds
  - Bond insurer ratings and financial strength crumble
  - Variable rate
  - Material adverse clauses
  - Liquidity facilities that must be periodically reviewed

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Municipal Bonds

- SEC protection for municipal bond investors
  - Required to report annual financial and operating data
- SEC hearings on Municipal Markets
  - Address a wide range of issues that focus on the needs of investors
- Plans for additional hearings have been suspended due to the budgetary constraints under which the Commission is operating

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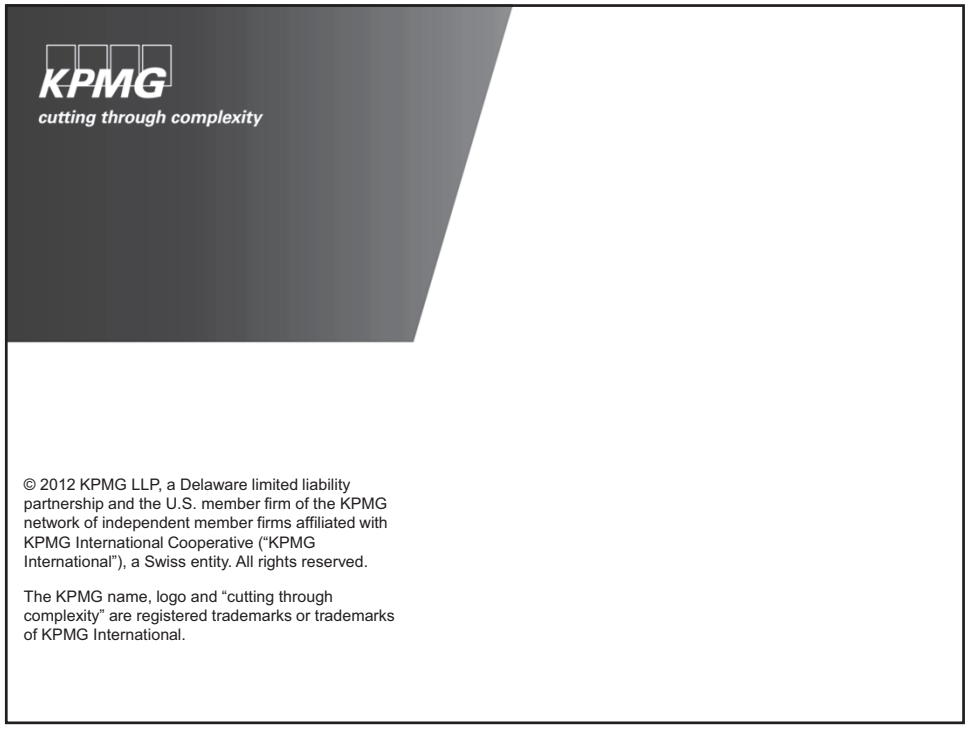

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Breakout 14: Bundled Payments and Acute Care Episode – Risks & Rewards

Stephen W. Forney, MBA, CPA, FACHE, FHFMA

Stephen W. Forney, MBA, CPA, FACHE, FHFMA

Vice-President & Chief Financial Officer

Lovelace Health System

Stephen Forney is Vice-President & Chief Financial Officer for Lovelace Health System (LHS) in Albuquerque, NM. LHS is an Integrated Delivery System comprised of four acute care hospitals, one acute rehab hospital, a retail pharmacy operation, and a 230,000 member health plan. LHS is owned by Ardent Health Services (AHS) in Nashville, TN. In addition to LHS, AHS owns the Hillcrest Health System (HHS) in Tulsa, OK. HHS is comprised of six acute care hospitals and 200+ employed physicians.

Stephen has 24 years of healthcare financial/operations experience in both for-profit and not-for-profit facilities, ranging from small rural hospitals to large urban hospitals/system. He is a recognized healthcare operations speaker and is a regular presenter for the American College of Healthcare Executives (ACHE) and the Healthcare Financial Management Association (HFMA).

Stephen received his MBA from St. Leo University in St. Leo, FL and is licensed in the State of Florida as a Certified Public Accountant. He is also a Fellow in both the ACHE and the HFMA.

Ardent℠
HEALTH SERVICES

MEDICARE
ACE
DEMONSTRATION

Bundled Payments and Acute Care Episodes -

Risks and Rewards

The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS.

The authors assume responsibility for the accuracy and completeness of the information contained in this document.

The Demonstration Project

- Bundled payment for Part A & Part B
  - Combined 835 to hospital
- Admit to discharge
  - All services; physician and hospital
- Provider incentive
- Quality reporting
- Patient incentive
  - Patients receive payment from CMS based on 50% of CMS savings
  - Average of $406 for cardiac procedures

The Demonstration Project

- Payments shift from fragmented components of care to a coordinated episode of care
- Economic incentives aligned to benefit all four parties
  - Physician
  - Hospital
  - CMS
  - Patient

Goals of ACE Demonstration

- Improve coordination and quality of care
- Align incentives between hospitals and physicians through "global pricing" and cost savings incentives
- Designate selected centers as "value based care centers"
- Reduce Medicare payments

Project Guidelines

- 3-year demonstration
- Clinical and operational reporting requirements to CMS
- Annual update to global fees
- 28 cardiovascular procedures
- 9 orthopedic procedures
- Patient eligibility
- 90-day termination option

Ardent Demonstration Sites

Hillcrest Healthcare System

- 6 hospitals
- 1,159 beds
- 1 teaching hospital
- Multi-specialty physician group

Procedure Groups

- Cardiac
- Ortho

Ardent Demonstration Sites

Lovelace Health System

- 4 hospitals
- 580 Beds
- 1 health plan (247,000 members)
- 11 retail pharmacies

Procedure Groups

- Ortho
- Cardiac (beginning 11/01/11)

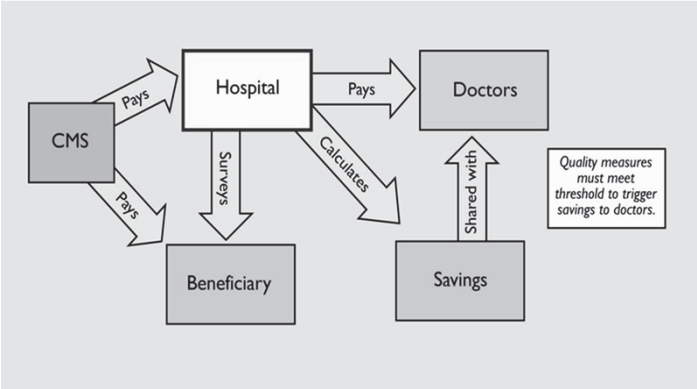
Why We Decided to Participate

- Enhance care coordination
- Improve quality care
- Be on cutting edge of global pricing
- Improve physician collaboration
- Lower costs
- Increase market share

How We Shaped the Program

- Competitive bid
- Selected based on point system
- Physician involvement
- Vendor negotiation
- Comprehensive hospital team
- Marketing
- Claims management

How the Payment Flows



Payment Flow – *Expense Comparison*

Current Model

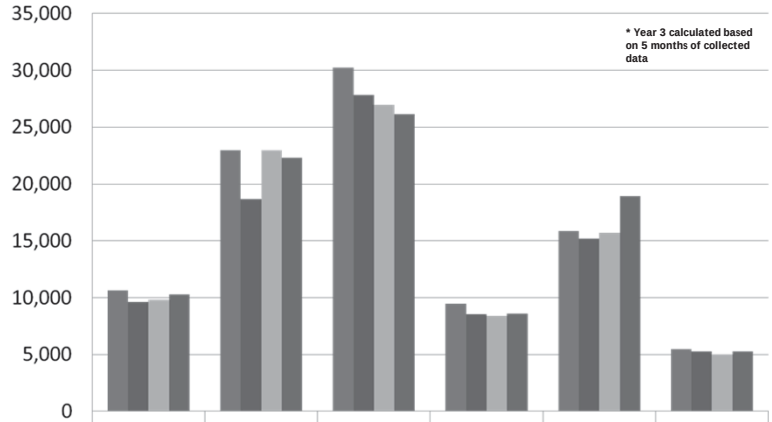
- **$14,250 - Part A Payment**
- **$10,600 – Expenses**
- *$3,650 - Margin*

ACE / Bundled Model

- **$15,900 – Bundled Payment**
- **$2,150 – Part B Payment**
- **$450 – Admin/Vendors**
- **$400 – PIP Payment**
- **$9,250 – General Expenses**
  (reduced as a result of PIP)
- *$3,650 – Margin*

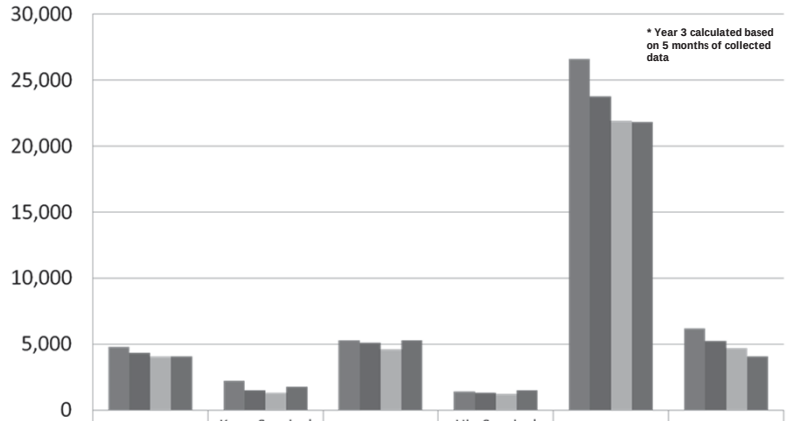
(Example Only)

Direct Cost per Case



	Joint Replacement	Valve Replacement	Defribrillator Implants	Pacemaker Implants	Coronary Bypass	Percutaneous CV Intervention
Base Year	10,614	22,957	30,250	9,469	15,833	5,485
Year 1	9,612	18,683	27,852	8,524	15,168	5,283
Year 2	9,836	22,961	26,946	8,363	15,694	4,989
Year 3*	10,261	22,321	26,144	8,577	18,929	5,266

Materials Cost per Case



	Knee Implant	Knee Surgical Supplies	Hip Implant	Hip Surgical Supplies	Defibrillator	Pacemaker
Base Year	4,767	2,214	5,283	1,406	26,598	6,184
Year 1	4,353	1,482	5,094	1,330	23,785	5,228
Year 2	4,085	1,330	4,612	1,243	21,920	4,687
Year 3*	4,045	1,744	5,296	1,514	21,834	4,066

RESULTS

- Key quality measures remain strong
- Surgical volume increased by 25 to 40%
- Savings to CMS of $4.09m
- Contribution margin of $18.48m

Contribution Margin

- **Orthopedics**
  - Medicare $ 2,674,284
  - All payors $ 5,243,235
- **Cardiac**
  - Medicare $ 7,008,126
  - All payors $13,238,349

Savings

- **Orthopedics**
  - Medicare $2,399,915
  - All payors $3,479,532
- **Cardiac**
  - Medicare $1,697,704
  - All payors $5,811,863

Lessons Learned

Case manager is critical

Choose a program liaison

Expect challenges with CMS and fiscal intermediary

Patient incentive is added value, not primary driver

Key quality measures remained strong

Lessons Learned – *Key Risk Areas*

Outlier cases

Patient liability collection

Part B discounts not shared with physicians

Lessons Learned – *Cost Accounting*

- Administration of gain sharing program is complex
- Major modifications to cost accounting system
  - Discrete implant tracking by patient
  - Pharmaceutical costing by patient
  - Consideration of physician practice expense
- Expansion of reporting to assist with materials management and vendor negotiations

Lessons Learned – *Claims Admin*

- Processing approximately 10,000 Part B claims per year for qualified procedures
- Claim volume is cost prohibitive in typical health plan claims processing operation
- Technology solution needs to be scalable in anticipation of additional bundled services or expanded product lines

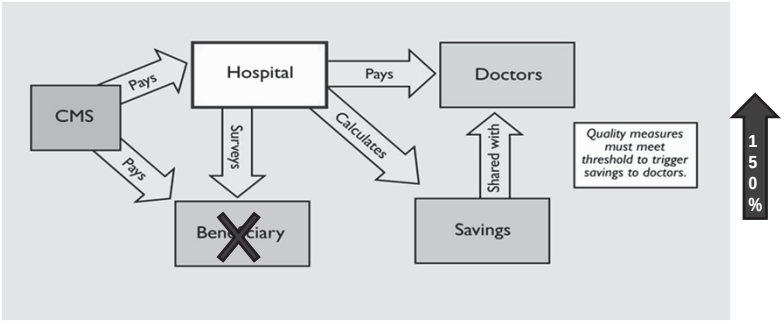
CMS Innovation

- **Bundled Payments for Care Improvements**
  - **Published 08/23/11**
  - **4 models**
    1. **Retrospective payment acute IP stay only**
    2. **Retrospective bundled payment for hospitals, physicians and post acute**
    3. **Retrospective bundled payments for post acute**
    4. **Prospectively bundled = ACE demonstration**

Key Differences

- **Gain sharing**
  - **NTE 50% amount normally paid to physicians**
- **No beneficiary incentive**
- **Discounts**

Bundled Payment Initiative



QUESTIONS

Breakout 15: Access to Financing For Healthcare Providers

Pierre M. Bogacz

Pierre M. Bogacz

Founder and Managing Director

HFA Partners

Pierre is founder and managing director of HFA Partners in Tampa, an independent financial advisory firm specialized in helping providers lower the cost of debt and minimize balance sheet risk.

Pierre's 20-year career in non-profit healthcare finance includes bond underwriting, derivatives, business valuation and M&A and strategic advisory services. Pierre has helped raise over $3 billion for healthcare providers via a variety of funding structures. Before co-founding HFA, Pierre was a director with B.C. Ziegler covering hospitals for the southeastern U.S. Before, he worked as a healthcare banker and financial consultant for Deloitte, Alex. Brown, First Boston, Sumitomo Bank, and Citibank.

Pierre received his B.A. in Economics and Political Science from Southern Methodist University and M.B.A. with a Concentration in Finance and Accounting from The University of Texas.

Pierre is an active pilot with instrument ratings who files his puddle-jumper around the US (for business) and Caribbean (definitely not for business!).

Access To Financing for Healthcare Providers in a Slippery Market

Pierre M. Bogacz
Managing Director
HFA Partners, LLC

April 26, 2012

HFA PARTNERS
capital markets advisors to healthcare providers

Agenda

- Bond Market Trends 2
- Credit Trends 11
- Debt Structures 15
- Preserving Access to Capital 23
- Speaker Info 26

Bond Market Trends

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Out Of Whack

- The hospital municipal bond markets are currently out of balance – demand far exceeds supply:
- Demand: institutional investors (mutual funds) competing with commercial banks for tax-exempt hospital paper.
- Supply: hospitals continue to postpone non-essential projects until there is more clarity on the impact of healthcare reform, the economy in general –borrowing less.
- Net result –rates at or near historical lows.

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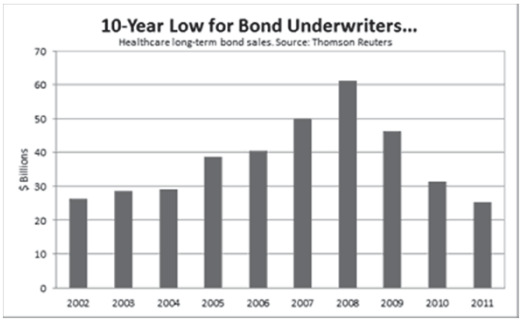
Hospitals Aren't Borrowing

- Hospitals are postponing capital projects:
  - "Our Board says no new debt for now"
  - "We're paying down debt with cash from operations"
- Age of plant going up.



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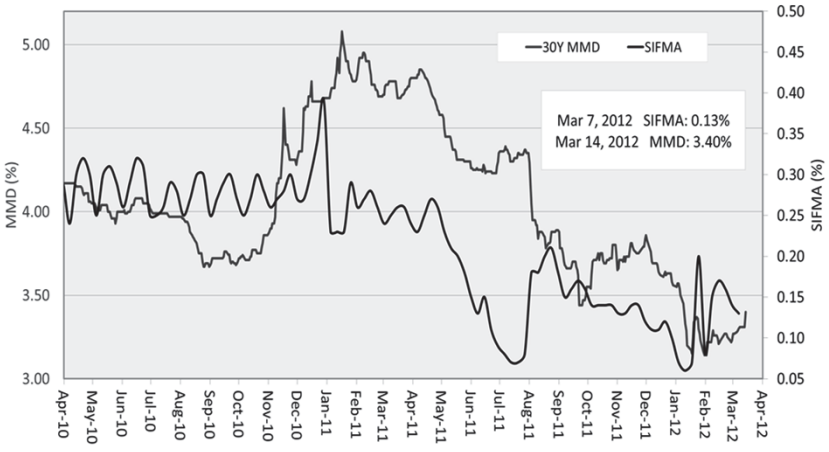
Benchmark Rates Are Low

- Municipal Market Data (MMD) and 7-day SIFMA tax-exempt indexes are at or near historical lows:



Source: Thomson Reuters, SIFMA.

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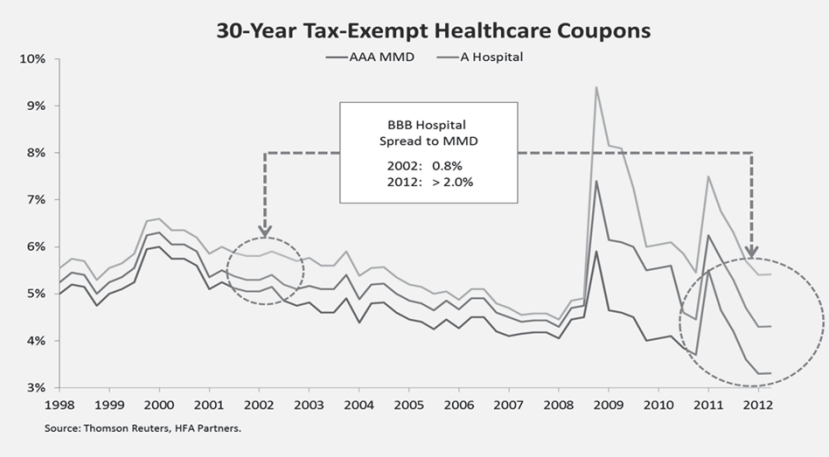
But Credit Spreads Remain High

- Investors are more wary of credit risk.



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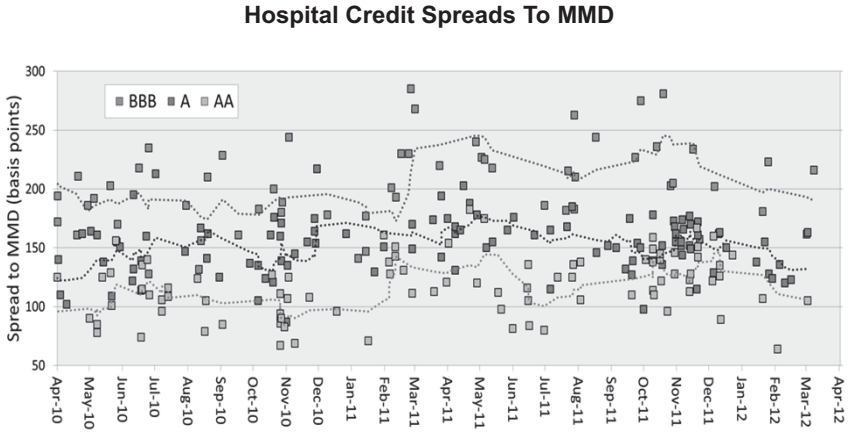
Spreads May be Tightening



Source: HFA Partners.

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But All-In Yields Aren't Much Lower

- Higher hospital credit spreads negate the benefit of the lower MMD.

	3/15/2002	3/15/2012
"AAA" 30-yr MMD	5.25%	3.40%
+ BBB spread	0.75%	2.00%
= BBB coupon	6.00%	5.40%
"AAA" 30-yr MMD	5.25%	3.40%
+ A spread	0.25%	1.00%
= A coupon	5.50%	4.40%

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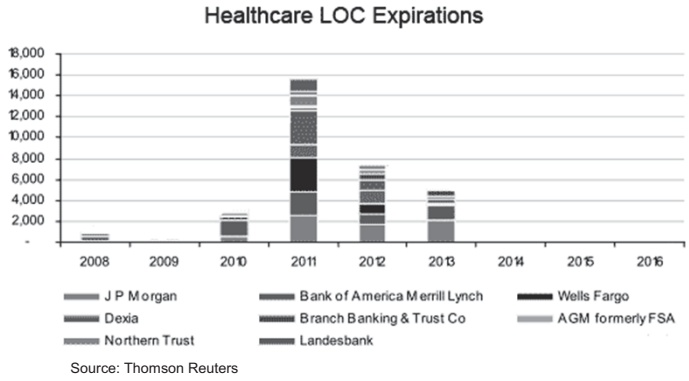
Letters Of Credit RenewalsRenew

- A record number of bank LOC's expired in 2011, many replaced with bank direct placements.



Source: Thomson Reuters

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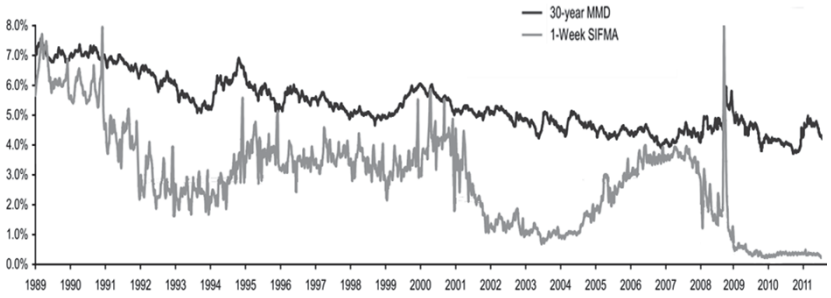
Fixed vs. Variable

- Over the long term, variable rate debt is cheaper than fixed rate debt.



Source: Thomson Reuters, SIFMA. Excludes LOC and remarketing costs.

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Credit Trends

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Rating Agency 2012 Industry Outlooks

- Rating agencies are cautious:
  - Fitch (222 ratings): “Stable” outlook for not for profit hospitals in 2012. Profitability metrics in line with 2011. M&A activity to accelerate.
  - Moody (650 ratings): “Negative” outlook for at least the next several years. Lower utilization and reimbursement; investment losses. M&A activity a positive.
  - S&P (540 ratings): “Relatively Stable” outlook. Expecting operating environment to deteriorate beyond 2012. M&A to consolidate service lines.

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2011 Rating Actions

- Fitch: 1.4:1 downgrades to upgrades
- Moody: 1.5:1 downgrades to upgrades
- S&P: 1.6:1 upgrades to downgrades
- Upgrades/downgrades ratios do not paint the full picture:
  - 80-90% of hospital ratings were affirmed in 2011.

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What Rating Analysts Look For

- Beyond operational profitability, cash is king –buys more short term predictability:
  - More cash and debt better than less cash and debt / predictability.
- How quickly can investments be liquidated?
- Disclosure timeliness and quality:
  - Quarterly (EMMA), bank facilities (rating agencies)
  - "Is Your Hospital Bond Disclosure Up to Snuff?" (http://www.hfapartners.com/research/articles 2/4/11)
- Is the Board getting independent advice?
- Key ratios:
  - DCOH, Cash to Debt, DSCR, Debt to Cap
- "Top Ten Things A Hospital Can Do To Improve Bond Ratings" (http://www.hfapartners.com/research/articles 3/10/11)

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Debt Structures

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Major Options

- Public bond offering (fixed rate)
- Bank direct placement (variable and fixed)
- LOC-backed VRDO (variable rate)

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Public Offering

- Fixed rate bonds sold in a public offering ("underwritten") to multiple investors.
- Amortization up to 40 years, usually 30 years or less.
- Sold unenhanced with a 10-year call provision.

Positives	Negatives
Long term funding up to 40 years	Laborious offering document preparation and public issuance process
Fixed rate coupon	Costs of issuance prohibitive < $15 million
No put or renewal risk	Tax exemption requires exempt assets
	No call provision for first 10 years

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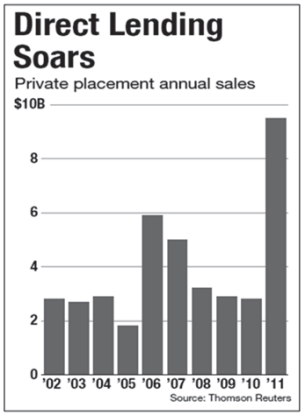
Bank Direct Placement

- Healthcare sector has seen the largest volume of privately-placed deals: $2.89 billion in 72 deals in 2011, $503 million in 19 deals in 2010 --475% jump.

"Health care issuers are often more familiar with bank lenders than typical municipal issuers, in part because they typically have several bank facilities, like letters of credit, according to Pierre Bogacz, a managing director at Florida-based HFA Partners LLC, a health care financial advisory firm. "When banks really started to focus on deploying their balance sheets and started to offer these direct purchases, hospitals were higher on their calling list than state or local governments," he said."

"Bond Buyer: Healthcare Private Placements Took Off In 2011" (http://www.hfapartners.com/research/articles 2/12/12)



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Bank Direct Placement

- Variable rate bonds sold in a negotiated, limited offering to a single investor, usually a bank; 1-month Libor + spread.
- Amortization up to 10-year depending on credit; schedule up to 25 years (with balloon) eg. 10 over 25.
- "HFMA SFP Newsletter: The Pros and Cons of Bank Direct Placements" (http://www.hfapartners.com/research/articles 10/17/11)

Positives	Negatives
No rating required	Short final maturity
No DSRF	Limited par amount
No underwriter	Fixed rate may require a swap
Low issuance costs	Whole relationship
Limited disclosure	
Streamlined documentation	

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Direct Placements: Pros & Cons

	Public Offering	Direct Placement
Final maturity	30-40 years	5-10 years
Amortization	30-40 years	20-25 years
Mode	Fixed	Variable
Swap required for fixed rate	No	Maybe
Cost of issuance	High	Low
Call feature	10 years	Anytime
Debt service reserve fund	Yes	No
Structural impact on rating	Neutral	Neutral
Offering complexity	High	Low
Rating required	Yes	No
Borrower downgrade risk	No	Yes
Mortgage pledge	Yes	Maybe

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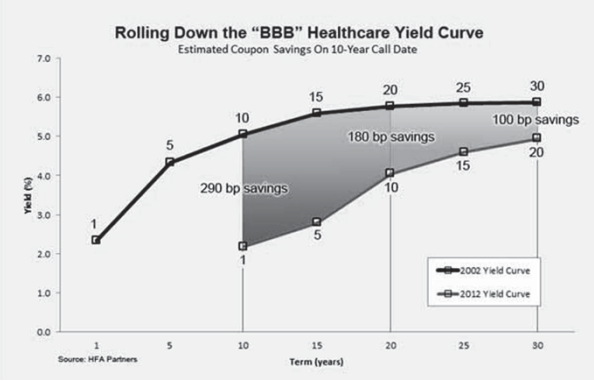
Partial Refundings

- Bank direct placements are increasingly being used for partial refundings as they allow shorter maturities.
- "When Less Is More: A Look at Partial Refundings" (http://www.hfapartners.com/research/articles 3/27/12)



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Swap: A Four-Letter Word?

- In the heydays, swaps were 70% of Wall Street public finance revenues.
- Hospitals borrowed variable and swapped to fixed rate --cheaper than selling fixed rate bonds.
- Mismatch: swaps were structured to final maturity (up to 30 years) but LOC's had 1-5 year terms.
- Most pay-fixed swaps have negative mark-to-market value and LOC's have become hard to renew.
- If refinancing LOC-backed debt with a bank direct placement, the swap can be left in place and the hospital avoids having to terminate.
- "Swap Termination: Pay Now, Or Pay Later" (http://www.hfapartners.com/research/articles 3/10/2010)

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Preserving Access to Capital

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Preserving Access to Capital

- Anticipate –renew facilities early, expect + plan for the unexpected.
- Preserve cash --even with higher leverage.
- Identify and mitigate balance sheet risk --liquidity, swaps, investments.
- Understand how markets differentiate –credit spreads.
- Monitor debt capacity –how much and on what terms.
- Manage ratings –as an integral part of the planning process.
- Trust, but verify –to ensure market pricing and terms.
- Diversify funding sources –some banks may not be there tomorrow.
- Disclose regularly –not just when going to market.
- Get independent advice!

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Questions

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Speaker

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- Pierre is founder and managing director of HFA Partners in Tampa, an independent financial advisory firm specialized in helping providers lower the cost of debt and minimize balance sheet risk.
- Pierre's 20-year career in non-profit healthcare finance includes bond underwriting, derivatives, business valuation and M&A and strategic advisory services. Pierre has helped raise over $3 billion for healthcare providers via a variety of funding structures. Before co-founding HFA, Pierre was a director with B.C. Ziegler covering hospitals for the southeastern U.S. Before, he worked as a healthcare banker and financial consultant for Deloitte, Alex. Brown, First Boston, Sumitomo Bank, and Citibank.
- Pierre received his B.A. in Economics and Political Science from Southern Methodist University and M.B.A. with a Concentration in Finance and Accounting from The University of Texas.

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Legislative and Regulatory Update

Lawrence Goldberg

Lawrence Goldberg

Senior Advisor for Health Care
Legislative and Regulatory Matters
Grant Thornton LLP

Larry brings more than 40 years of health care experience and is a well-known expert in Medicare legislation and regulation. In his role with Grant Thornton, Larry provides advice on health care issues at the federal level to our practitioners and clients. He monitors health care legislation and regulation for the firm's rapidly growing Health Care Practice. Larry is the author of Grant Thornton's Washington Bulletin and Health Care Alerts, health care publications analyzing and summarizing changes in federal health care legislation and regulatory issues.

Larry was the Director of Deloitte and Touche's Office of Washington National Affairs for Health Care, where he served as expert on Medicare and Medicaid health care financial issues and assisted both firm individuals and clients on health care financing issues for more than 22 years. Larry wrote two major Deloitte health publications, Washington Commentary and Health Care Review. These publications have been highly praised as leading, timely and concise analysis and thought products. Larry retired from Deloitte in 2006.

Prior to joining Deloitte in 1984, Larry was with the American Hospital Association. During his 11 year tenure, he was responsible for numerous financial issues including the Medicare program. He was instrumental in working with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) in implementing the hospital inpatient prospective payment system. He also chaired the UB-82 billing committee and was responsible for the form's adoption. Larry continues to analyze Medicare legislative and financial changes and provide such information to organizations and individuals. He is a recognized expert speaker and writer, frequently speaking to hospitals, trade associations and related organizations.

Professional qualifications and memberships
Member, Healthcare Financial Management Assn.

Education
Long Island University, MBA, Management
Hofstra University, BBA, Accounting

Grant Thornton

FICPA
Florida Institute of Certified Public Accountants

Washington Medicare Legislative and Regulatory Changes

Larry Goldberg

Senior Advisor for
Healthcare Legislative and Regulatory Matters

April 26, 2012

American Healthcare.....

If you can't afford a doctor, go to an airport - you'll get a free x-ray and a breast exam, and; if you mention Al Qaeda, you'll get a free colonoscopy.

Agenda

- **The ACA – its legal challenge**
- **Middle Class Tax Relief And Job Creation Act of 2012**
- **The FY 2013 Budgets going nowhere?**
  - **President's Budget**
  - **Republican's Budget**
- **Where is Medicare Heading**
  - **Accountable Care Organizations (ACOs)**
  - **Value-Based Purchasing Programs (VBP)**
  - **Bundling**
- **PPS Updates**

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Federal Register Access Prior to Publication Date

- **1. Start here:**
  - **http://www.archives.gov/federal-register/public-inspection/**
- **2. Scroll down and click on:**
  - View the Special Filing Document List
  - Look under Centers for Medicare & Medicaid

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Federal Register Access After Publication Date

- 1. http://www.gpoaccess.gov/fr/index.html is now "deactivated :
- 2. Go to: http://www.gpo.gov/fdsys
- 3. Choose Federal Register from right side menu
- 4. Know date
- 5. Select CMS

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The ACA and the Supreme Court

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The ACA and the Supreme Court

- Oral arguments have been heard
- Decision in June?
- Issues
  - Is whole law unconstitutional?
  - Is the individual mandate unconstitutional?
  - Other
- Pundits
  - Who did better in oral arguments?
- Politics
  - 5-4 outcome??
  - Roberts mark on court could be the big factor

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The ACA and the Supreme Court

- OK – the whole Act is ruled unconstitutional – what happens to Medicare?
- What happens to the providers savings incurred?
- Do you believe Congress will allow the savings to date to lapse?
- What happens to demos including ACOs and value based purchasing programs?

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Middle Class Tax Relief And Job Creation Act of 2012

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Middle Class Tax Relief And Job Creation Act of 2012

- HR 3630
- Part of a larger bill to extend payroll tax cut
- Date of Enactment is February 22
- P.L.112-96

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Middle Class Tax Relief And Job Creation Act of 2012

- **Extension of Freeze on Medicare Physician Payment Rates.** Extends current payment rates through December 31, 2012. *The cost of this provision is $18 billion over eleven years*
- **Extension of MMA section 508 reclassifications.** The bill would extend these reclassifications through March 31, 2012. *The cost of this provision is $100 million over eleven years*
- **Extension of Medicare work geographic adjustment floor.** This provision boosts payments for the work component of physician fees in areas where labor cost is lower than the national average. The provision would extend the existing 1.0 floor on the "physician work" index through December 31, 2012. *The cost of this provision is $400 million over eleven years*

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Middle Class Tax Relief And Job Creation Act of 2012

- **Extension of exceptions process for Medicare therapy caps.** Current law places annual per beneficiary payment limits on outpatient therapy services provided by non-hospital providers
  - Beneficiaries can get an exception to the cap for medically necessary therapy services. This provision extends the exceptions process through December 31, 2012
  - The provision also expands the cap on outpatient therapy services by applying both the cap and exceptions process to therapy services provided in hospital outpatient departments. Both the exceptions process and expansion of the therapy caps to the outpatient setting expire at the end of 2012.
  - *The net cost of this provision is $700 million over eleven years*

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Middle Class Tax Relief And Job Creation Act of 2012

- **Extension of payment for technical component of certain physician pathology services.** Extends the ability of independent laboratories to receive direct payments for the technical component for certain pathology services through June 30, 2012. *The estimated cost of the provision is $100 million over eleven years*
- **Extension of ambulance add-ons.** Extends the add-on payment for ground and air ambulance services, including in super rural areas, through December 31, 2012. *The cost of this provision is $100 million over eleven years*
- **Extension of outpatient hold harmless provision.** Extends the outpatient hold harmless provision through December 31, 2012, except for sole community hospitals with more than 100 beds who will no longer be held harmless. *The cost of this provision is $100 million over eleven years*

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Middle Class Tax Relief And Job Creation Act of 2012

- **Extension of the qualifying individual (QI) program.** Under current law, QI expires February 29, 2012. The provision would extend the QI program until December 31, 2012. *The cost of this provision is $600 million over eleven years*
- **Extension of Transitional Medical Assistance (TMA).** Transitional Medical Assistance (TMA) allows low-income families to maintain their Medicaid coverage for up to one year as they transition from welfare to work. Under current law, TMA expires February 29, 2012. The provision extends TMA until December 31, 2012. *The cost of this provision is $1.1 billion over eleven years*

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Middle Class Tax Relief And Job Creation Act of 2012

- The bill fails to extend two Medicare provisions that were included in the Temporary Payroll Tax Cut Continuation Act enacted in December.
  - **Mental Health Add-On:** Medicare payments for certain mental health services have been increased to ameliorate a past payment reduction that disproportionately affected non-physician mental health providers. This provision expired on March 1, 2012
  - **Payment for Bone Density Tests**: Dual energy x-ray absorptiometry (DXA) is a test measuring bone mineral density to identify individuals who may have osteoporosis, or are at risk of osteoporosis. These tests currently receive a special Medicare payment amount, which expired on March 1, 2012

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Middle Class Tax Relief And Job Creation Act of 2012

- **Reduction of Bad Debt Treated as an Allowable Cost.** The provision would phase down bad debt reimbursement for *all* providers for *all* populations to 65 percent.
  - Providers currently receiving 100 percent reimbursement for their bad debt would have a three-year transition of 88 percent, 76 percent, and 65 percent, respectively.
  - Providers currently reimbursed at 70 percent for their bad debt would be reduced to 65 percent. This provision does not continue the existing accommodation for bad debt incurred by SNF providers on behalf of dual eligibles, which is currently reimbursed at 100 percent.
  - *The savings from this policy are $6.9 billion over 11 years (2012-2022)*

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Middle Class Tax Relief And Job Creation Act of 2012

- **Prevention and Public Health Fund.** The ACA established the Prevention and Public Health Fund to help shift the focus of the health care system to prevention rather than treatment.
- The provision reduces the authorized amount for the Fund, for a reduction in spending of $5 billion. This does not account for further cuts anticipated in the **sequestration** that will go into effect beginning in FY 2013.
- *The savings from this policy are $5 billion over 11 years*

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Middle Class Tax Relief And Job Creation Act of 2012

- **Rebasing Medicaid State DSH Allotments.** The Affordable Care Act (ACA) reduced DSH payments, starting in 2014, to reflect the expected decrease in uncompensated care as reform increases the number of patients with insurance. This policy would extend the DSH payment reductions for an additional year, through fiscal year 2021.
  - *The savings from this policy are $4.1 billion over 11 years*
- **Rebase Medicare Clinical Laboratory Payment Rates.** This policy reduces clinical lab payment rates by 2 percent in 2013.
  - *The savings from this policy are $2.7 billion over ten years*

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President's Budget

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President's Budget

- President Released FY 2013 Budget Proposals on February 12
- Includes Reductions of Approximately $303 Billion in Medicare and $56 Billion in Medicaid over 10 Years
- Already considered DOA

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President's Budget

- ***Align Medicare Drug Payments with Medicaid Policies for Low-Income Beneficiaries: --*** would allow Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy beginning 2013 [$155.6 billion in savings over 10 years]
- ***Adjust Payment Updates for Certain Post-Acute Care Providers: --*** would gradually realign payments [payments too high] with costs through adjustments to payment rate updates for Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals, Skilled Nursing Facilities (SNFs), and Home Health agencies, by 1.1 percentage points beginning in 2014 through 2021 [$56.7 billion in savings over 10 years]

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President's Budget

- ***Reduce Medicare Coverage of Bad Debt:*** would reduce bad debt payments to 25 percent for all eligible providers over three years starting in 2013 [$35.9 billion in savings over 10 years]
- ***Better Align Graduate Medical Education Payments with Patient Care Costs: --*** would reduce the IME adjustment by 10 percent beginning in 2014 [$9.7 billion in savings over 10 years]
- ***Encourage Appropriate Use of Inpatient Rehabilitation Facilities (IRF): --*** would return the IRF compliance threshold to its previous 75 percent level beginning in 2013 [$2.3 billion in savings over 10 years]

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President's Budget

- ***Equalize payments for certain conditions commonly treated in Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNF): --*** would reduce the differences between IRFs and SNFs in payment for treatment of specified conditions commonly treated in both settings. Care for hip and knee replacements, hip fractures, and certain pulmonary diseases are currently provided in both IRFs and SNFs. This proposal would reduce IRF payments for selected conditions, beginning in 2013. [$2.0 billion in savings over 10 years
- ***Adjust SNF Payments to Reduce Hospital Readmissions: --*** reduces SNF payments by up to three percent beginning in 2016 for facilities with high rates of care-sensitive, preventable hospital readmissions [$2.0 billion in savings over 10 years]

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President's Budget

- ***Reduce Critical Access Hospital (CAH) payments from 101 percent of reasonable costs to 100 percent of reasonable costs***. [$1.4 billion in savings over 10 years]
- ***Prohibit CAH Designation for Facilities Less Than 10 Miles from Nearest Hospital: --*** Beginning in 2014, this proposal would prevent hospitals that are within 10 miles of another hospital from maintaining designation as a CAH and receiving the enhanced rate [$590 million in savings over 10 years]
- ***Update Medicare Payments to More Appropriately Account for Utilization in Advanced Imaging:*** Beginning in 2013, would adjust payment for advanced imaging equipment to account for higher levels of utilization of certain types of equipment [$820 million in savings over 10 years]

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President's Budget

- Beneficiary changes
  - ***Increase Income-Related Premiums under Part B and Part D: --*** Beginning in 2017, this proposal would increase income-related premiums [$27.6 billion in savings over 10 years]
  - ***Medigap Coverage:*** would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, effective in 2017 [$2.5 billion in savings over 10 years]
  - ***Modify Part B Deductible for New Beneficiaries: --*** would apply a $25 increase to the Part B deductible in 2017, 2019, and 2021 for new beneficiaries [$2.0 billion in savings over 10 years]

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President's Budget

- Beneficiary changes
  - ***Introduce Home Health Copayments for New Beneficiaries: --*** would create a co-payment for new beneficiaries of $100 per home health episode, starting in 2017 [$350 million in savings over 10 years]
- ***Require Prepayment or Earlier Review for Power Mobility Devices:*** test the effectiveness of using prior-authorization and pre-payment review on some PMDs through a demonstration [$140 million in savings over 10 years]

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President's Budget

- ***Apply a Single Blended Matching Rate to Medicaid and CHIP Starting in 2017:*** Beginning in 2017, would replace complicated federal matching formulas with a single matching rate specific to each state that automatically increases if a recession forces enrollment and state costs to rise [$17.9 billion in savings over 10 years]
- ***Phase Down Medicaid Provider Tax Threshold Beginning in FY 2015: --*** would limit states' ability to use provider taxes to pay the state share of Medicaid by phasing down the Medicaid provider tax threshold from the current law level of 6 percent in FY 2014, to 4.5 percent in FY 2015, 4 percent in FY 2016, and 3.5 percent in FY 2017 and beyond [$21.8 billion in savings over 10 years]

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Republican Budget
Ryan Plan

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Republican Budget
Ryan Plan

- **Does not contain specifics – leaves to authorizing committees "to fill in the blanks"**
- Would seek $1.028 trillion in discretionary spending in 2013 – below the $1.047 trillion spending cap Democrats and Republicans agreed to in their debt deal last August
- **"Repeals the President's Health Care Law**; Advances bipartisan solutions that power away from government bureaucrats and put patients in control; No disruption for those in or near retirement; Ensures a strengthened Medicare program for future generations, with less support given to wealthy and more assistance for the poor and sick"

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Republican Budget
Ryan Plan

- Would convert the federal share of Medicaid spending into a **block grant** indexed for inflation and population growth
- **Would constrain Medicaid's growing cost trajectory by $810 billion** over ten years, contributing to the long-term stability of the federal government's fiscal condition and easing the largest and fastest growing burden on state budgets
- For those **workers currently under the age of 55**, beginning in 2023, those seniors would be given a choice of private plans competing alongside the traditional fee-for-service option on a newly created Medicare Exchange. Medicare would provide a premium-support payment either to pay for or offset the premium of the plan chosen by the senior.

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Commuting-Based Area Wage Index

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Commuting-Based Area Wage Index

- Report as required by the ACA section 3137(b)
- Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html
- Too soon to "get excited"
- Many data sources not yet available
- Would require legislation
- Would be a hospital-specific index
- Would most likely eliminate most if not all reclassifications

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Commuting-Based Area Wage Index

- The report discusses five issues to consider in moving forward with implementation of a CBWI system for IPPS:
  - (1) the availability of accurate and up-to-date commuting data,
  - (2) the potential for labor market distortions due to hospitals altering hiring patterns in direct response to changes in wage index methodology,
  - (3) its portability to other Medicare payment systems,
  - (4) the need for exceptions, and
  - (5) a transition to the new wage index system.

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Where is Medicare Heading???

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Where is Medicare Heading???

- Accountable Care Organizations
  - 27 named
- Value-based purchasing
- Bundling
- Paying lowest price irrespective of setting
- More immediate payment constraints

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PPS Updates

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Questions

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Chief Executives Panel: Future Challenges for Health Care Organizations

Jeffrey M. Herschler (moderator)
and
Michael W. Garner, Ph.D.
and
Michael Mueller

Jeffrey M. Herschler

President

FHIcommunications

Jeffrey Herschler is currently the President of FHIcommunications, a digital media and marketing consulting firm serving Florida's Health Industry. Key accounts include Miami Children's Hospital, Bay Imaging Group, MF healthcare Solutions, Goldstein Schechter Koch and Danna Gracey.

Mr. Herschler graduated from the University of Maryland in 1986 with a B.S. in Finance and a B.A. in Economics. He is a member of the Phi Beta Kappa Honor Society.

He moved to Miami in 1988. There, Mr. Herschler pursued a career in hospitality management. After running the famous Tropics nightclub during South Beach's late 80's renaissance, Mr. Herschler joined Brad Weiser's popular Floribbean cuisine, tapas bar concept, Cafe Tu Tu Tango. First working in the original Coconut Grove location he then assisted in the opening of the Atlanta and Orlando branches. Later, Mr. Herschler worked with Dennis Max's Unique Restaurant Concepts and managed the successful Prezzo's restaurants in South Florida.

In 1997, Mr. Herschler launched a new career in marketing and advertising. He "learned the ropes" in the intensely competitive alternative weekly segment with a two year stint at Miami New Times. Later he joined the leading worldwide visitor guide publisher, Guest Informant. In 2001, Mr. Herschler went to work for Florida Medical Business, an award-winning healthcare business magazine read by physicians and hospital executives. There he managed such prestigious advertising accounts as Memorial Healthcare System, University of Miami, Greenberg Traurig, Medtronic, Medtronic, Ely Lilly and Berkshire Hathaway's Medical Protective. Mr. Herschler's media experience also includes a two year stretch at the Daily Business Review.

In January of 2010, Mr. Herschler launched FHIcommunications to serve healthcare clients in the areas of digital branding, e-mail marketing, events and media buying. The firm publishes the digital newsletter FHIweekly & Specialty Focus in addition to producing the website FloridaHealthIndustry.com.

Mr. Herschler is a board member of the South Florida Healthcare Executive Forum and a member in good standing with the American College of Healthcare Executives. An avid motorcycle enthusiast and amateur chef Mr. Herschler resides in Coral Gables with his daughter and significant other.

To contact Mr. Herschler, please call 305.299.3937 or e-mail Jherschler@Comcast.net.

Michael W. Garner, Ph.D.

President and CEO

Florida Association of Health Plans (FAHP)

Dr. Garner currently serves as President and CEO of the Florida Association of Health Plans (FAHP), the state trade association for HMOs and PPOs in Florida. The association represents 20 health plans serving every health care market in the state, including Commercial, Medicaid, Medicare, Children's Health Insurance, and the Federal Employee Health Plan.

Michael received his bachelor's, master's, and doctorate from the University of Florida in Political Science with specialties in health and environmental policy. During this time, he conducted research on the effects of persistent impoverishment on health status and the effects of maternal and child health programs on reducing low weight births and infant mortality.
Michael has worked for both the private and public sectors.

He started his career as a Health Planner with the North Central Florida Health Planning Council in Gainesville, Florida, conducting community needs assessments and implementing Florida's Healthy Start program, a program providing screening and services for pregnant women and infants. After the Health Planning Council, Michael worked for Blue Cross and Blue Shield of Florida (BCBSFL) as a Senior Policy Analyst, focusing on state and federal health policies including mandates (e.g., mental health parity and any willing provider), civil remedy, and the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. From BCBSFL, Michael worked for a period with the Mayo Clinic in Jacksonville establishing a Medicare outpatient reimbursement system before moving to Tallahassee in 2000, to work for the Florida Legislature.

His career with the Florida Legislature included working as a Senior Analyst with the Legislature's evaluation office, the Office of Program Policy Analysis and Government Accountability (OPPAGA). Michael worked on a wide range of policy issues while with OPPAGA including Medicaid efficiencies, Medicaid fraud and abuse prevention and detection, environmental assessment methodologies, and administrative structures in school districts in Florida.

Michael moved to the Florida House of Representatives' Committee on Health Care in 2004 where he served as a Senior Legislative Analyst, with primary focus on Medicaid, KidCare, and private health insurance reform. In 2005, he joined the Florida Senate Health Committee where he focused on Medicaid, KidCare, long-term health care, private health insurance, and environmental health. During this time, he served as the lead staff on the Senate Select Committee on Medicaid Reform. Michael left the Florida Senate as a Chief Legislative Analyst.

Michael is married to Elizabeth (Lisa) E. Garner, Ph.D. They have two daughters together.

Michael Mueller

Chief Financial Officer

Health Central

Michael Mueller is the Chief Financial Officer of Health Central. This community hospital is located 15 minutes north of Disney on the west side of Orlando. It has a 171-bed hospital in addition to 228-bed nursing home, surgery center, urgent care and employed physician practices. In April 2012, the hospital was successfully sold to Orlando Health. Mr. Mueller has been a CFO in governmental, non-profit and for-profit hospitals along with executive experience in an academic medical center and corporate healthcare. He graduated with a Bachelor's in Accounting and Master's in Taxation from the University of Illinois, is a CPA and previously worked in public accounting before discovering his love of healthcare finance.

There is no PowerPoint presentation for this session.

Breakout 16: OMB Circular-A133 and Government Auditing Standards Update

John P. DiSanto

John DiSanto

Executive Director

Ernst & Young LLP

John began his professional accounting career in 1985. John serves a variety of governmental, not-for-profit and health care organizations, including pension plans. Experience includes alternative investments, public offerings, tax-exempt financings, statutory compliance and internal control engagements, and operational reviews.

John joined Ernst & Young in September 1996 as a manager in the public sector industry group serving primarily government, college and university, and not-for-profit clients. John was promoted to executive director in July 2002.

John's recently-served clients include the following: City of Tampa, including Fire and Police and General Employees Pension plans, City of Orlando, including Fire and Police and General Employees Pension plans (defined benefit and defined contribution plans), Hillsborough County, Pinellas County, Collier County, Government of the US Virgin Islands, Hillsborough County Aviation Authority, District School Board of Polk County, University of South Florida Foundation, University of Tampa, St. Leo University, Eckerd College, Tampa Bay Water Authority and University of Central Florida Foundation.

John holds a bachelor of science in accounting from St. John's University and a master's degree in accounting from the University of South Florida. John is a certified public accountant in Florida, New York and Puerto Rico. John is a regular speaker for, various government organizations including the Florida Government Finance Officers Association, Florida Association of School Business Officers and the Florida School Finance Officers Association.

The New 2011 Yellow Book:

… What You Need to Know

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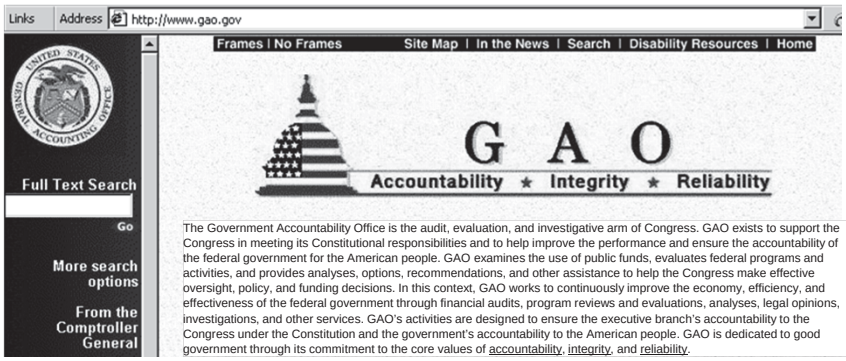
Objectives of Session

- To cover the following topics
  - A high level summary of changes in the 2011 Yellow Book;
  - A more detailed exploration of the new independence standards;
  - The Yellow Book's independence conceptual framework and related additional documentation requirements;
  - How the 2011 Yellow Book's independence rules compare to the AICPA's rules;
  - Discussion of a few practical real-life situations and how the independence standards would apply;
- Answer your questions!

Government Auditing Standards (GAS) requirements

- GAS, otherwise known as the Yellow Book is located in PM-GAAIT. The Yellow Book can also be downloaded from the www.gao.gov website.



Engagement subject to Government Auditing Standards

- Crosses many industries and public companies as well
  - Provider Care and Life Sciences
  - Colleges and Universities
  - Not for Profit
  - Government
  - Banking
  - Energy and Utilities
  - Proprietary educational corporations
  - Federal programs and state grant projects require financial statement audit in accordance with Government Auditing Standards

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Types of Governmental Auditing Standards Engagements –Financial Statement Audits

- Financial statements audited in accordance with Government Auditing Standards
  - Provider Care, Government, Not for Profits and Colleges and Universities
  - Banking
  - Proprietary educational corporations
  - Lender Servicers

Types of Government Auditing Standard Engagements– Compliance Audits and Attestation Engagements

- OMB Circular A-133 for States, Local Governments, Not for Profits, Hospitals and Colleges and Universities
- Department of Housing and Urban Development Audit Guide
  - Mortgage banking
- Department of Energy Audit Guidance
  - Energy and utilities
- Department of Education Attestation Guides
  - Lenders
  - Lender servicers
  - Proprietary educational entities
- Others
  - Performance Audits

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Why the Yellow Book was revised

- ► Promote the modernization of auditing standards
- ► Streamline with standard setters
- ► Address issues GAO has observed

Effective Dates

- For financial audits and attestation engagements, changes are effective for periods ending after December 15, 2012
- For performance audits, changes effective for audits beginning on or after December 15, 2011

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Primary Yellow Book Changes

- Updated independence
  - Included a conceptual framework
- Focused on converging where practical
  - Incorporated clarified SASs
  - Fewer differences
- Added documentation requirements
  - Additional documentation in independence
  - Focus on non-audit services
- Made minor changes for performance audits

Overall Changes for Financial Audits

- Considered Clarity Project conventions
- Streamlined language to harmonize with AICPA
- Clarified additive requirements

No new requirements were added for financial audits and attestation engagements

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Requirements Beyond AICPA

- Additional requirements relate to
  - Auditor communication
  - Previous audits and attestation engagements
  - Noncompliance with provisions of contracts or grant agreements, or abuse
  - Developing elements of a finding
  - Documentation
    - *For attestation engagements, this applies*
      - *only at the examination level*

Requirements Beyond AICPA

- Additional requirements relate to
  - Reporting auditors' compliance with GAGAS
  - Reporting on internal control, compliance with provisions of laws, regulations, contracts, and grant agreements, and other matters
  - Reporting views of responsible officials
  - Reporting confidential or sensitive information
  - Distributing reports

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Removed Duplicative Requirements

- Financial Audits
  - Restatements
  - Internal control deficiency definitions
  - Communication of significant matters
  - Consideration of fraud and illegal acts
- Attestation Engagements
  - Internal control deficiency definitions

Deleted Requirements

- Covered by the Quality Control system
  - Develop policies to address requests by outside parties to obtain access to audit documentation
- Covered by AICPA Standards
  - Document terminated engagements
    - Retained requirement for performance audits

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Attestation Engagements

- Separated attest requirements
  - Examination
  - Review
  - Agreed-Upon Procedures

- **Update considerations**
  - Identified practice issue
  - Clarified distinctions between engagement types
  - Emphasized AICPA reporting requirements

No Changes

- No changes to the CPE requirements
- No changes to the requirement to submit the peer review report to the party contracting for the audit

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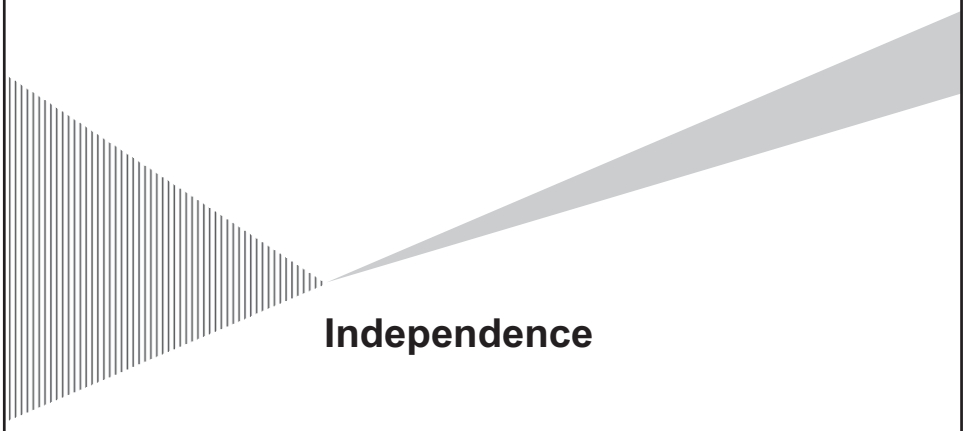
Supplementary Materials

- From GAO Web site
  - Summary of Major Changes
  - Listing of Technical Changes
- http://www.gao.gov/yellowbook



Independence

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Chapter 3 – General Standards: Independence

- Defines independence of mind and in appearance
- Emphasizes the importance of considering individual threats to independence both individually and in aggregate

Chapter 3 – General Standards: Independence

Conceptual Framework

- Allows the auditor to assess unique circumstances
- Adaptable
- Consistent with AICPA and IFAC frameworks

Significant differences from AICPA Int. 101-3

- Entry point for use of the framework
- Emphasis on services “in aggregate”
- Documentation requirement

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Applying the Framework

- New approach combines a conceptual framework with certain rules (prohibitions)
  - Balances principle and rules based standards
  - Serves as a hybrid framework
- Certain prohibitions remain
  - Generally consistent with Rule 101 AICPA
- Beyond a prohibition
  - Apply the conceptual framework
  - Will be used more often than AICPA

Chapter 3 – General Standards: Independence

- Threats could impair independence
  - Do **not** necessarily result in an independence impairment
- Safeguards could mitigate threats
  - Eliminate or reduce to an acceptable level

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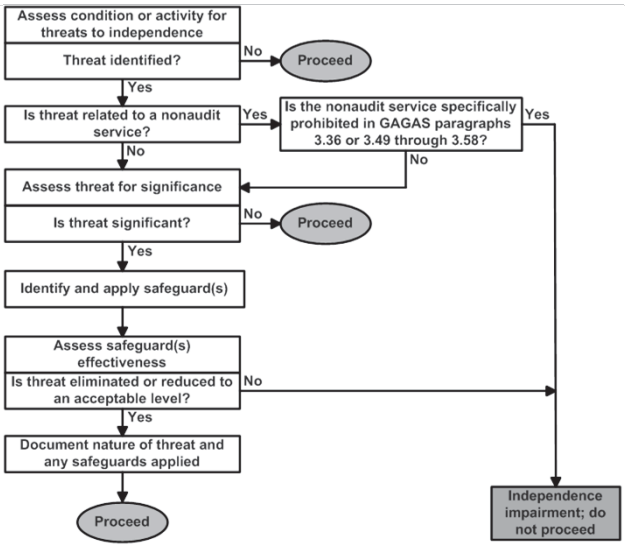
GAGAS Conceptual Framework for Independence



Independence Categories of Threats

1. Management participation threat
2. Self-review threat
3. Bias threat
4. Familiarity threat
5. Undue influence threat
6. Self-interest threat
7. Structural threat

See Supplemental Guidance in Appendix 1 for examples

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Assessing Significance in the Conceptual Framework for Non-audit services

The framework requires the auditor to assess the significance of threats

- Threats related to non-audit services often include
  - Management participation threat
  - Self review threat

- Indicators of a significant threat include:
  - Level of services provided (aggregation assessment)
  - Significance to the audit objective
  - Basic understanding of the service enough to recognize material errors
  - Facts and circumstances that increase the perception that the auditor is working as part of management

Documentation Requirement Conceptual Framework

New documentation requirement

- Must document when safeguards have been applied
  - Beyond the threat level
  - Only once safeguards are applied
  - Document how safeguards sufficiently mitigate the threats

Peer Review

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Independence Q&A Guide

- GAO will retire current *Government Auditing Standards: Questions and Answers to Independence Standard Questions* guidance

Preconditions to Performing Nonaudit Services

- Management should take responsibility for nonaudit services performed by the auditors
- Auditors should document their understanding with management regarding the nonaudit service
- Auditors should assess (AICPA) and document (GAGAS) whether management possesses suitable skill, knowledge, or experience to oversee the nonaudit service

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Assessing Management's Skill, Knowledge, or Experience

- Factors to document include management's:
  - Understanding of the nature of the service
  - Knowledge of the audited entity's mission and operations
  - General business knowledge
  - Education
  - Position at the audited entity
- Some factors may be given more weight than others
- GAGAS does not require that management have the ability to perform or re-perform the service

Sufficiency of Skills, Knowledge and Experience

- Sufficient skills, knowledge and experience may be judged in part based on:
  - Ability of the identified client personnel to identify material errors or misstatements in a non audit service work product
  - Ability of the client to understand the nature and results of the audit service
  - Ability of management to take responsibility and understand the work
- Client prepared material in poor condition may indicate the client is not capable of taking responsibility for the service. Significant audit findings and adjustments may also be indicative of this issue.

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Safeguards – Non audit services

- Auditors should document safeguards when significant threats are identified.
  - Auditor has responsibility to perform the assessment, this cannot be a management assertion
  - Assessment should be in writing and indicate actions the auditor has taken to mitigate the threat
  - Assessment should include a conclusion
  - Auditor should document actions taken to mitigate the threat
    - Examples may include:
      - Actions taken by the client to gain an understanding of the non-audit service and detect any errors
      - Actions taken by the auditor to preserve independence such as an extra level of review or secondary review

Routine Audit Services and Nonaudit Services

- Routine audit services pertain directly to the audit and include:
  - Providing advice related to an accounting matter
  - Researching and responding to an audited entity's technical questions
  - Providing advice on routine business matters
  - Educating the audited entity on technical matters
- Other services not directly related to the audit are considered nonaudit services

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Routine Audit Services and Nonaudit Services

►Services that are considered non-audit services include:

- ► Financial statement preparation
- ► Bookkeeping services
- ► Cash to accrual conversions (a form of bookkeeping)
- ► Other services not directly related to the audit

►Unless specifically prohibited, nonaudit services MAY be permissible but should be documented

- ► In relation to the conceptual framework
- ► In relation to the auditor's assessment of managements' skill, knowledge or experience

Bookkeeping Services

May be performed provided the auditor does not

- ► Determine or change journal entries, account codes or classifications for transactions, or other accounting records without obtaining client approval
- ► Authorize or approve transactions
- ► Prepare source documents
- ► Make changes to source documents without client approval

Consistent with AICPA Int. 101-3

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Prohibitions within Internal Audit

Services provided by external auditors

- Setting internal audit policies or the strategic direction
- Deciding which recommendations resulting from internal audit activities to implement
- Taking responsibility for designing, implementing and maintaining internal control

Prohibitions within IT Services

External auditors may not

- Design or develop an IT system that would be subject to or part of an audit
- Make significant modifications to an IT system's source code
- Operate or supervise an IT system

Significant change in auditing prohibitions for future periods after a system implementation

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Prohibitions Related to Internal Control Monitoring

External auditors

- May not provide ongoing monitoring services
- May not design the system of internal controls and then assess its effectiveness

- May evaluate the effectiveness of controls
- *Management is responsible for designing, implementing and maintaining internal control*

Prohibitions within Valuation Services

External auditors may not provide valuation services that

- Would have a material effect,
- Involve a significant degree of subjectivity, and
- Are the subject of an audit

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Performance Audits and Agreed Upon Procedures Engagements

Nonaudit services that are otherwise prohibited by GAGAS may be provided when such services do not relate to the subject matter of the engagement

- Performance audit
- Agreed-upon procedures

Document considerations and conclusion

Financial Statement Preparation

Auditors may prepare financial statements

- Considered by GAGAS a non-audit service
- Must apply the conceptual framework
- Two additional documentation requirements
  - Document application of safeguards
  - Document assessment of management's skill, knowledge or experience

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Assessing Significance for Bookkeeping and Financial Statement Preparation

Relative significance is a continuum

- Indicators of significant threats for bookkeeping and financial statement preparation may include:
  - Financial statement preparation with other non-audit services such bookkeeping or cash to accrual conversions
  - Condition of client prepared books and records
  - Level of anticipated "correction" or adjustments to client prepared schedules and documents
  - Condition of the general ledger/trial balance
- Less significant may be:
  - Purely mechanical calculations

Yellow Book vs. AICPA - Similarities

- Specific threats & safeguards
  - Except GAO "structural threat" is unique to governments
- Prohibitions on nonaudit services
- AICPA Int. 101-3 general requirements

  Audited entity must:

  a. assume all management responsibilities;

  b. designate an individual to oversee the services who has suitable skill, knowledge, or experience;

  c. evaluate adequacy and results of services performed;

  d. accept responsibility for the results of the services.
- Documentation of –
  - Understanding with the audited entity
  - Significant threats to independence that require the application of safeguards

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Yellow Book vs. AICPA - Differences

- Conceptual framework approach
  - Yellow Book requires all circumstances/relationships that may result in threats to undergo threats/safeguards analysis
  - AICPA only requires threats/safeguards analysis if circumstance/relationship not specifically addressed in Code
- Permitted Nonaudit services
  - Yellow Book requires all permitted nonaudit services to undergo threats/safeguards analysis which may result in need for safeguards
  - If nonaudit service is permitted under AICPA Int. 101-3, additional safeguards are generally not required
- Documentation of management's skills, knowledge or experience

Case Study – Background

ST has the following employees involved in the audit:

A Ten Member Town Council – Meets Monthly

Brandon – Town Manager
Dave – Finance Director
Shelley – Accounting Clerk

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Case Study – 1

ABC meets with Brandon, the Executive Director of ST at the beginning of the audit engagement. Brandon indicates that he and Dave have closed the trial balance but will not prepare the year end financial statements of ST. Can ABC prepare the year end financial statements and remain independent under AICPA and YB standards?

A. Yes
B. No
C. Maybe

Financial Statement Preparation

May be permissible provided

- Management possesses suitable
  - Skill,
  - Knowledge, or
  - Experience

  To evaluate the adequacy and results of the services performed

Consistent with AICPA Int. 101–3

- *Otherwise no safeguard could reduce the threat to an acceptable level*

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Suitable skill, knowledge, and/or experience

- Individual designated to oversee the nonattest service has the ability to understand the nature, objective, and scope of the nonattest service.
- Does not require the designated individual to supervise the member in the day-to-day rendering of the services.
  - make all significant judgments;
  - evaluate the adequacy and results of the service;
  - accept responsibility for the service results; and
  - ensure that the resulting work product meets the agreed-upon specifications.

Case Study – 2

During the audit ABC identifies the following issues:

- ST's trial balance is not in balance
- The balance sheet has account balances that appear to be materially wrong – assets with credit balances and liabilities with debit balances
- Bank reconciliations are materially different from the trial balance

ABC has been asked by ST to do whatever necessary to get the books in order to complete the audit. Would ABC's independence be impaired if it agrees to do so?

A. Yes
B. No

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Case Study -3

- What documentation must ABC have in order to comply with the proposed Yellow Book independence requirements given that ABC has prepared the year end financial statements?

AICPA 101-3 Documentation requirements

- *In connection with nonaudit services, an auditor should establish and document in writing their understanding with the audited entity's management or those charged with governance, as appropriate, regarding the following:*
  - *objectives of the nonaudit service engagement;*
  - *services to be performed;*
  - *audited entity's acceptance of its responsibilities;*
  - *the auditor's responsibilities; and*
  - *any limitations of the nonaudit service engagement*

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Additional Yellow Book Documentation Requirements

- New audit documentation requirements include:
  - Documentation of the conceptual framework for issues requiring application of safeguards.
    - Under AICPA, documentation required but only applicable when circumstances not addressed in Code
  - For any non-audit service there is an additional documentation requirement
    - Assessing management's skill, knowledge or experience
    - Note: The assessment is required by the AICPA, GAGAS requires documentation of that assessment

Sample Documentation

ABC has determined that there exists a threat of both self review and management participation through its preparation of the financial statements of ST. ABC believes that the threat is of such significance that documentation of the evaluation is necessary and that application of safeguards is necessary to reduce the threat to acceptable levels.

ST has assigned Dave to oversee the engagement. ABC has determined that Dave has suitable skills, knowledge and experience to oversee the engagement as demonstrated by the following:

- *Dave has 20 years experience in local governments and is knowledgeable of governmental GAAP*
- *He utilizes various reporting and disclosure practice aids to review the financial statements*
- *He has attended continuing education in the last year on current GAAP standards*

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Sample Documentation – cont.

ABC has determined that the following safeguards are necessary:

- *Documentation through the engagement letter that management assumes all responsibility for the financial statements and that management will a)oversee the services by designating an individual, who possesses suitable skill, knowledge, and/or experience; b)evaluate the adequacy of the service performed and c) accept responsibility for the service*
- *Documentation of our evaluation of the sufficiency of Dave's SKE as well as his responsibilities with ST*

Sample Documentation – cont.

ABC has determined that the following safeguards are necessary:

- *Have the statements prepared by an individual within the firm who is not responsible for planning and supervising the engagement and*
- *Have the statements reviewed by an individual within the firm not on the audit team*

► Conclusion – ABC has determined that Dave has suitable SKE to oversee the engagement and that independence is not impaired by virtue of preparing the financial statements

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Proposed changes to OMB Circular A-133 Audits

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Proposed Circular A-133 changes

- Increase threshold to $1 million
- New category of audit $1 million to $3 million
  - 2 compliance requirements
- Changes for larger single audits
  - Greater than $3 million
  - Full single audit required
  - Federal agency identify compliance requirements
- Involvement of cognizant/oversight agency
  - Audit follow up
  - Pass-throughs and subrecipients

Proposed Circular A-133 Changes (continued)

- Changes to cost principles
  - Extent of auditing
  - Consideration of a “flat” rate
- Administrative requirements
  - Requesting awards and awarding grants
  - Reduce administrative burden

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Breakout 17: Third Party Reimbursement and Operational Issues for Long-Term Care

Steven R. Jones, CPA

Steve Jones, CPA

Shareholder

Moore Stephens Lovelace

Steve is a Shareholder in the Clearwater office Moore Stephens Lovelace and is the Firm's Long Term Care Practice Group Leader. Steve has over 30 years of experience in public accounting, primarily serving clients in Long Term Care. He focuses his practice on skilled nursing facilities, home health agencies, and hospice organizations, providing reimbursement consulting services and serving as an advocate for his clients to various healthcare regulators and third-party payers.

Steve has had extensive involvement in the Long Term Care industry both as a professional and as a member of industry policy committees. His experience includes:

- Financial audits, reviews and compilations
- Reimbursement consulting and modeling
- Client representation in third-party payment audits
- Certificate of Need applications and hearings
- Pre-purchase due diligence
- Operation reviews
- Cost reporting
- Financial feasibility forecasts and projections
- Licensure applications

A few of Steve's notable accomplishments include:

- Developing Florida benchmarking data for skilled nursing facilities
- Serving as the Firm's primary representative to the Florida Health Care Association since 1986
- Author of a monthly article on reimbursement accounting and compliance issues for the FHCA newsletter
- Trainer for negotiating contracts with managed care organizations.
- Expert testimony at administrative hearings, specifically on Certificate of Need issues or issues arising from Medicaid audits

<u>Education and Certifications</u>
B.S.B.A. Degree in Accounting, University of Florida
C.P.A., Certified Public Accountant - State of Florida, State Board of Accountancy

38 Years of Excellent Client Service

FICPA Health Care Conference

3rd Party Reimbursement & Operational Issues for CPAs Serving Long-Term Care

Presented by:
Steven R. Jones, CPA

So much more than an accounting firm...

Long-Term Care Defined

- CMS – Medical & Non-Medical (ADL Assist).
- Usually Elderly, with Chronic Conditions
- Skilled Nursing Facilities (SNFs)
- Assisted Living Facilities (ALFs)
- Intermediate Care Facilities for Disabled(ICFDD)
- Home Health
- LTCH, Hospice

Business & Regulatory Environment

- **State – Certificate of Need (CON) Required?**
- **Medicaid Funding & Managed Care Transition**
- **Federal – Medicare Payment "Refinements"**
- **Health Care Reform**
  - Demonstrations, Pilots, and the "Boomer Tsunami"
  - Center for Medicare Medicaid Innovation (CMMI)
    - ACO, PACE, Bundled Payment

Normal Audit Risk Assessment

- **Accounts Receivable**
  - Assisted Living (Private pay, some SSI)
  - Home Health (Medicare HHRG)
  - ICF/DD (Medicaid)
  - Hospice (Medicare)
  - Nursing Homes
    - Patient Responsibility

Normal Audit Risk Assessment
(Continued)

- **Other Receivables**
  - Nursing Homes
  - Medicare Cost Report
- **Other Payables**
  - Assisted Living
  - Home Health (HHRG problem)
  - Nursing Homes
    - 3rd Party Audits

Other Risk Factors

- **3rd Party Compliance Reviews**
  - Medicare Refund Audit Contractor (RAC) Reviews
  - Medicaid Integrity Contractor (MIC) Reviews
  - Zone Program Integrity Contractor (ZPIC) Audits
  - False Claims Act & Qui Tam Actions

Other Risk Factors *(Continued)*

- **Regulatory Issues**
  - Surveys
  - Medicare re-enrollment issues
  - Payroll issues
  - Health Insurance Portability & Accountability Act (HIPAA)

Other Operating Risks

- **Managed Care contracts**
- **Quality Measures**
- **ALF Case Mix Creep**
- **Lease Covenants**
- **Legal Liability**
- **Competition**

Medicaid Managed Long-Term Care

- **Overview**
  - Covered Services/Provider Types
  - Beneficiary Eligibility & Enrollment
  - Contract Requirements
  - Rates & Payment

Medicaid Managed Long-Term Care *(Continued)*

- **Implementation Timeline**
- **April 2012 - AHCA Requests Non-binding LOIs**
- **July 2012 - Invitation to Negotiate Issued**
- **April 1, 2014 - Full State-wide Implementation**

Web Resources

- Center for Medicare Medicaid (CMS) Skilled Nursing Facility Center http://www.cms.gov/center/snf.asp (Browse by Provider Type on left side lists Hospice & Home Health Centers)
- Center for Medicare & Medicaid Innovation http://www.innovations.cms.gov/
- Agency for Health Care Administration (AHCA)- Reimbursement Plans http://ahca.myflorida.com/Medicaid/cost_reim/plans.shtml (Structure at top of page lists Cost Reporting & rate links)
- FL Medicaid LTC Managed Care http://www.fdhc.state.fl.us/Medicaid/statewide_mc/index.shtml#ltchome

Web Resources *(Continued)*

- AHCA Health Facility Regulation Home Health Agencies http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Home_Care/index.shtml
- AHCA Health Facility Regulation Long Term Care Unit (incl ICF DD, Special Homes, Transitional Living Facilities, Pediatric Extended Care Ctrs) http://ahca.myflorida.com/MCHQ/Long_Term_Care/LTC/index.shtml
- AHCA Assisted Living Unit (incl Family Care Homes and Adult Day Care) http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/index.shtml

Breakout 18: Positioning Your Healthcare Organization for the Future

Carlos G. Hernandez (moderator)
and
James P. Grigg
and
Donald Sibery, MHA, FACHE
and
Michael B. Zenn, MBA

Carlos G. Hernandez

Senior Manager

Crowe Horwath, LLP

Professional Summary

Carlos joined Crowe Horwath, LLP in 2011 as the regional lead of the healthcare practice with over 16 years of public accounting and financial management experience primarily focused in the healthcare industry:

Carlos provides audit, consulting, accounting and review services for a variety of healthcare clients. His experience includes:

- Over eleven years of public accounting experience providing audit and consultative services to hospice and palliative care organizations, home health agencies, multi-hospital healthcare systems, government owned hospitals, not-for-profit stand-alone hospitals, FQHCs, private equity group funded healthcare organizations, long-term care facilities, physician practices, dental offices, retirement communities, behavioral health facilities, and related foundations.
- Over five years of experience as the Assistant Vice President of Finance and member of a major medical center's executive team responsible for the strategic and operational direction of the facility. Directly responsible for accounting, payroll, admitting, insurance verification, central scheduling, cashiering, and revenue cycle related projects.
- Facilitating national trainings on topics including healthcare related business and accounting issues, technical accounting literature, health care reform, and audit approach and methodology.
- Leading a hospital-wide revenue cycle initiative through a partnership with The Advisory Board which resulted in significant net revenue improvement. This was the result of leading and implementing eight different teams throughout the revenue cycle process.
- Team lead on two different hospital wide computer conversions. Computer conversions included nursing, emergency room, surgery, purchasing, registration, scheduling, billing and collecting, payroll, and general ledger modules.
- In addition, he has audited numerous health care related associations including; the American Medical Association and the American College of Surgeons; as well as auditing other not-for-profit and governmental entities; life sciences companies; SEC registrants (including preparation of and assistance with 10-K and S-4 filings); life insurance companies (including preparation of and assistance with Statutory Blue Books); and financial institutions, with an emphasis on credit unions.

Licenses and Certifications

- Carlos is a Certified Public Accountant and licensed in the states of Illinois and New York.

Professional Affiliations

- Healthcare Financial Management Association
- AICPA
- FICPA
- Association of Latino Professionals in Finance and Accounting

Community Involvement and Other Professional Activities

- Alzheimer's Association, Central and North Florida Chapter (Board Member)

- Education
- Bachelor of Arts in Accountancy from MacMurray College in 1996 (located in Jacksonville, Illinois)

Jim Grigg

Partner

Crowe Horwath LLP

Professional Summary

Jim Grigg has a passion for the healthcare industry and serves as the firm's Healthcare Assurance Practice Leader. In that role, he is responsible for managing and growing the practice. His experience encompasses over 25 years of healthcare industry involvement. Today, Jim works primarily with hospitals and health systems and their related organizations, such as medical practices, foundations, and joint ventures. He has worked with numerous community and urban hospitals in the Midwest, as well as safety net hospitals in both Chicago and Cleveland. In additional to his audit experience, his experience includes numerous tax exempt bond issues, risk assessments and internal audit outsourcing engagements, financial projections, board education, forensic audit procedures, A-133 federal compliance audits and a significant hospital CFO outsourcing engagement in Chicago. Early in Jim's career, he served as an interim CFO at a Chicago safety net hospital, while still engaged in the practice of public accounting.

In addition to Jim's work with hospitals and health systems, he has served as the audit partner on numerous health care related associations, including the American Hospital Association and HFMA. Jim also has served as the audit partner on numerous other types of healthcare engagements including: CCRCs and senior living organizations, home health agencies, physician practices, IPAs, hospice organizations, a large Chicago based medical equipment company, and one of the largest organ networks in the United States.

Prior to joining Crowe Horwath, Jim was responsible for growing and managing McGladrey's healthcare practice in the Great Lakes Region. In that role, he was responsible for client acceptance, quality reviews and the growth of the practice.

Professional and Community Involvement

HFMA
American College of Healthcare Executives
AICPA and the ILCPAS - Past President of the Northern Chapter of the ILCPAS
Rockford Area VNA – Past President
Cleveland Institute of Art – Executive Committee member and Audit Committee Chairman
The Palette & Chisel Academy of Fine Arts – Artist member

Interests

Jim resides in downtown Chicago not far from our downtown Chicago office. In addition to raising two sons, he is a licensed private pilot, PADI certified master scuba diver and amateur painter. His paintings have been shown in Chicago on two occasions in recent years.

Education

Bachelor of Arts in Accounting, Bradley University, Peoria, Illinois
Master of Science in Accountancy, Illinois State University, Normal, Illinois

Donald C. Sibery, MHA, FACHE

President and Managing Partner

Decisive Consulting Solutions, LLC

Don Sibery is President and Managing Partner of Decisive Consulting Solutions, LLC (DCS). DCS is a healthcare consulting company concentrating its work in the areas of turnarounds, interim management services, operating and financial consulting, regulatory and accreditation assessment and compliance, strategic planning, executive coaching and cultural transformation. Prior to forming DCS, in 2004 Don founded and was the President and Managing Partner of The Sibery Group, LLC based in Oak Brook, IL. Don has served as the interim CEO of an inner city hospital in Chicago, Illinois, where TSG was engaged to undertake a quality/operating/financial turnaround through a total facility management contract. He is serving as a Governance and C-Suite consultant and executive coach to various hospitals, health systems and physician groups and serves as the engagement partner for client engagements. He has developed strategic plans, Board restructuring plans, succession plans, incentive plans and CEO performance evaluation tools.

He has been a hospital or health system CEO for nineteen years and prior to that a COO for ten years at Munson Medical Center in Traverse City, Michigan. He has overseen significant accomplishments in all dimensions of the hospitals and health systems where he has served. Two of his chief executive officer roles have been with vertically integrated systems: one in Wisconsin and the other in the western suburbs of Chicago. Under his leadership, Wausau Hospital (Wisconsin) was listed among Modern Healthcare's "Top 100" hospitals. The heart and gastrointestinal programs there have sustained being on the "Top 100" list since 1996. Also, the heart program went from 70 open hearts in 1985 to 400 in 1996. Central DuPage Health, located thirty miles outside of Chicago, succeeded in attaining the third largest CON awarded in the history of the State of Illinois. It also earned a Standard & Poors AA bond rating, added many new clinical programs, achieved market share growth, and doubled the size of the emergency room to accommodate 60,000 visits per year.

Michael B. Zenn, MBA

Partner

Decisive Consulting Solutions, LLC

Michael Zenn, MBA, is a Partner with Decisive Consulting Solutions (DCS). Mike brings a significant and diverse background through having served a multitude of roles throughout his career. He has been a hospital and healthcare COO for five years and prior to that a CFO for sixteen years. Mike's initial hospital executive responsibilities were that of CIO, which expanded into executive responsibilites for revenue cycle and utilization management functions. He started his healthcare career as a consultant for Arthur Andersen & Co.

As first CFO and finally Executive Vice President & COO for Northwest Community Healthcare, in Arlington Heights, Illinois, Mike spent nearly two decades spearheading several programs and initiatives that contributed to Northwest Community's considerable success and its numerous national recognitions by such organizations as Thomson Reuters, HealthGrades, ANCC and Fortune Magazine. As EVP & COO, Mike's focus was on maintaining and improving all aspects of performance through the simultaneous optimization of quality, financial, patient satisfaction, employee and physician satisfaction, and growth. With significant involvement in strategic planning and implementing critical aspects of the strategic plan, Mike coordinated information systems and facility planning processes. This included implementing systems and facilities with a long term focus on bringing workflow to the bedside whenever practical and appropriate, accomplished with the ongoing goal of ensuring process adaption as a critical measure of success, including the activation of CPOE and readiness for timely "meaningful use" certification. In addition, Mike led the strategic initiative to enhance operational performance, resulting in cost reduction and revenue enhancement representing over $40 million in annualized benefit.

Mike led the design, construction and activation of a 200-bed addition. This $250M project utilized guiding principles that achieved measurable quality, safety, satisfaction and productivity improvements. This included structured processes for obtaining key stakeholder input, support and ownership. Mike's initiatives supported organization-wide clinical process enhancements aimed at an integrating team approach to change which led to recognitions such as: Thomson Reuters Top 100 designations, many HealthGrades accolades, three times named as a Top 100 employer by Fortune Magazine, and receiving a second four-year designation as Nursing Magnet hospital by the ANCC.

As CFO, Mike implemented financial planning disciplines targeted at stabilizing and enhancing long-term asset strength. He introduced process measures integrated with financial measures as an organization focus for sustained performance improvement. He spearheaded strategic, financial and operational performance initiatives resulting in achievement of a standalone AA bond rating for the consolidated corporate entity. This included the developing/implementing of investment and debt policies that accomplished strategic integration of these funding facilities along with operational performance and capital acquisition strategies that integrated all of these aspects of financial management. Throughout Mike's tenure at Northwest Community healthcare, he collaborated with and nurtured various medical staff constituencies and Board members/leaders, including participating in ongoing governance education and development.

During his tenure at Munson Medical Center/Munson Healthcare, Mike played a significant role in establishing it as a 391-bed regional referral center, the flagship for a diverse healthcare delivery system serving 32 counties in Northern Michigan. He led the automation of Munson

with the first hospital wide Information Technology platform and was instrumental in initiating Munson's continuous quality improvement disciplines, the foundation for its many years of being recognized as a process improvement leader. Munson has been repeatedly ranked among the Top 100 hospitals, being a 12 time recipient of the designation by Thomson Reuters/Solucient and twice being honored with an Everest Award for continued improvement. Mike led the integration of all aspects of revenue cycle management, driving significant accounts receivable performance enhancements. He introduced and educated all medical staff members to clinical decision support information and collaborated with all physician specialties in determining clinical ordering protocols.

Mike is a member of the American College of Healthcare Executives (ACHE), the Healthcare Financial Management Association (HFMA) and the Healthcare Information and Management Systems Society (HIMSS). He has a BBA and MBA from the University of Michigan.

There is no PowerPoint presentation for this session.

Breakout 19: RAC Audits Update

Rebecca K. Hart, RHIA

Presentation Will Be Available
On-line After the Conference

Breakout 20: Slaying Demons in the Revenue Cycle - A Physician Perspective

Bernard J. Emkes, MD

Bernard J. Emkes M.D.

Medical Director Managed Care Services

St. Vincent Health

Dr Emkes is a board-certified family physician who holds the title of Medical Director Managed Care Services at St Vincent Health in Indianapolis.

After graduation from Wabash College and Indiana University School of Medicine, he trained at Methodist Hospital in Indianapolis. After 21 years of full time family practice, he accepted the job of part time medical director of the St Vincent Care Management Organization – the Physician Hospital Organization used for managed care contracting. As the enrollment in the PHO increased, that job became full time two years later.

In January of 2003 he accepted the position of Medical Director Managed Care Services at St Vincent – a newly created physician position focused on improving hospital efficiency, assuring payments for appropriately provided services, and reducing payment denials. In this role his goals have been to provide medical expertise to Patient Financial Services and Revenue Cycle Operations, as well as support criteria-based utilization and decision-making. He has worked to improve processes across various departments of the organization, worked with medical staff physicians on specific cases, and become involved with various insurance plans and the medical directors of those plans. The intent of all these activities is to improve quality, reduce utilization and costs, and begin to change the culture of the St Vincent organization and the medical staff.

St Vincent Health

Working under the CFO and VP for Managed Care he acts as an interface between finance and clinical medicine, he brings a knowledge set and perspectives that are somewhat unique among physicians.

Past President St Vincent Medical Staff
Past President Indianapolis Medical Society
Past President Indiana State Medical Association

Slaying Demons in the Revenue Cycle – A Physician Perspective

Bernard J. Emkes M.D.
Medical Director Managed Care Services
St Vincent Health
4.27.2012

St Vincent Health

- Indiana based system – part of Ascension Health
- 20 –plus hospitals
  - Major tertiary referral center in Indy -
    - Peyton Manning Children's Hospital – 55 beds
    - Stress Center for behavioral health – detox.
  - Carmel – 1000 Bariatric cases, 1000 OB, and 1000 other surgical, 2400 medical
  - Two other PPS facilities – Kokomo and Anderson
  - Eight Critical Access facilities
  - Seton Long Term Acute Care hospital – 2 locations - 104
  - New Hope – transitional and group homes
  - Employ 1242 physicians and extenders
    - 406 Primary; 535 Specialist; 301 Extenders

Life as We Know It

Defining the issues facing health care in the 21st century and resolving them

Health Care is nothing more than one large Whack-a -Mole game.

Bernie Emkes M.D. 2011

What Have We Evolved To?

A complex system that does not work is invariably found to have evolved from a simpler system that worked just fine.

Business Model of Health Care

- Are hospitals and doctors' offices businesses?
  - Whether for-profit or NFP, can we agree – yes?
- What is the purpose of American business?
  - Can we agree that it is to make some level of profit in order to both stay in business and prosper?
- Does a business which is not profitable stay in business indefinitely?
  - Can we agree the answer is – no?
  - Federal Government exception here.

Health Care Premise

Much of health care is provided by publicly traded companies. To whom are these companies beholden?

Stockholders

- Did the words patient, hospital or physician appear in that answer? That in a nutshell is a lot of the problem.

Follow Up Question

Is Medicaid profitable for most doctors, hospitals or other health care providers? *Profit is defined as covering all costs with margin left over that would be considered profit.*

NO!

In most cases Medicaid pays well below costs.

Demons in the Revenue Cycle

- So if the motives of most Medicaid third party administrators is shareholder profit, and there is not enough money in the Medicaid system to adequately pay for the care needs of those enrolled, what happens?
  - Administrative rules to avoid payment
  - Denial of payment for various "arbitrary" reasons
    - Failure to Prior Auth
    - Not medically necessary
    - Untimely filing of claims

Demons in the Revenue Cycle

- Medicare and commercial payers follow this same process
  - If there is not enough money to satisfy shareholders and employees (including bonuses), or there is not enough money furnished by taxpayers to pay for promised services, something must give
  - Denying payments by whatever means necessary is the ONLY way to balance the budget
    - So much for managing care, coordinating care, etc; this is about not paying for care
    - LCD determinations, IP Only procedures

Means to Their End

- Prior auths required
- Rules to reduce or avoid payments
  - Timely notification
  - Rules based denials
- Experimental / Investigational services SHOULD be the same for all payers – but they are not
  - Same literature and expert panels
    - Why different?
      - Unexplained variation
      - Marketing propaganda – *we can save you money*

Complexity Breeds Denials

- The complexity of ANY system compounds the likelihood of errors, missteps, and operational failures
- *Rules are put in place so that people do not have to think. For those who can think, rules become simply guidelines by which to live one's life*– Author unknown
  - Allowing providers to provide care and be paid properly for needed care does not meet the needs of those paying claims; therefore – more rules

Disconnected Model of Care

- Physicians and patients decide on a needed service – test, surgery, etc.
- Hospital provides a place for them to get together – a lab in which to work
  - Yet it is the Hospital that is denied payment for care
  - Even though what is done that later turns out to be "experimental, investigational , or non-covered" may not even known at the time of registration, or the service can be modified / changed by the physician while in the "lab"

All models are wrong, some are useful.

Deming

The Problem

- Denials of payment for numerous reasons
- Numerous models of denial management within organizations
  - Revenue cycle is everything between when a physician has an idea that some test or procedure is needed - and the patient agrees, until the correct amount of money, as agreed upon contractually, is deposited into the provider account
    - Hugely complex – and not all under any one provider control – multiple providers – MD, facility, etc
    - Understanding the complexity of the process is required to improve payments

The Problem

- Innumerable chances for errors and missteps
- Innate complexity reduces payments
- Hospitals suffer – when it is not their fault
  - Physicians do not know or understand certain rules – nor do they feel it is their responsibility
    - It's not my job to get the auth
    - Medicare Inpatient Only procedures
      - Minimal changes in procedure can result in non-payment
    - InterQual Guidelines
    - Milliman Care Guidelines
    - High value, quality, outcome-based care – value-based

St Vincent Health Process

- Recognized denials problem prior to *SICKO*
- Non-clinical appeal letters had minimal impact on resolving denials
- Sending additional records without clearly defining the – "*Why we should be paid"* resulted in only a few reversals of denials
  - Using trained nurses to craft appeal letters citing both clinical reasons and quoting research or payer policy made a big difference

St Vincent Health Process

- Reallocating resources in 2003 – no new PFS staff hired
  - Payer focused denial management
  - Three high functioning account reps made managers over commercial, government and Anthem / WellPoint specifically
    - Focused best use of talent - improved job satisfaction
    - All three reps are still with SVH in 2011 – one retired 2012
- One "audit nurse" asked to do appeal letters
  - More hired after "proof of concept" – now 5
- Medical Director Managed Care Services

St Vincent Health Process

- Denial received – Someone, somewhere has stated they are not going to pay for a service we have provided
  - Records – if requested are mailed by PFS rep
- If not paid, elevates to one of three teams
  - If administrative, team lead handles the case
    - Research and connect-the-dots required
  - If clinical input necessary, case referred to audit / appeal nurses (RN's) and first level appeal written
- If remains denied, case sent to me for second physician level appeal - if appropriate

Data Slides

- Actual denial management results data will be provided during the presentation, but is not included in handout materials

How Did We Get There?

- Attention to specific details of each denial
- Work plans to address physician, internal case management and revenue cycle issues
- Clinical Level One appeal letters - nurses
- Physician review of Level One denials
- Working relationships with major plan medical directors
- Working relationships with state and federal program staff and managers
- Persistence – “accept no denials”

How Did We Get There?

- Monthly denial management meetings with entire team across silos
  - Registration, CM, Rev Cycle, Compliance, Appeals
- Accurate data system to support processes
- Specifically assigned "to do" items for next monthly meeting – with expected report back
- Topic focused approach with new issues addressed at each meeting
  - Examples – IMRT, Medicaid radiation brachytherapy, LMRP issues with ER, Bone Morphogenic Protein, Wound dressings, IP Only cases

Write Offs

- Failure to have a proper Prior Auth
  - Harder and harder with added rules
- LMRP write offs
  - Pre-op testing; certain labs in ER; Dx not c/w test
- Medical necessity
  - Plan determined; lopping off end-of-stay days; level of care in NICU and Progressive bed charges
- Administrative
  - Easy to become wastebasket
- Medicare Inpatient Only Procedures
  - Value uncertain; inane rules; changed yearly; illogical

Drill Down on Write Offs

- Failure to have a proper Prior Auth
  - Registration, MD offices, case managers
- LMRP write offs
  - Pre-procedure specialists, ER physicians, specialists
- Medical necessity
  - Aggressive CM, using Executive Health Resources
- Administrative
  - Should be minimal – can be BIG and become BIGGER
- Medicare Inpatient Only Procedures
  - Spine and chest physicians – others less an issue

Other Opportunities

- Integrated contract renewal processes to be certain operational details can be met
- Clinical documentation improvement
- Missing charge reviews
- Discharge status audit
  - Reduced payment for SNF transfers and home health care – but what if the pt never got there?
- Conversion of OBS to IP care based on clinical and beyond Milliman and InterQual
- Denial management at ALL facilities

Requirements

- System to track expected payments and variances
- Processes to address initial denials
  - We write off less than 3% of initial denials
  - We successfully defend 97% of initial denials
- Quality staff, well-trained with passion for getting us paid
- Clinical expertise – physician involvement to develop medical director relationships
- Persistence – zero tolerance for denials

Advantages

- Develop in-house skills and expertise
- Vested interest in outcomes of cases
- Best understanding of internal processes and involved clinicians
- MD engagement over time – partners in caring for the patient
  - Improved hospital payment results in additional resources for physicians
  - Eventual tie-in between facility and MD coding - 2012 – in order for EITHER to get paid

Challenges

- Having or building the expertise – some may opt to buy
- Cost to maintain internal resources
- External vendors say they can do this better
  - Easier to off-load work
  - Harder to face commitment and skill-building needed to make this work
- System pressures regarding how to manage Revenue Cycle

A Joy to go to Work

- Every day is a chess game
  - Paid to play chess with payers
- As providers, we know we are in the right as we provide care and services to patients
  - If we are NOT, then we need to admit that honestly
  - If we are, then we should fight to be paid properly for services we have provided
  - Payers have developed policies and procedures that meet their needs
    - It is unfortunate, but we must fight to continue to be paid what is rightfully ours

Thanks

- I appreciate the opportunity to share our model of denial management from a MD perspective
- Happy to take any QUESTIONS

Bernard J Emkes M.D.
Medical Director Managed Care Services
St Vincent Health
8402 Harcourt Road Suite #720
Indianapolis, Indiana 46260
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Breakout 21: An Operational Perspective on the Form 990 and Community Based Assessment Requirements

Nicole Bencik, CPA, MST
and
Cindy B. Kushner, CPA

Nicole M. Bencik, CPA, MST

Tax Partner

Chicago, Illinois

Professional Summary

Ms. Bencik has over fourteen years of tax experience concentrating in services to the not-for-profit sector. She has served healthcare, trade associations, private foundations, cultural arts organizations, governmental entities and other not-for-profit organizations.

Experience

Ms. Bencik has served not-for-profit organizations in both a tax reporting and consulting role and has significant experience in the following areas:

Tax compliance. Ms. Bencik has managed all tax compliance aspects for many 501(c) organizations and private foundations. She is well versed in the recent changes in IRS Form 990 as well as electronic filing.

Tax controversies. Ms. Bencik has acted as liaison between the IRS and her clients on numerous occasions handling notices, compliance checks and audits.

Tax consulting. Ms. Bencik has researched a significant number of issues affecting not-for-profit organizations such as unrelated business income tax, employment tax, sales & use tax and self-dealing issues.

Educational seminars. Ms. Bencik has conducted numerous training seminars in both general taxation and specific tax-exemption issues. Nicole continues to monitor pending legislative changes, Senate Finance Committee recommendations, States' Attorneys General and enforcement initiatives conducted by the IRS in order to better inform her clients about upcoming changes in the not-for-profit sector.

Education

- Masters in Tax, University of Illinois, Urbana, Illinois
- Bachelor of Science, Accounting, DePaul University, Chicago, Illinois

Publications and Speaking Engagements

- Articles & Other Publications
- NACUBO Form 990 Electronic Manual, June 2009
- IRS Loses St. David’s Case; Court Clears Joint Ventures, Exempt, May 2004
- External Presentations
- ACPEN National Satellite Program
- Florida Hospice and Palliative Care
- Healthcare Financial Managers Association – Florida Chapter
- Indiana Association of Homes & Services for the Aging
- Illinois CPA Society
- Indiana CPA Society
- LeadingAge
- Life Services Network
- National Association of Black Accountants
- National Hospice & Palliative Care Organization
- Ohio Health Care Association

Cindy Kushner, CPA

Tax Partner

Crowe Horwath LLP

Professional Experience

Cindy has 27 years in public accounting, 24 of which were with Big Four firms, concentrating in tax services to the healthcare industry. She has served private, publicly held and not-for-profit healthcare, including not-for-profit healthcare systems, physician practice management companies, nursing homes, hospices, durable medical equipment companies, cooperatives, medical staffing companies, pharmaceuticals, and medical device companies.

Areas of Expertise

- Cindy serves in both a tax reporting and consulting role and she has significant consulting experience in the following areas:
- Not-for-profit healthcare organizations
    - Unrelated Business Income Studies.
    - Evaluate, document and remediate/improve internal controls around the tax process; including assistance with policies and procedures
    - Excess benefit transactions and intermediate sanction reviews. Assisting organizations in reviewing their transactions for potential excess benefit violations, establish positions under the rebuttable presumption under I.R.C. 4958.
    - Mock audits of tax exempt organizations. A comprehensive review process can identify potential issues and correct them before an IRS review.
    - FIN 48 analysis and tax advice memorandums.
    - Restructuring assistance. Cindy has assisted clients with establishing for-profit subsidiaries, joint ventures and legal structures to best safeguard an organization's exempt status while minimizing the organization's overall tax liability.
- Privately and Publicly held healthcare companies
    - Cindy has extensive experience with business and tax strategy planning with private and publicly held healthcare companies, tax provision reengineering, ASC 740 (f/k/a Fas 109) and ASC 740.10 FIN 48, domestic and international tax compliance, planning, and structuring.
    - Cindy manages several tax outsourcing engagements where she and her team function as the tax department including income, property, sales and use, and franchise taxes, including Expat/Inpat tax compliance, transfer pricing, tax provision assistance, internal controls and processes around each tax function, and participating in company business and strategy planning meetings. Cindy has extensive experience with mergers and acquisitions, tax structuring for global and multi-state companies, accounting periods and methods, debt restructuring and recapitalization; including experience with multi-state tax compliance, apportionment planning, tax efficient supply chain planning.
- Cindy has been a guest speaker for the Tax Executive Institute (TEI), HFMA, WEL, FICPA, and firm-sponsored conferences.

Education

Philadelphia University, Bachelor of Science degree in Accounting and Finance,
summa cum laude 1983
Certified Public Accountant, Pennsylvania and Florida

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FICPA 2012: An Operational Perspective on the Form 990 and Community Needs Assessment

April 27, 2012

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Objectives

- Introduction
- 2011 Form 990 Changes
  - Core Form
  - Schedule H
  - Tips and Recommendations
- IRS Workplan FY 2012
- Summary

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2011 Form 990 Filing Thresholds

- Form 990
- Form 990-EZ
  - Gross receipts > $50,000 *and* Total assets > $500,000 for tax years ending on or after December 31, 2011.
- Form 990-N
  - Gross receipts < $50,000 for tax years ending on or after December 31, 2011.
  - Some states have their own versions of the 990-N that may be required.
  - Not allowed for private foundations or certain supporting organizations.

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2011 Form 990

Good News!!!!

Minor Changes to the Form 990

BUT.....

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Form 990 Update – Core Form: Part VI Governance

- Part VI, Line 1a: Voting Members
  - 2010: Provide the number of voting members as of the end of the tax year
  - NEW: Disclose material differences in voting rights and explain what authority is delegated to other committees by the board in Schedule O.

Tip: Review bylaws periodically!!!

- Part VI, Line 1b: Independent Voting Members
  - NEW: No loss of independence if the director or family member was a key employee of an entity doing business with the organization
    - ✓ Modification of Schedule L Instructions

1a	Enter the number of voting members of the governing body at the end of the tax year . .	1a
	If there are material differences in voting rights among members of the governing body, or if the governing body delegated broad authority to an executive committee or similar committee, explain in Schedule O.	
b	Enter the number of voting members included in line 1a, above, who are independent .	1b

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Form 990 Update – Core Form: Part VI Governance

- Part VI, Section B, Line 11a: Board Review of Form 990
  - 2010: Need to provide each voting member a copy prior to filing with the IRS
  - NEW: Clarification that "no" is required if only informed the board its available upon request

11a	Has the organization provided a complete copy of this Form 990 to all members of its governing body before filing the form?
b	Describe in Schedule O the process, if any, used by the organization to review this Form 990.

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Form 990 Update – Core Form: Part VI Governance

Part VI: Line 15a/b: Compensation Review Process

15 Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision?

a The organization's CEO, Executive Director, or top management official . . . . . .

b Other officers or key employees of the organization . . . . . .

- 2010: Answer yes if the following review and approval process for compensation was followed for officers and key employees:
  - Review and approval by a governing body or compensation committee, provided that persons with a conflict of interest regarding the compensation arrangement at issue were not involved.
  - Use of data as to comparable compensation for similarly qualified persons in functionally comparable positions at similarly situated organizations.
  - Contemporaneous documentation regarding the compensation arrangement.
- NEW: ONLY "yes" IF the three-part review process was applied during the tax year.

Tip: If organizations do not conduct a full-blown rebuttable presumption compensation review during each tax period and rather rely on comparability data for two or three years between review cycles they cannot answer this question "yes".

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Form 990 Update – Core Form: Part VII Compensation

Part VII: Compensation Revisions/Clarifications:

- Reporting Compensation:
  - ✓ 2010: Box 5 Medicare Wages of Form W-2
  - ✓ NEW: Required to report the LARGER amount of Box 1 or Box 5 of Form W-2
- NEW: Do not report deferred compensation if paid within 2.5 months after year end (for purposes of Part VII, Section A Column (F) or Schedule J, Part II, column (C)
- Clarification: Must include in Part VII, Section A Column (F) the increase/decrease in actuarial value of defined benefit plan
- Clarification: Only check one Position unless you are an 'Officer" and "Director"

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Check if Schedule O contains a response to any question in this Part VII . . . . . ☐

Section A. Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name and Title	(B) Average hours per week (describe hours for related organizations in Schedule O)	(C) Position (do not check more than one box, unless person is both an officer and a director/trustee)					(D) Reportable compensation from the organization (W-2/1099-MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual trustee or director	Institutional trustee	Officer	Key employee	Highest compensated employee	Former			

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Form 990 Update – Core Form: Part VII Compensation

- Part VII, Section B:
  - 2010: Required to report the five highest paid independent contractors that received more than $100,000 in compensation.
  - NEW: Same rule but clarified that independent contractor reporting should be based on calendar year ending with or within the tax year.

Section B. Independent Contractors

1 Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization. Report compensation for the calendar year ending with or within the organization's tax year.

(A) Name and business address	(B) Description of services	(C) Compensation

2 Total number of independent contractors (including but not limited to those listed above) who received more than $100,000 of compensation from the organization ▶

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Form 990 Update – Schedule J Compensation

- Schedule J: Line 3
  - 2010: Organizations were required to check the boxes for the methods used for establishing compensation for the CEO/Executive Director
  - NEW: Same rule but clarification was made by adding that the organization should NOT check any boxes for methods used by related organizations to establish compensation of the CEO/Executive Director. Instead explain in Part III of Schedule J.

3 Indicate which, if any, of the following the filing organization used to establish the compensation of the organization's CEO/Executive Director. Check all that apply. ~~Do not check any boxes for methods used by~~ a ~~related organization to establish compensation of the CEO/Executive Director. Explain in Part III.~~

- ☐ Compensation committee
- ☐ Independent compensation consultant
- ☐ Form 990 of other organizations
- ☐ Written employment contract
- ☐ Compensation survey or study
- ☐ Approval by the board or compensation committee

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Form 990 Update – Joint Venture Reporting

- 2010: Report joint venture activities based on presentation in audited financials.
- NEW: Changed the financial reporting requirements a partner or member of a joint venture, partnership, LLC, or other entity treated as a partnership for federal tax purposes.
  - Parts VIII: Statement of Revenue and IX: Statement of Expenses, report the organization's distributive share of the joint venture's income and expenses on the appropriate lines.
    - ✓ Use Schedule K-1 tax year ending with or within the organization's tax year.
  - Part X: Balance Sheet, report the organization's distributive share of assets, according to the organization's ending capital account as reported on Schedule K-1 on line 12, Other Securities.

OPTIONAL FOR 2011 FOR 990!!!!!

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IRS Workplan FY 2012

- AKA: *Tax Exempt and Government Entities Division Strategic and Program Plan.*
- "Exempt Organizations (EO) respects the nonprofit's sector work and supports its efforts by helping ensure that the public maintains trust in the exempt sector."
- Three major themes:
  - EO Integrates – Several projects focusing on specific segments of the sector, as well as particular compliance issues affecting a cross-section of exempt organizations.
  - EO Support and Collaborates – Agency-wide attention on certain critical issues, including international activities and compliance with the passage of recent legislation.
  - EO Invests – Wide array of initiatives.

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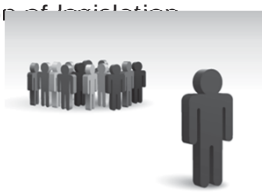
IRS Workplan: Political Activities

- **What is a political activity?**
  - Participation in any political campaign on behalf of (or in opposition to) any candidate for elective public office.
  - ALL 501(c)(3) organizations are PROHIBITED from participation in these activities (including publishing or distributing statements).
- **What is lobbying?**
  - Attempting to influence legislation if it contacts, or urges the public to contact, members or employees of a legislative body for the purpose of proposing, supporting, or opposing legislation, or if the organization advocates the adoption or rejection of legislation.
  - Permitted as long as its not substantial.



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Impact on Form 990: Schedule C

- Required to report lobbying activities and amounts spent
- Includes allocated dues paid to hospital member associations and state hospital member associations

Part II-B **Complete if the organization is exempt under section 501(c)(3) and has NOT filed Form 5768 (election under section 501(h)).**

For each "Yes" response to lines 1a through 1i below, provide in Part IV a detailed description of the lobbying activity.		(a) Yes	(a) No	(b) Amount
1	During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of:			
a	Volunteers?			
b	Paid staff or management (include compensation in expenses reported on lines 1c through 1i)?			
c	Media advertisements?			
d	Mailings to members, legislators, or the public?			
e	Publications, or published or broadcast statements?			
f	Grants to other organizations for lobbying purposes?			
g	Direct contact with legislators, their staffs, government officials, or a legislative body?			
h	Rallies, demonstrations, seminars, conventions, speeches, lectures, or any similar means?			
i	Other activities?			
j	Total. Add lines 1c through 1i			
2a	Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
b	If "Yes," enter the amount of any tax incurred under section 4912			
c	If "Yes," enter the amount of any tax incurred by organization managers under section 4912			
d	If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

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IRS Workplan: 990-T and UBIT

- IRS will be looking at organizations that reported unrelated business activities on Form 990 but have not filed a Form 990-T.
- Analyze organization's Form 990-T data to develop risk models that will help identify organizations that consistently report significant gross receipts from unrelated business activities but declare no tax due

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IRS Workplan: International Focus

- Ongoing Priority for the IRS.
- Issue: Determining whether exempt organizations operations overseas are consistent with their charitable purpose.
- Further Exploration of Specific Entities
  - Whether the organization maintains adequate books and records to ensure assets are used for charitable purposes.
  - Whether the organization has maintained proper discretion and control over funds that have left the US.
  - Whether the organization has met all filing requirements.
  - How foreign operations or grantmaking furthers the organization's exempt purpose.
- IRS plans to release two new publications describing the special rules that apply to both foreign and domestic charities.

Impact on Form 990: Schedule F

- Form 990, Part IV, Line 14b

14 a Did the organization maintain an office, employees, or agents outside of the United States? . . . . .
b Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, investment, and program service activities outside the United States, or aggregate foreign investments valued at $100,000 or more? *If "Yes," complete Schedule F, Parts I and IV*. . . . .

- 2010: Required to report activities over $10,000, including investment activity.
- NEW: Required to report foreign investments valued at $100,000 or more.

SCHEDULE F (Form 990)

Department of the Treasury Internal Revenue Service

Statement of Activities Outside the United States

► Complete if the organization answered "Yes" to Form 990, Part IV, line 14b, 15, or 16.

► Attach to Form 990. ► See separate instructions.

OMB No. 1545-0047

2011

Open to Public Inspection

3 Activities per Region. (The following Part I, line 3 table can be duplicated if additional space is needed.)

(a) Region	(b) Number of offices in the region	(c) Number of employees, agents, and independent contractors in region	(d) Activities conducted in region (by type) (e.g., fundraising, program services, investments, grants to recipients located in the region)	(e) If activity listed in (d) is a program service, describe specific type of service(s) in region	(f) Total expenditures for and investments in region

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Alternative Investments

What is an Alternative Investment?

- An alternative investment is an investment product other than traditional investments such as stocks, bonds or cash.
- For example, alternative investments include venture capital, private equity, hedge funds, limited partnerships, LLCs and other derivative funds.
- Many of these investments are off-shore funds.

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Alternative Investments: IRS Filing

- Whether or not an alternative investment generates UBI, it may require additional filings by the organization.
- Investment in foreign partnerships and foreign corporations may give rise to additional filings with the IRS.
- Investments can be either:
  - Direct investment in a foreign partnership or corporation.
  - Indirect investment through a partnerships (which have invested in foreign partnerships or corporations).
- Additional filing requirements:
  - Form 926 (Foreign corporations)
  - Form 8621 (Passive foreign investment company)
  - Form 5471 (Controlled foreign corporations
  - Form 8865 (Foreign Partnership)
  - Form 8886 for Reportable Transactions

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Schedule F: Foreign Forms

Schedule F (Form 990) 2010 Page 4

Part IV Foreign Forms

1	Was the organization a U.S. transferor of property to a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 926, Return by a U.S. Transferor of Property to a Foreign Corporation (see Instructions for Form 926)*	☐ Yes	☐ No
2	Did the organization have an interest in a foreign trust during the tax year? *If "Yes," the organization may be required to file Form 3520, Annual Return to Report Transactions with Foreign Trusts and Receipt of Certain Foreign Gifts, and/or Form 3520-A, Annual Information Return of Foreign Trust With a U.S. Owner (see Instructions for Forms 3520 and 3520-A)*	☐ Yes	☐ No
3	Did the organization have an ownership interest in a foreign corporation during the tax year? *If "Yes," the organization may be required to file Form 5471, Information Return of U.S. Persons with respect to Certain Foreign Corporations. (see Instructions for Form 5471)*	☐ Yes	☐ No
4	Was the organization a direct or indirect shareholder of a passive foreign investment company or a qualified electing fund during the tax year? *If "Yes," the organization may be required to file Form 8621, Return by a Shareholder of a Passive Foreign Investment Company or Qualified Electing Fund. (see Instructions for Form 8621)*	☐ Yes	☐ No
5	Did the organization have an ownership interest in a foreign partnership during the tax year? *If "Yes," the organization may be required to file Form 8865, Return of U.S. Persons with respect to Certain Foreign Partnerships. (see Instructions for Form 8865)*	☐ Yes	☐ No
6	Did the organization have any operations in or related to any boycotting countries during the tax year? *If "Yes," the organization may be required to file Form 5713, International Boycott Report (see Instructions for Form 5713)*	☐ Yes	☐ No

Schedule F (Form 990) 2010

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IRS Workplan: National Research Program – Study of Employment Taxes

- Third and Final Year of the Project
- Participation by ALL IRS Divisions
  - EO Portion: Examination of 1,500 Employment Tax Returns
    - ✓ 500 selected randomly each year over a 3-year period
- The result of this project will inform improvements
  - to IRS procedures for auditing, processing and
  - resolving employment tax return cases.

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Form 990, Schedule H – Key Metrics

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)						
b Medicaid (from Worksheet 3, column a)						
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total** Financial Assistance and Means-Tested Government Programs						

Note – for 2011 IRS removed reference to reporting <u>at cost.</u>

Section A. Bad Debt Expense

1	Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?	
2	Enter the amount of the organization's bad debt expense	2
3	Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy	3

Section B. Medicare

5	Enter total revenue received from Medicare (including DSH and IME)	5
6	Enter Medicare allowable costs of care relating to payments on line 5	6
7	Subtract line 6 from line 5. This is the surplus (or shortfall)	7

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Charity Care….as defined by IRS

- Financial assistance includes **free or discounted health services** provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services.

- Financial assistance does NOT include:
  - Bad debt or uncollectible charges that the organization recorded as revenue but wrote off due to a patient's failure to pay, or the cost of providing such care to such patients;
  - The difference between the cost of care provided under Medicaid or other means-tested government programs or under Medicare and the revenue derived therefrom; or
  - Contractual adjustment with any third-party payors.

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Methods to Calculate Charity Care…as prescribed by IRS

- IRS provided worksheets or equivalent documentation using the hospital's "most accurate cost accounting methodology" which can include:
  - Cost accounting system;
  - Cost-to-charge ratios;
  - Combination thereof; or
  - Other

- Regardless of whether the worksheets or alternative equivalent documentation is used to compile and report the required information, such documentation must be retained by the organization to substantiate the information reported.

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Increased Emphasis on Charity Care

Audited Financial Statements
- Footnote Disclosures

Medicare Cost Reporting
- EHR Incentives
- Future "DSH" Reimbursement

Form 990, Schedule H
- Tax Exempt Status
- Property Tax Exemptions
- Sales Tax Exemptions
- Public Scrutiny

Community Benefit Reporting
- Annual State Reporting
- A Means to "Telling Your Story"

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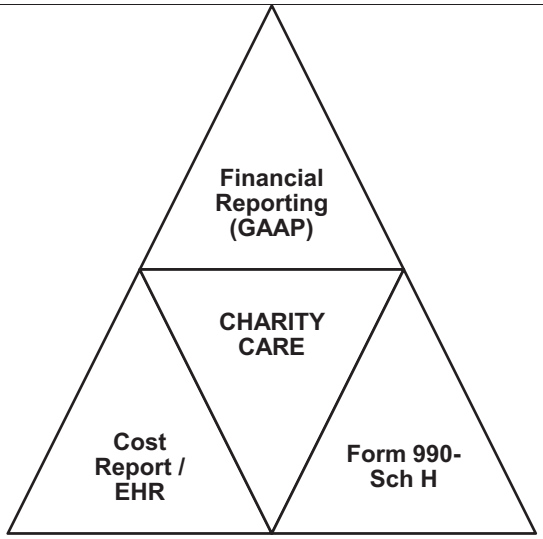
Charity Care – Connecting the Dots



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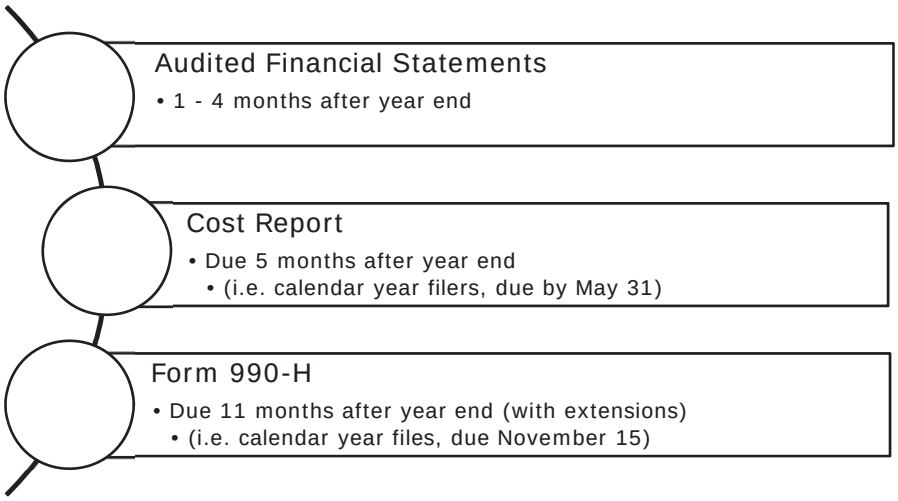
Timing



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Form 990, Schedule H

- Reporting of Charity Care / Community Benefits key metric.
- Methodology for calculating charity care provides inconsistencies in reporting on S-10.

Key Metric	990, Sch H	CMS 2552-10
Charity Care	*Part I, 7a*	*S-10, Line 20*
Bad Debt	*Part III, Line 3*	*S-10, Line 26*
Medicare - Surplus / (Shortfall)	*Part III, line 7*	**

*** To get to this amount from the cost report requires data from different schedules.*

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Community Health Needs Assessment

- IRS Notice 2011-52 – To ensure that community needs are being met, hospitals must document CHNA from each of their facilities in separate written reports…..

BUT….

- "It isn't saying that you cannot collaborate with other hospitals if you all serve the same community and that you all can't have a report that looks pretty much the same." Preston Quesenberry, Senior Technical Reviewer, IRS (March 15, 2012)

BUT….

- Addressing each community health need = EITHER describing how the hospital facility plans to meet the health need, or identifying as one the hospital does not intend to meet and explain why…..

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2011 Form 990, Schedule H, Part V, Section B

- Line 1-7 – OPTIONAL FOR 2011
  - Most Recent CHNA – *Widely available to public*
    - Note: Web address must be disclosed in Part VI.
- Line 8-21 – MANDATORY FOR 2011
  - *Financial Assistance Policy* – If "no" for Lines 9 and 10, required narrative in VI to determine eligibility for free care or discounted care.
    - Publicize FAP within community, check line 13g and describe in Part VI.
  - *Billing and Collections* – Lines 15 and 16 "yes" for only those actions that take place *BEFORE* the facility made reasonable efforts

TIP: Articulate response in Part VI

  - *Individuals Eligible for Financial Assistance* – Definition broadened to include FAP-eligible individuals.

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What's the right number?

• Affordable Care Act of 2010 (ACA) added new requirements, Section 501(r), that tax-exempt hospitals must meet to maintain their tax-exempt status.

• Reviews required at least once every three years!!

• According to the 2012 EO Workplan, Exam formed and trained a Review of Operations group dedicated to completing the statutorily required community benefit reviews which began in March 2011.

• IRS working with Treasury and Counsel to develop further guidance on new 501(r) requirements.

• By no later than March 23, 2015, IRS shall submit a report to Congress on trends relating to charity care.

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Summary

- The Form 990 is a critical document
  - Involves significant participation
  - Requires oversight
  - Tone-at-the-top is crucial
- Challenges include:
  - Reconciliations when requirements vary
  - Balancing "attention to detail" with "the big picture"
  - Keeping the "end in mind"
- Landscape may continue to change
  - Legislative
  - Federal/State/Local Regulatory bodies
  - Public perception

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Lunch Presentation: Charting Your Course to Tremendous Success

Ford Kyes

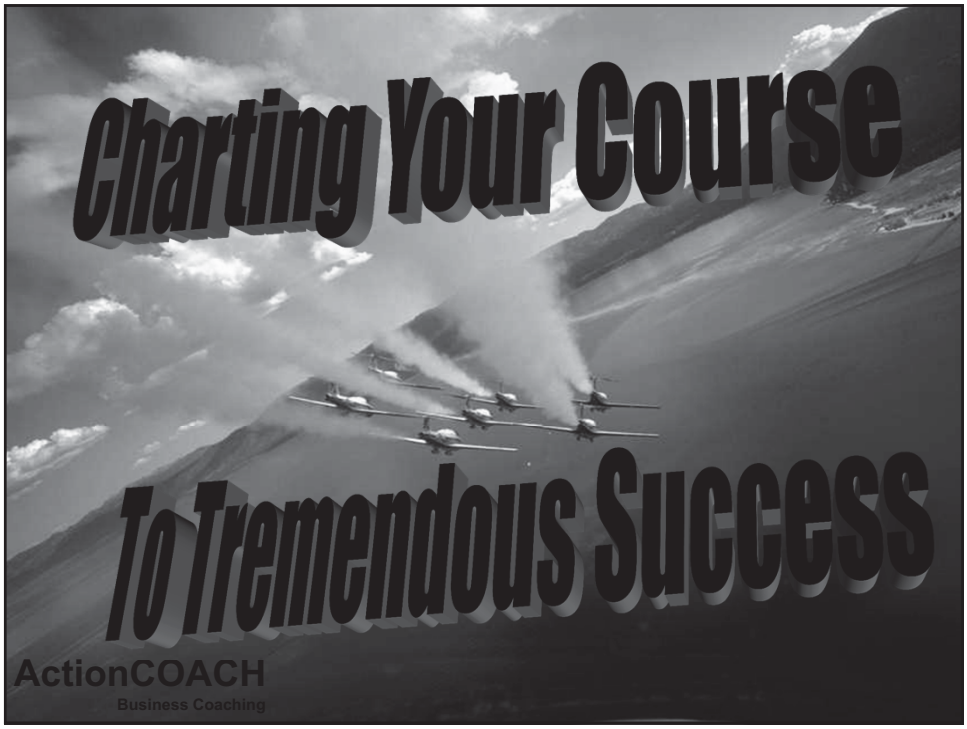
Ford Kyes

Founding Partner
ActionCOACH Pinellas

As a founding Partner of ActionCOACH Pinellas, Ford has focused on leadership development and growing profitability in companies of all sizes through education and coaching of senior executives and business owners. Ford's firm, ActionCOACH Pinellas, was recently recognized as one of the top ten ActionCOACH firms in the world (#6).

Ford received his undergraduate degree in nursing from Penn State and masters in public management from the prestigious Carnegie Mellon University in Pittsburgh.

Prior to launching ActionCOACH Pinellas, Ford served for six years as President and CEO of St. Anthony's Health Care in St. Petersburg, Florida and Executive Vice President for the 10 hospital BayCare Health System.

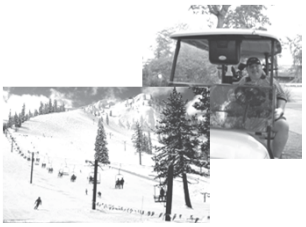


ActionCOACH Pinellas Firm Coaches

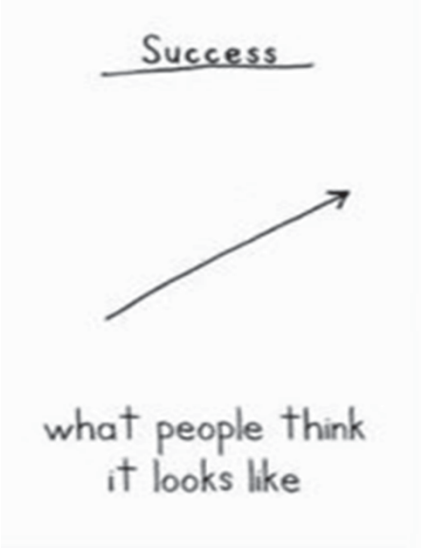
FINALIST 2008 ActionCOACH North American Seminar Coach of the Year
WINNER 2011 ActionCOACH Global Action Man Award

Ford Kyes

- 20 years business and leadership experience in health care, purchasing and distribution; 15 years in Pinellas county.
- Former CEO of St. Anthony's Hospital and Executive Vice President of BayCare Heath System.
- Former Chairman of the St. Petersburg Area Chamber of Commerce & current Chair of the Chamber's Foundation



- BS from Penn State and Masters in Public Management from Carnegie-Mellon University
- Master Business Coach, Coach other Coaches
- Lifelong Mentor to Young Professionals
- Avid Golfer and Snow Skier



What You Get Out of Today

You will Learn:

- ✓ 5 Keys to Tremendous Success
- ✓ Get Some Simple Effective Tools for Achieving Real Results
- ✓ Make a Commitment to Implement at Least One Strategy

The Five Keys to Tremendous Success

What our successful clients have in common

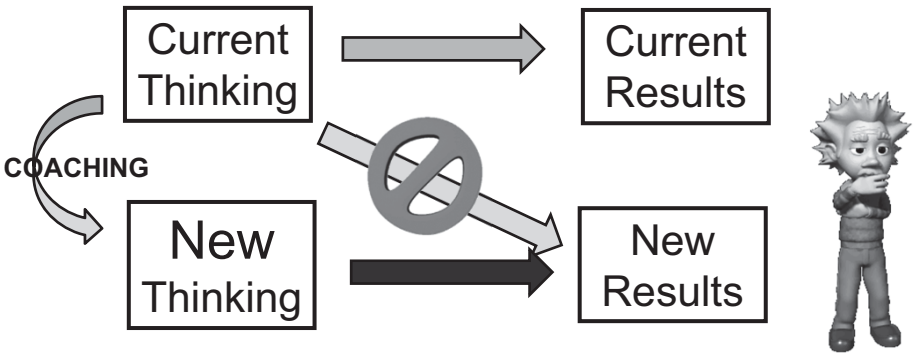
Mindset

Are you Above or Below the Line?

Ownership
Accountability
Responsibility

Blame
Excuses
Denial

Einstein Definition of Insanity?

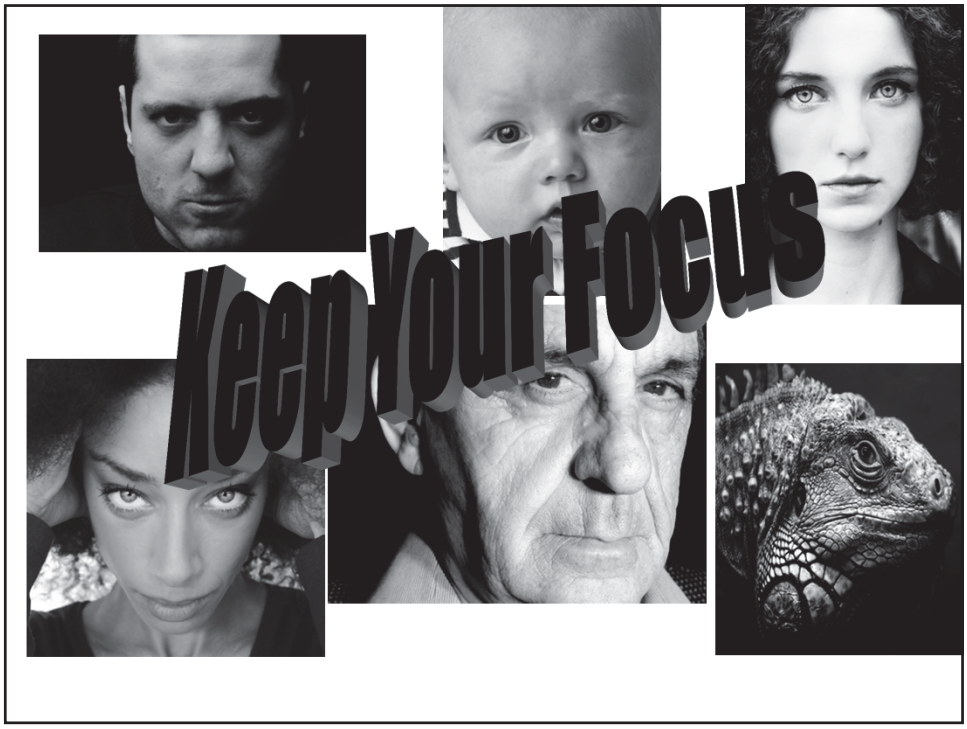


Knowledge x Planning + Action = Success

Thinking is VITAL to attitude, response, relationships, actions, outcomes, and results

The Five Keys to Tremendous Success

What our successful clients have in common



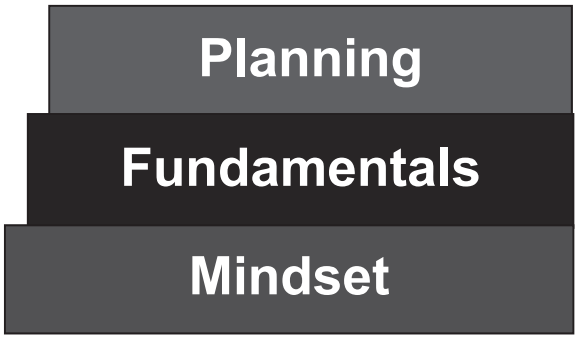
Multi-tasking

Multi-tasking

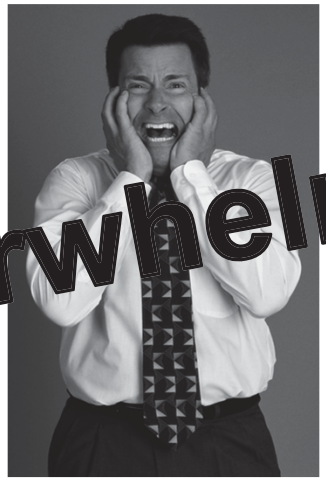
- Distraction from incoming email and phone calls = 10 pt drop in IQ
- Multi-tasking vs. Switch-tasking
  - Up to 40% loss in productivity
- Does Practice Improve Performance?
  - Heavy multi-taskers are *less* competent
  - The more you multi-task the worse you are at it!

The Five Keys to Tremendous Success

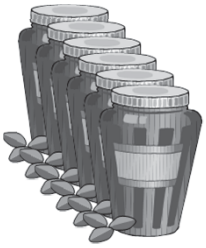
What our successful clients have in common



Have you ever been

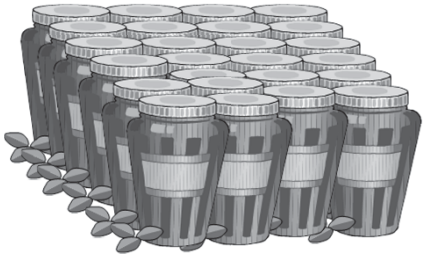


Overwhelmed?

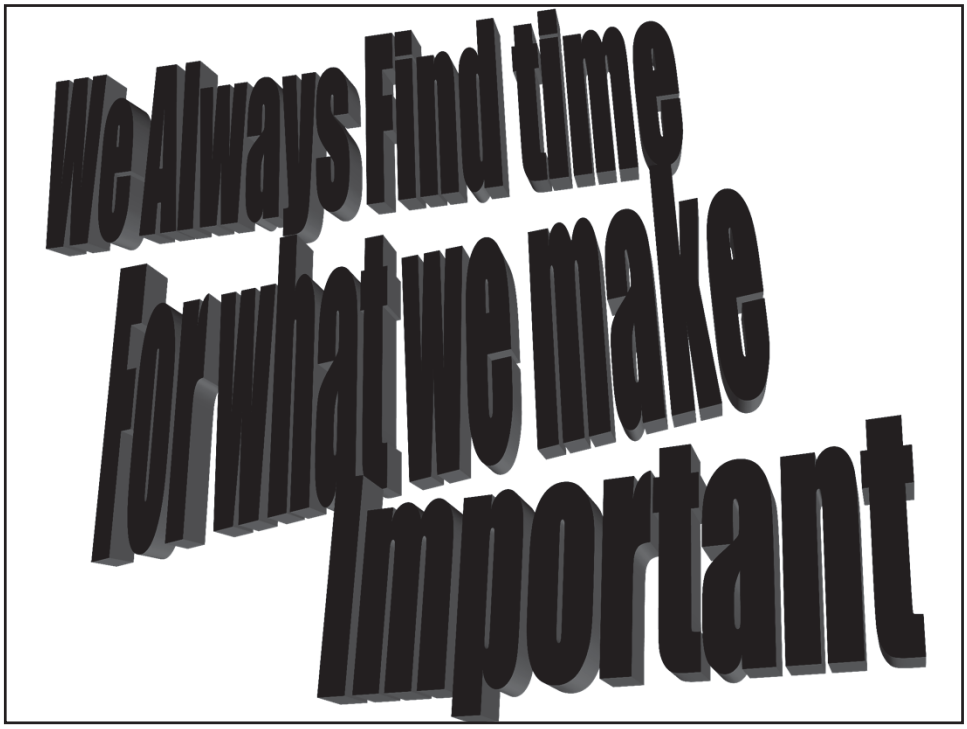


10X

VS.



Columbia University Business School



MI5

Daily Planning Ritual

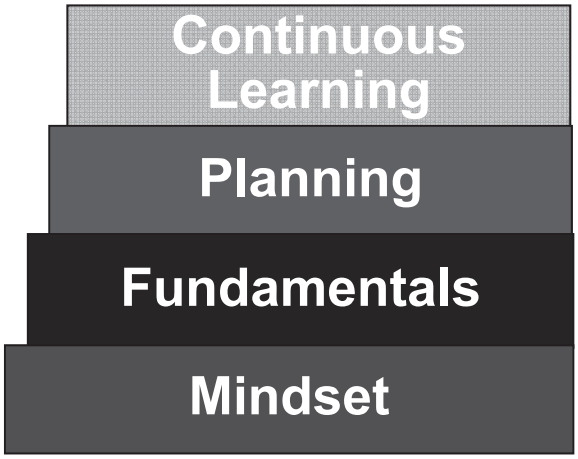
A Weekly Default Diary

DEFAULT ACTIVITY SCHEDULE

	Monday	Tuesday	Wednesday	Thursday	Friday
6:00 AM					
7:00 AM	IVVM - AFFIRMATIONS	IVVM - AFFIRMATIONS	IVVM - AFFIRMATIONS	IVVM - AFFIRMATIONS	[illegible]
8:00 AM	[illegible]	COLD CALLS	COLD CALLS	COLD CALLS	COLD CALLS
9:00 AM	Gateway	COLD CALLS	Return/FU Calls prospects/Mailing	COLD CALLS	COLD CALLS
10:00 AM	Direct Mail to Seminar attendees	90-Day Plan	Clean/Create Documents/Systems	Group Coaching	Gateway
11:00 AM			COLD CALLS		FORUM
12:00 PM	[illegible]	LUNCH	BNI	LUNCH	Toastmasters
1:00 PM	Client Prep	Return/FU Calls prospects/Mailing	Practice Seminar	90-Day Plan	Coffee News Coaching
2:00 PM	Quarterly Articles	Clean/Create Documents/Systems		Database management	OFF
3:00 PM	FORUM				OFF
4:00 PM	Education/Reading	Education/Reading	Gateway	TOM COACHING	OFF
5:00 PM	PLAN FOR TOMORROW	PLAN FOR TOMORROW	PLAN FOR TOMORROW	PLAN FOR TOMORROW	PLAN FOR TOMORROW
6:00 PM	EXERCISE	EXERCISE	EXERCISE	EXERCISE	EXERCISE

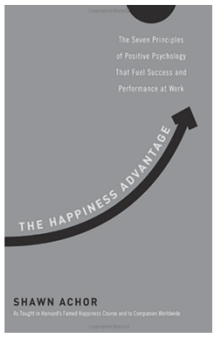
The Five Keys to Tremendous Success

What our successful clients have in common

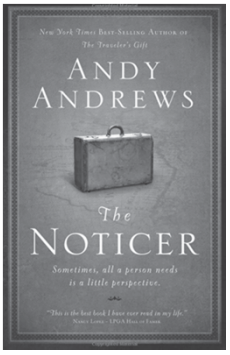


The # 1 Reason Businesses Fail?

Our Top Two Books to Read Right Now!



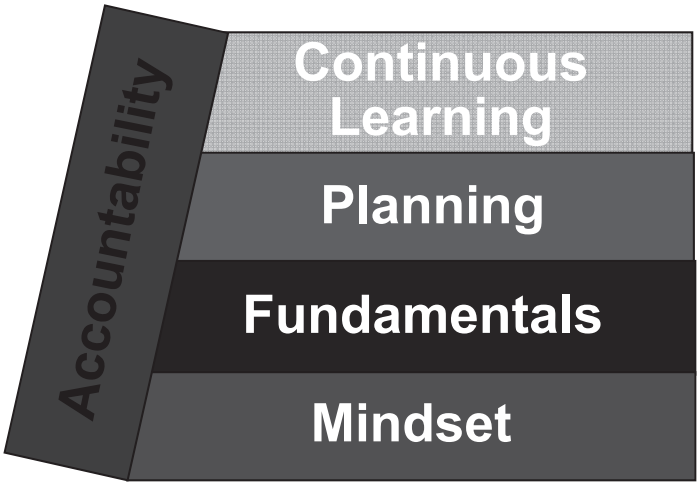
The Happiness Advantage



The Noticer

The Five Keys to Tremendous Success

What our successful clients have in common



Formula for CHANGE

(D x V) + F > R

Dissatisfaction

Vision

First Steps

Resistance

"The greater danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low, and achieving our mark."

-Michelangelo

Continuous Learning
Chart your Success…
By Design or By Luck?
Fundamentals
Mindset

Top Insights?
Action Steps

Breakout 22: Healthcare Merger & Acquisition: Physician Plan Integration & Accounting

Richard Sacher, CPA
and
Robert Wilson

Richard Sacher, CPA

Audit Services, Florida Health Care Practice Leader

Grant Thornton LLP

Richard is an audit senior manager with more than 14 years of experience in public accounting.

Experience

Richard's experience includes supervising and coordinating audits of publicly and privately-held clients in a variety of industries. His experience also includes audits of and reporting for SEC registrants, licensed HMOs and insurance companies and other regulated industries. Within these areas he has significant involvement with in-depth work in audit and accounting, Sarbanes-Oxley related services, registration statements and private placements, acquisition evaluations and due diligence and various other services.

Industry experience

Richard has worked with clients in a variety of industries, with specific expertise in the health care industry, including audits of managed care organizations, bio-tech companies, distributors,
as well as for-profit and not-for-profit health care providers, ranging from stand-alone facilities to entire hospital systems.

Professional qualifications and memberships

- American Institute of Certified Public Accountants (AICPA) – Member
- Florida Institute of Certified Public Accountants (FICPA) – Member
- Healthcare Financial Management Association (HFMA) – Member

Education

- University of Notre Dame, Bachelors of Business Administration, Accounting
- Florida International University, Masters in Accountancy

Bob Wilson

Executive Director, Health Care Advisory Services

Grant Thornton, LLP

Bob Wilson is an executive director in the Health Care Advisory Services practice of Grant Thornton, focusing on health system strategy and performance improvement. He also leads the firm's physician strategy and operations improvement practice. He is based in the firm's Phoenix, Arizona office.

Industry experience

Bob has over 30 years of experience in the health care industry as a financial auditor and advisor, strategy and operations performance improvement consultant, senior health system executive and board member.

Bob has:

- Led teams focusing on improving the financial and operational performance of hospitals and physician enterprises (primarily health system sponsored).

- Focused on the core dimensions of: revenue cycle; clinic operations and support staff productivity and staffing levels; provider work contribution and productivity; physician compensation and incentive alignment; and physician network strategic capacity and discernment.

- Consulted health systems on a variety of physician alignment and integration issues and models.

- Served in the role of chief implementation officer for comprehensive, integrated enterprise-wide performance improvement projects

Previously, Bob led the physician services practice of Huron Healthcare (formerly Wellspring Partners) and was a partner in Arthur Andersen LLP. In addition, he was the chief financial officer for a $400+ million revenue physician-driven, integrated health care provider organization with 200+ multi-specialty physician group. He also had been on the governing board of several health care organizations, including one of the five largest faith-based health systems in the U.S.

Education

- BA Business Administration, University of Washington
- MBA, California State University, Los Angeles

Grant Thornton
An instinct for growth™

How to Optimize Your Investment in Your Physician Enterprise: *Operational and Financial Considerations*

Florida Institute Annual Healthcare Conference
Orlando, Florida
April 27, 2012

Robert Wilson, Managing Director
Richard Sacher, Senior Manager

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Objectives

- Understand the elements of high performance physician enterprises and the key financial drivers of physician group financial performance
- Describe tools to self-evaluate the performance of a physician enterprise
- Identify and quantify areas for significant improvement and the path
- Describe initial and ongoing accounting considerations

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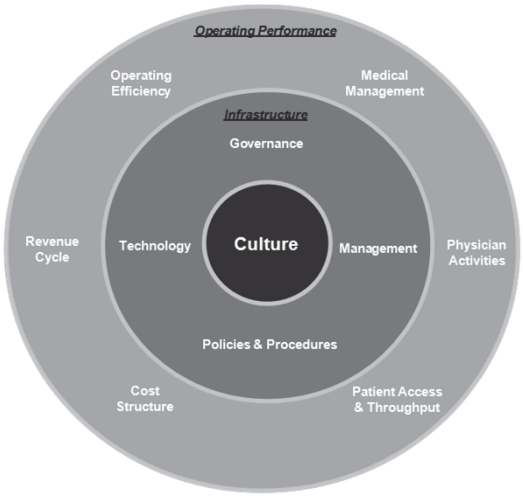
Elements of high performing medical groups



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Understanding physician financial performance

Organizing financial information

	Medical Group A
Revenue	
Gross Patient Revenue	$208,472,135
Total Deductions	(91,554,544)
Total Net Patient Revenue	**$116,917,591**
FFS Collection %	44%
Other Operating Revenue	2,446,170
Total Operating Revenue	**$119,363,761**
Expenses	
Non-Physician Provider and Staff Salaries	37,893,951
All Provider and Staff Benefits	106,558
Non-Phyician Provider and Contract Support Staff	3,144
Total Non-Physician HR Expense	**$38,003,653**
Administrative Supplies and Services	1,466,281
Billing Expense	6,583,184
Building and Occupancy	7,945,511
Contracted Services	447,404
Laboratory Expense	3,499,529
Drug Supplies	15,002,504
Furniture and Equipment	1,042,354
Depreciation	2,528,704
Goodwill Ammortization	941,081
Information Technology	110,114
Medical Supplies	2,052,991
Other Operating Costs	455,796
Professional Fees	1,706,813
Purchased Services	1,718,918
Liability Insurance	288,254
Radiology and Imaging	141,503
Bad Debt	12,781,618
Total Operating Expense	**$96,716,216**
Net Income/(Loss) bef Physician Comp	**$22,647,545**

Physician Salaries & Benefits	93,376,628
Net Income/(Loss) Before Allocation	($70,729,083)
General Unallocated Administrative Expense	12,512,641
Net Income/(Loss) after Allocations	($83,241,724)
Net Income/(Loss) Per Physician	($316,505)
Physician	263.00

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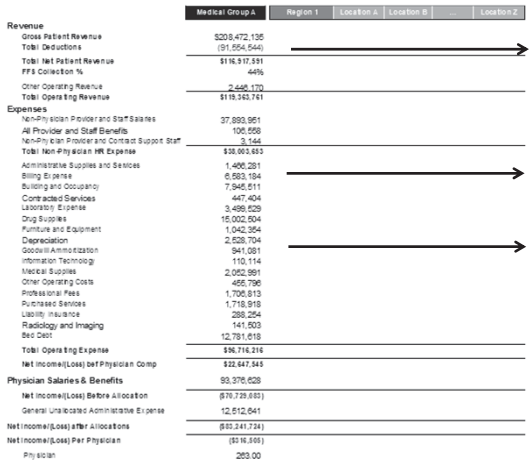
Understanding physician financial performance

Creating transparency into group and individual practices and providers



	Medical Group A	Region 1	Location A	Location B	...	Location Z
Revenue						
Gross Patient Revenue	$208,472,135					
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Revenue drivers

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- Physician productivity/volumes
  - Ambulatory Visits
  - Hospital Visits
  - Procedures
- Coding
  - Office E/M Coding – Time and Complexity
- Strategic Pricing

- Government and Contracted Commercial Payer Rates
- Billing Denials
  - Eligibility
  - Medical Necessity/Coding
  - Timely Filing
- Collections at Point of service -Copays
- Accounts Receivable
- Bad Debt Collections

- Rental Revenue
- Outside Services Provided

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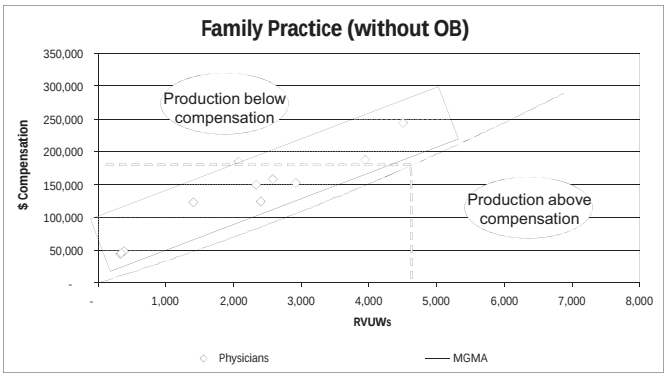
Revenue drivers

Patient access and provider clinical productivity

Measures of Physician Volume

- Gross Charges
- Collections
- Visits
- Procedures
- RVUw
  - Government set values assigned to all work a providers does



National Surveys with large N used to compare productivity and Compensation

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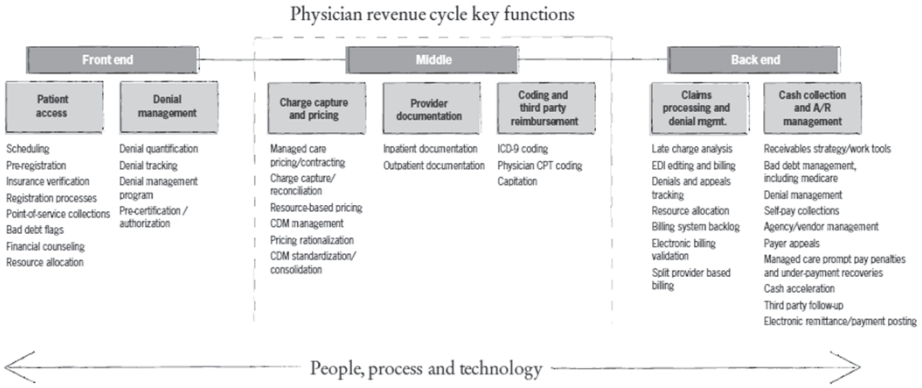
Revenue drivers

Revenue cycle management



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Expense drivers

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Staffing

- Front office support staff
- Clinical support
- Medical records
- Coders
- Management – Span of Control

Building and Occupancy

- Own vs. rent
- Providers per office
- Exam rooms per provider
- Locations relative to practices/hospital
- Technology and infrastructure

Provider Compensation

- Plan design - incentives
  - Salary
  - Productivity driven
  - Other components

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Expense drivers

Staffing expense

- Front Office and Clinical Support Staff
  - Specialty specific
    - per physician FTE
    - per visit/encounter
    - per RVUw
  - Key is proper alignment of resources to volume
    - Too few; throughput and revenue cycle suffer
    - Too much; misalignment of expenses
- Span of Control
  - Common to have extensive use of managers, assistant directors, directors
  - Key is balance

Have a defined staffing model

Strategically Planned Org Structure

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Expense drivers
Occupancy expense

- Common practice; practices are acquired space is not strategically aligned
- Capacity Utilization
  - Exam room utilization
  - Providers per office
- Alignment of providers in market
  - Practice locations relative to hospitals and complimentary specialties

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Expense drivers
Provider compensation

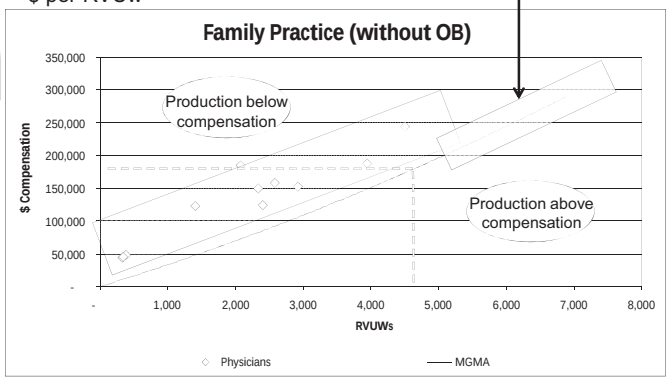
Productivity Models

- Salary
- % of Collections
- $ per RVUw

- Base salary plus productivity incentive
- % of Collections
- $ per RVUw

Keys to Success

- Physician participation in design
- Alignment with market and production
- If a hybrid base salary set low enough to encourage productivity
- Include quality



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Identifying areas of opportunity for operational improvement

Using internal and external metrics

- Fully allocated investment per physician > $100,000 (recent literature says average is > $200,000—that is unacceptable and unnecessary!)
- Investment per physician varies internally within specialties
- Collection rates vary internally within specialties
- Denial rates >10%, days in AR >40, bad debt expense >3-5%
- Use outside surveys AMGA/MGMA to identify productivity and compensation percentiles
  - RVUw's @ 30th and compensation at 60th = trouble
- No standardized staffing model
- No consistently deployed physician compensation model and compensation expense > 70% of net patient revenue
- Occupancy expense > 6% of Net patient revenue

Spotting "early warning" indicators before the investment becomes unsustainable is imperative

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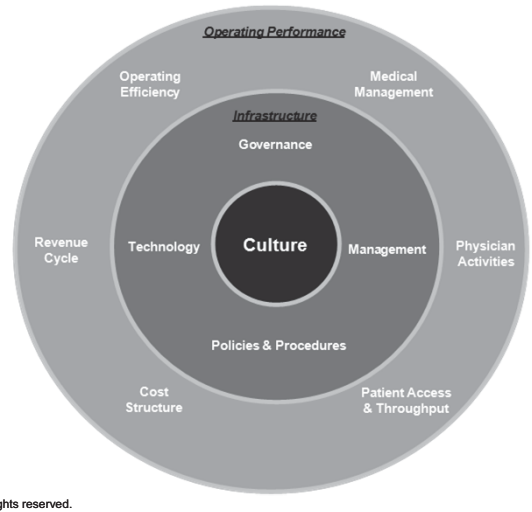
Implementing change

The interrelationship between operating performance and infrastructure



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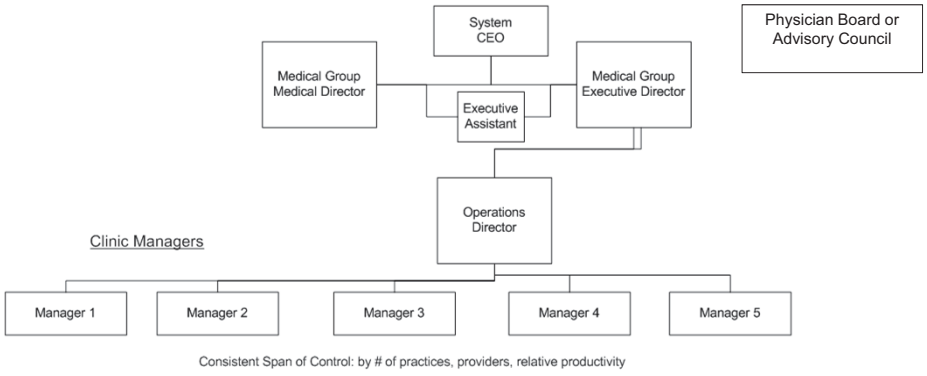
Implementing change

Designing an effective management structure



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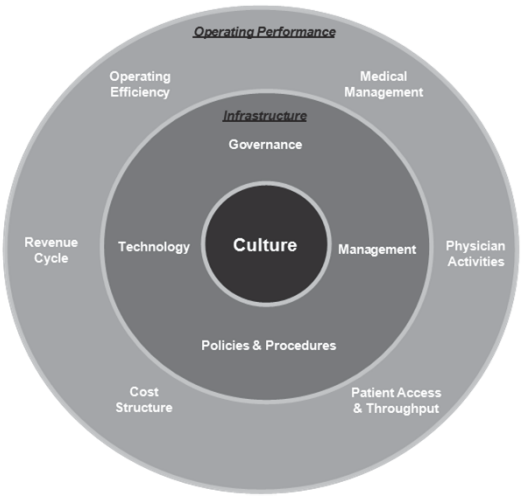
Implementing sustainable change

….of course, in the end it's all about….



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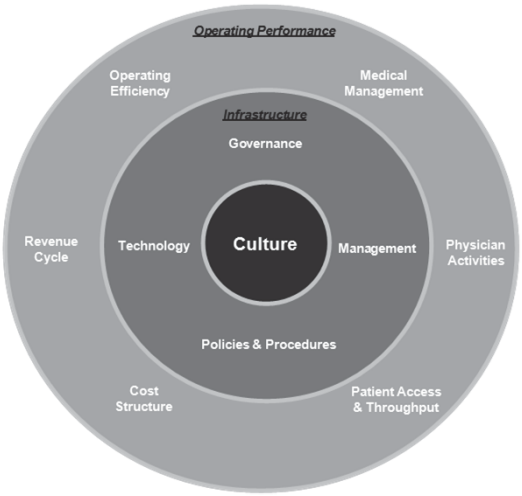
A short self-diagnostic survey



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Culture

- There is a clear sense of multi-specialty interdependence ("group-ness") among the various physician practices and specialty groups.
- Physicians have a clear understanding of how as individual practitioners they contribute to the overall mission and strategic objectives of the system.
- Physicians have a clear understanding of how as a medical group they contribute to the overall mission and strategic objectives of the system.
- Physician performance expectations are clearly documented.

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Infrastructure

- The medical group governance structure is well respected by physicians, has sufficient authority to promote accountability throughout the organization and to make difficult decisions for the good of the physician organization and the System.
- The information architecture and metrics are sufficient to enable the governing board to measure and monitor performance at the individual physician, department or division and overall physician enterprise levels.
- There is a strong, explicit interconnection between the medical group's governance and the health system's board of directors.
- All practice sites and departments share a common IT platform.
- The IT system is state of the art and meets the enterprise's needs.

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Operations

- There are group and individual performance standards or practice for physicians in terms of clinical effort, administrative time and responsibilities, and research and/or teaching.
- There are processes or tools in place to enable physicians to achieve performance standards.
- Processes in the physician enterprise that support achievement of performance standards include (check all that apply):
  - centralized scheduling
  - common scheduling template
  - workspace and staffing that facilitates efficient patient access and through-put,
  - patient contact hour expectations
  - clear administrative duty expectations and standards

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Operations

- Physician compensation is in line with the market.
- Physician compensation is commensurate with actual physician performance.
- The design of the compensation plan promotes and creates adequate incentives to drive actual performance toward expected performance levels.
- Patient access processes (patient contact hours, scheduling, fill process for no-shows) facilitate timely and convenient access to providers.

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Operations

- The revenue cycle processing functions (contracting, rate setting, billing and collection) are sufficient to reduce revenue leakage to an acceptable level and optimize revenue.
- Revenue cycle staffing levels are acceptable to reduce revenue leakage and optimize revenue.
- Support staffing levels are in line with industry comparative benchmarks.
- Some of our physicians or geographic practice sites are performing at a sub-par level and/or are not a preferred strategic fit for the physician enterprise or the system.
- We have a strategic discernment process for evaluating and making alternative disposition decisions for these physicians or practices.

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Accounting considerations – identifiable intangibles

ASC 805-20-25-10

The acquirer shall recognize separately from goodwill the identifiable intangible assets acquired in a business combination. An intangible asset is identifiable if it meets either the separability criterion or the contractual-legal criterion described in the definition of identifiable.

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Accounting considerations – identifiable intangibles

An identified intangible asset must be recognized as a separate asset from goodwill if either or both of the following criteria are met:

- The intangible asset is separable; that is, it is capable of being separated or divided from the acquired entity and sold, transferred, licensed, rented or exchanged (regardless of whether there is an intent to do so). An intangible asset that cannot be sold, transferred, licensed, rented or exchanged individually is considered separable if it can be sold, transferred, licensed, rented, or exchanged in combination with a related contract, asset or liability
- The intangible asset arises from contractual or other legal rights, regardless of whether those rights are in fact transferable or separable from the acquired entity or from other rights and obligations.

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Accounting considerations – identifiable intangibles

Potential acquired intangible assets in a physician practice acquisition:

- Non compete arrangements
- Medical records
- Favorable / unfavorable leases
- Other contracts
- Licenses

Valuation method considerations:

- Cost approach
- Market approach
- Income approach

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Accounting considerations – purchase consideration vs. compensation expense

ASC 805-10-55-24

Whether arrangements for contingent payments to employees or selling shareholders are contingent consideration in the business combination or are separate transactions depends on the nature of the arrangements. Understanding the reasons why the acquisition agreement includes a provision for contingent payments, who initiated the arrangement, and when the parties entered into the arrangement may be helpful in assessing the nature of the arrangement.

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Accounting considerations – purchase consideration vs. compensation expense

ASC 805-10-55-25

If it is not clear whether an arrangement for payments to employees or selling shareholders is part of the exchange for the acquiree or is a transaction separate from the business combination, the acquirer should consider the following indicators:

- Continuing employment
- Duration of continuing employment
- Level of compensation
- Incremental payments to employees
- Number of shares owned
- Linkage to the valuation
- Formula for determining consideration
- Other agreements and issues

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Ongoing accounting considerations

- Fair value of contingent consideration (re-measurement)
- Allocation of overhead costs to physician practices
- Methodology for estimating contractual allowances and allowances for doubtful accounts
- Integration of physician billing with central business office

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Ongoing accounting considerations – impairment considerations - goodwill

ASC 350-20-35-1

Goodwill shall not be amortized. Instead, goodwill shall be tested for impairment at a level of reporting referred to as a reporting unit.(Paragraphs 350-20-35-33 through 35-46 provide guidance on determining reporting units.)

ASC 350 was recently amended to permit an entity to first assess qualitative factors, as described in paragraphs 350-20-35-3A through 35-3G, to determine whether it is necessary to perform the two-step goodwill impairment test. (i.e. an entity may assess qualitative factors to determine whether it is more likely than not (that is, a likelihood of more than 50 percent) that the fair value of a reporting unit is less than its carrying amount, including goodwill). If determined to be necessary, the two-step impairment test shall be used to identify potential goodwill impairment and measure the amount of a goodwill impairment loss to be recognized (if any).

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Ongoing accounting considerations – impairment considerations - goodwill

In evaluating whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, an entity shall assess relevant events and circumstances. Examples of such events and circumstances include the following:

- Macroeconomic conditions
- Industry and market considerations
- Cost factors
- Overall financial performance
- Other relevant entity-specific events
- Events affecting a reporting unit
- If applicable, a sustained decrease in share price

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Ongoing accounting considerations – impairment considerations – indefinite lived intangible assets

ASC 350-30-35-18

An intangible asset that is not subject to amortization shall be tested for impairment annually, or more frequently if events or changes in circumstances indicate that the asset might be impaired. Paragraph 360-10-35-21 includes examples of impairment indicators. The impairment test shall consist of a comparison of the fair value of an intangible asset with its carrying amount. If the carrying amount of an intangible asset exceeds its fair value, an impairment loss shall be recognized in an amount equal to that excess.

There currently is no qualitative testing option, although there is a currently outstanding proposed accounting standard update that, if approved, will permit such an option.

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Ongoing accounting considerations – impairment considerations – other intangible assets

ASC 350-30-35-14

An intangible asset that is subject to amortization shall be reviewed for impairment in accordance with the *Impairment or Disposal of Long-Lived Assets Subsections* of Subtopic 360-10 by applying the recognition and measurement provisions in paragraphs 360-10-35-17 through 35-35. In accordance with the *Impairment or Disposal of Long–Lived Assets Subsections* of Subtopic 360-10, an impairment loss shall be recognized if the carrying amount of an intangible asset is not recoverable and its carrying amount exceeds its fair value. After an impairment loss is recognized, the adjusted carrying amount of the intangible asset shall be its new accounting basis. Subsequent reversal of a previously recognized impairment loss is prohibited.

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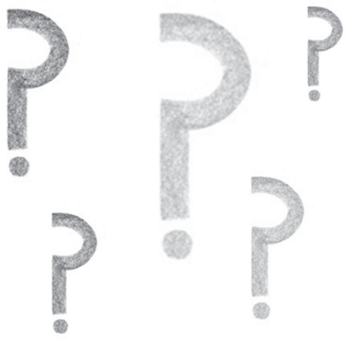
Any questions?



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Breakout 23: Diagnosimetrics: The Science of Diagnostic Cost Reduction & Quality Improvement

David A. Hernandez, PhD, MPH

David A. Hernandez, Ph.D., M.P.H.

Chief Science Advisor

The Center of Excellence In Diagnosimetrics

A former Yale University Student, Dr. Hernandez earned a Masters in Public Health from the University of Tennessee at Knoxville, with a concentration in Health Radiation Risk Assessment in 1987. He earned his doctoral degree in Applied Radiation Physics, from The Union Institute, in Cincinnati, Ohio. An expert in Low-Dose Ionizing Radiation effects on Human Populations, his dissertation was published in part at The 10th International Congress of the International Radiation Protection Association, on May 14- 19, 2000, in Hiroshima Japan.

An inventor, Dr. Hernandez has patents pending in the USA and Internationally. His latest invention is *Illness Specific Diagnostic System (ISD)*. ISD is a new method for disease diagnosis in humans. Rooted in the science of Diagnosimetric - *The application of quantitative analysis to the art of disease diagnosis*; ISD Technology destroys the myth of a single national medical standard of care, establishes local diagnostic medical standard, and focuses on the diagnostician as the individual most capable of diagnosing disease(s) in human beings. The application unit of ISD tables result in significant reduction in patient population ionizing radiation burden, while increasing a medical center's diagnostic specificity and sensitivity Dr. Hernandez, is licensed and has certificates to practice Diagnostic Radiation, and Nuclear Medicine Physics throughout the United States of America.

In addition to his scholarly work, Dr. Hernandez is a Trustee at Saint Leo University, where he serves on the Academic Affairs Committee. He serves on numerous boards and committees least of which is his association with the Center for Catholic-Jewish Studies, the Southeast leader in interfaith dialogue between Catholic and Jews, where he is the Chairman of The Board. A longtime supporter of the Arts, his most recent activity includes support of arts for the voiceless—underserved and aging population.

Married to his beloved Camille, who he met at Yale, they have 4 children, a dog (no cats) and live in the rolling hills of east Pasco County, Florida.

DIAGNOSIMETRICS: THE SCIENCE OF COST REDUCTION AND QUALITY IMPROVEMENT

DAVID A. HERNANDEZ, PH.D., M.P.H.

CHAIRMAN, CEO, & CHIEF SCIENCE OFFICER
HEALTHCARE RESOURCE DEVELOPMENT, INC.

Senior Fellow
The Center of Excellence in Diagnosimetrics
Located at Saint Leo University,
Saint Leo, Florida

ACKNOWLEDGEMENTS AND DISCLOSURES

- **Acknowledgement of Support**
  - **Galo Alava, MD,** Chairman of the Board CED & Assistant Professor of Healthcare Management, The School of Business at Saint Leo University
  - **Rhonda Waddell, Ph.D.,** Member of the Board of Directors & Professor of Interdisciplinary Education and Family Health Issues, The School of Education and Social Science at Saint Leo University,
  - **Patricia Camion**, **Ph.D.**, Member of the Board of Directors CED & Associate Professor of Sociology, The School of Education and Social Science at Saint Leo University
- **Disclosures**
  - Healthcare Resource Development has funded part of this work

PROPERTY OF THE HEALTHCARE RESOURCE DEVELOPMENT, INC.

MY CONVERSATION WITH YOU WILL BE SUCCESSFUL WHEN YOU REMEMBER THESE FOUR THINGS:

- Disease diagnosis is the most expensive component of a hospital stay
  - *It now costs more to diagnose a disease than it does to treat it*
- Diagnostic cost savings require modification of physician/practitioners behavior
  - *Medicine is driven by science and influenced by money*
- Accountants need tools to measure Effectiveness and Efficiency
- Know how to apply the DEP at your medical facility

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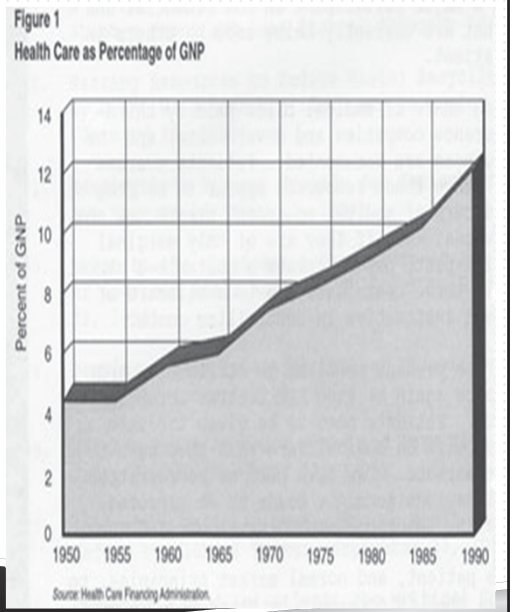
Why Has Healthcare Proven Resistant to Present and Historical Reform Efforts?

As measured by the GNP, healthcare reform efforts have failed to hold back rising healthcare expenditures-costs.

Private Payers will no longer accept the responsibility of rising healthcare costs. Businesses can no longer afford the risk that rising healthcare costs will negate any expectation of business profit.

Public side, you can't tax enough…asks the Greeks.



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It Now Cost More to Diagnose Disease Than It Does to Treat Disease

Jackson Memorial Hospital

Type of Control: Government (4)
Fiscal Year : 10/1/2007-9/30/2008 Type of Action:Unaudited Cost Report [1
Hospital Classification: Specialized/Statutory Teaching

	Total		Medicaid	
Type of Cost/Charge	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)
1. Ancillary	540,164,037.00	373,309,901.00	201,341,309.00	36,268,693
2. Routine	370,252,222.00		122,354,456.00	
3. Special Care	135,369,849.00		34,045,312.00	
4. Newborn Routine	47,044,686.00		18,458,515.00	
5. Intern-Resident	0.00		0.00	
6. Home Health				
7. Malpractice				
8. Adjustments	0.00	0.00	0.00	0.00
9. Total Cost	1,092,830,794.00	373,309,901.00	376,199,592.00	36,268,693.00
10. Charges	2,958,338,870.00	925,793,118.00	943,170,382.00	70,360,031.00
11. Fixed Costs	82,810,716.00		26,401,510.47	

Data Source

Florida Agency For Health Care Administration
Office of Medicaid Cost Reimbursement Planning and Analysis
Computation of Hospital Prospective Payment Rates
For Rate Semester January 1,2010 through June 30, 2010

100421 - 2010/01
1,186.54 / 159.00

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It Now Cost More to Diagnose Disease Than It Does to Treat Disease

Shands Teaching Hospital

Type of Control: Non-Profit (Other) (3)
Fiscal Year : 7/1/2006-6/30/2007 Type of Action:Unaudited Cost Report [1
Hospital Classification: Specialized: Statutory Teaching

	Total		Medicaid	
Type of Cost/Charge	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)
1. Ancillary	355,540,429.00	175,406,180.00	57,785,575.00	22,152,492
2. Routine	181,052,351.00		34,309,605.00	
3. Special Care	73,733,105.00		7,875,749.00	
4. Newborn Routine	19,333,644.00		12,478,922.00	
5. Intern-Resident	0.00		0.00	
6. Home Health				
7. Malpractice				
8. Adjustments	-7,996,017.08	-2,227,474.92	-1,427,995.43	-281,313.47
9. Total Cost	621,663,511.92	173,178,705.08	111,021,855.57	21,871,178.53
10. Charges	1,434,928,466.00	537,805,993.00	246,427,937.00	64,042,044.00
11. Fixed Costs	51,115,853.00		8,778,398.72	

Data Source

Florida Agency For Health Care Administration
Office of Medicaid Cost Reimbursement Planning and Analysis
Computation of Hospital Prospective Payment Rates
For Rate Semester January 1,2010 through June 30, 2010

100421 - 2010/01
1,186.54 / 159.00

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It Now Cost More to Diagnose Disease Than It Does to Treat Disease

Test Item: This is one of the concepts to remember

Englewood Community Hospital

Type of Control: Proprietary(1)
Fiscal Year : 1/1/2008- 12/31/2008
Hospital Classification: General

Type of Action:Unaudited Cost Report [1

	Total		Medicaid	
Type of Cost/Charge	Inpatient (A)	Outpatient (B)	Inpatient (C)	Outpatient (D)
1. Ancillary	12,720,243.00	12,267,878.00	294,403.00	405,774
2. Routine	10,793,094.00		202,400.00	
3. Special Care	2,094,322.00		74,561.00	
4. Newborn Routine	0.00		0.00	
5. Intern-Resident	0.00		0.00	
6. Home Health				
7. Malpractice				
8. Adjustments	-334,767.64	-160,377.36	-7,469.41	-5,304.66
9. Total Cost	25,272,891.36	12,107,500.64	563,894.59	400,469.34
10. Charges	$136,406,606.00	94,916,681.00	$3,029,120.00	2,904,719.00
11. Fixed Costs	4,350,943.00		96,619.43	

Data Source

Florida Agency For Health Care Administration
Office of Medicaid Cost Reimbursement Planning and Analysis
Computation of Hospital Prospective Payment Rates
For Rate Semester January 1,2010 through June 30, 2010

100421 - 2010/01
1,186.54 / 159.00

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BRIEF HISTORY OF HEALTHCARE REFORM

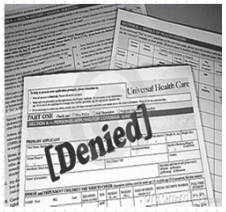
- All current healthcare reform efforts have been unable to solve the four policy resistant issues that have plagued healthcare for decades. Namely:

Access

Quality

Cost

Litigation



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KEY CONCEPT TO KNOW
BUT NOT TESTED

Healthcare Reform =

Healthcare Delivery Reform

+

Medical Practice Reform

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KEY CONCEPTS

These are examples of Healthcare Delivery Reform:

HMO, PPO and now ACOs are ***Healthcare Delivery Reform*** *methods* that attempt to modify physicians behavior.

So healthcare delivery reform attempts to hold cost through fiscal stimulus (stimulus can be – or +).

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KEY CONCEPTS

- Currently efforts are underway to define medical practice standards nationally:
  - The American College of Radiology- Appropriateness Criteria
  - The American College of Cardiology-Cardiology Practice Improvement Pathway
  - The American Academy of Neurology-Clinical Practice Guidelines.
- National clinical standards of diagnostic care ***do not enjoy*** overwhelming adherence.

Medicine is a local activity that operates under local facility specific standards. That is not a value statement. It simply supports the fact that physicians use the tools at hand. The way pneumonia is diagnosed in a small rural hospital in Kansas is different than the way its diagnosed at Tampa General Hospital.

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There are no efforts underway currently or historically to achieve Healthcare reform by modification of Medical Practice Reform!

That begs the question why?

Because until now, a scientific tool that defines diagnostic effectiveness and efficiency did not exist.
It does now!

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DIAGNOSTIC COST SAVINGS REQUIRES MODIFICATION OF PHYSICIAN / PRACTITIONER BEHAVIOR

Test Item: This is the second concept to remember.
The first was, "It now cost more to diagnose a disease than it does to treat it.

- Medicine is a local activity that operates under local facility specific standards.
- That is not a value statement.
- It simply supports the fact that physicians use the tools at hand.
- National standards of diagnostic care assume an equity among a medical center's diagnostic capacity
- That assumption proves not valid.

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DIAGNOSTIC COST SAVINGS REQUIRE MODIFICATION OF PRACTITIONER'S BEHAVIOR

How do you modify physician behavior?

- Medicine is driven by science and influenced by money.
- If you want to modify physician behavior, you must provide them with new scientific tools.
- What kind of tools? Tools of effectiveness and efficiency.

What tools do accountants have to modify physicians diagnostic behavior?

- None.
- Until Now!
- What do medical financial executives need to measure?

Effectiveness & Efficiency

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ACCOUNTANTS NEED TOOLS TO MEASURE EFFECTIVENESS AND EFFICIENCY

***Test Item**: This is the **Third concept** to remember*
*The **first was**, "It now cost more to diagnose a disease than it does to Treat it."*
*The **second item** was, "*Diagnostic cost savings require modification of physician / practitioner behavior."

So here is the tool:

Diagnostic Efficiency Profile (DEP) is a medical center's specific measure of a disease specific diagnostic accuracy. Or stated differently, what is the accuracy to diagnose a specific disease at a specific medical center?

It is statement of medical quality- it is a measure of medical diagnostic effectiveness! I have not explained how to do it, only what it is.

A consequence of the DEP is the understanding of your medical center's disease specific cost.

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ACCOUNTANTS NEED TOOLS TO MEASURE EFFECTIVENESS AND EFFICIENCY

DEP is derived by a retrospective analysis of disease specific medical records.

It is possible to look at a medical record through the lens of a cohort like a DRG. Let say pneumonia. If you abstract medical records under a disease specific cohort, it is possible to develop weighted ranked ordered concatenation that describes a medical center's DEP.

Let me show you an example.

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ACCOUNTANTS NEED TOOLS TO MEASURE EFFECTIVENESS AND EFFICIENCY

Illness Specific Diagnostic Table

Florida Hospital

DRG 193, 194, 195		Simple Pneumonia & Pleurisy w MCC, w CC, w/o MCC				
Diagnostic Test	Negative Results	Positive Results	Equivocal Results	Total Test Count		Diagnosimetric Test Value
CBC	34	106		140		32.767
BMP	20	74		94		23.150
CMP	26	50	1	77		17.717
XR Chest 1v	35	45		80		17.400
GLUCOSE POC	25	36	1	62		13.818
Glu POC	7	39	5	51		12.789
PT	24	23		47		9.975
BNP	9	25		34		8.484
GLUCOSE PEC	2	28		30		8.364
ABG	4	23		27		7.225
CPK	30	7	6	43		7.145
CKMB	38	5		43		6.859
MAGNESIUM	46		2	48		6.835
PTT	32	6	1	39		6.449
Culture - Blood	44			44		6.283
PHOSPHORUS	31			31		4.467
XR Chest 2v	3	13		16		4.222
TROP	22	3		25		4.052
BLOOD CULTURE	28			28		4.043
URINE ANALYSIS	17	4		21		3.628
UA	15	2	6	23		3.623
SPUTUM CULTURE	8	7		15		3.205
Troponin	20			20		2.904
US Ext Lower	18			18		2.617
CT Chest w/o	3	6		9		2.195
CT Chest PE	2	6		8		2.050
Folate	6	3		9		1.756
CT Brain w/o	12			12		1.752
PROTIME	5	3		8		1.610
TSH	11			11		1.607
US Echo	11			11		1.607
D Dimer		5		5		1.467
Lipid	6	2		8		1.464
Culture - Urine	8	1		9		1.463
GRAM SPUTUM STAIN?	1	1	7	9		1.463
Gram	6		4	10		1.462
CBC-DIFF	7	1		8		1.318

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DRG 193		Simple Pneumonia & Pleurisy w CC				
Diagnostic Test	Negative Results	Positive Results	Equivocal Results	Total Test Count		Diagnosimetric Test Value
GLUCOSE PEC	2	28		30		2.349
BMP	1	26		27		2.162
PT	7	12		19		1.290
CMP		15		15		1.280

DRG 194		Simple Pneumonia & Pleurisy w MCC				
Diagnostic Test	Negative Results	Positive Results	Equivocal Results	Total Test Count		Diagnosimetric Test Value
CMP	2	24		26		12.500
Glu POC	2	27		29		12.320
BNP	3	17		20		11.470
PT	12	11		23		9.320

DRG 195		Simple Pneumonia & Pleurisy w/o CC MCC				
Diagnostic Test	Negative Results	Positive Results	Equivocal Results	Total Test Count		Diagnosimetric Test Value
CBC	29	22		51		3.197
CMP	24	11	1	36		2.161
BNP	15	12		27		1.779
Glu POC	6	12	4	22		1.367

Complete Blood Count = CBC – How is the blood oxygenating

Comprehensive Metabolic Panel = CMP – Broad screening tests that give fee back on kidneys, liver, electrolyte and acid/base balance

Basic Metabolic Panel = BMP – Blood sugar

Brain natriuretic Peptide = BNP – Congestive heart failure

Glucose Personal Ear Clip = Glucose Personal Ear clip – Blood Sugar

Glucose POC

Prothrombin Time = PT- Blood clotting time

Know the value DEP brings to your medical facility.

***Test Item**: This is the **fourth concept** to remember.*

*The **first was**, "It now cost more to diagnose a disease than it does to Treat it."*

*The **second item** was, "*Diagnostic cost savings require modification of physician / practitioners behavior."

*The **Third** was, "Accountants* need tools to measure Effectiveness and Efficiency."

Illness Specific Diagnostic Table

Florida Hospital

DRG 193, 194, 195		Simple Pneumonia & Pleurisy w MCC, w CC, w/o MCC				
Diagnostic Test	Negative Results	Positive Results	Equivocal Results	Total Test Count		Diagnosimetric Test Value
CBC	34	106		140		32.767
BMP	20	74		94		23.150
CMP	26	50	1	77		17.717
XR Chest 1v	35	45		80		17.400
GLUCOSE POC	25	36	1	62		13.818
Glu POC	7	39	5	51		12.789
PT	24	23		47		9.975
BNP	9	25		34		8.484
GLUCOSE PEC	2	28		30		8.364
ABG	4	23		27		7.225
CPK	30	7	6	43		7.145
CKMB	38	5		43		6.859
MAGNESIUM	46		2	48		6.835
PTT	32	6	1	39		6.449
Culture - Blood	44			44		6.283
PHOSPHORUS	31			31		4.467
XR Chest 2v	3	13		16		4.222
TROP	22	3		25		4.052
BLOOD CULTURE	28			28		4.043
URINE ANALYSIS	17	4		21		3.628
UA	15	2	6	23		3.623
SPUTUM CULTURE	8	7		15		3.205
Troponin	20			20		2.904
US Ext Lower	18			18		2.617
CT Chest w/o	3	6		9		2.195
CT Chest PE	2	6		8		2.050
Folate	6	3		9		1.756
CT Brain w/o	12			12		1.752
PROTIME	5	3		8		1.610
TSH	11			11		1.607
US Echo	11			11		1.607
D Dimer		5		5		1.467
Lipid	6	2		8		1.464
Culture - Urine	8	1		9		1.463
GRAM SPUTUM STAIN?	1	1	7	9		1.463
Gram	6		4	10		1.462
CBC-DIFF	7	1		8		1.318

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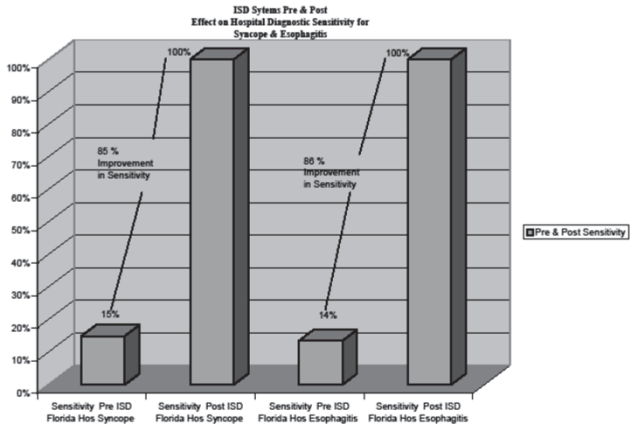
Figure 5



Notes: Prior to ISD system application, the Florida Hospital's sensitivity (a medical quality indicator) for Esophagitis was 14% (483/(483+805)). Post ISD, the Hospital's sensitivity is 100%, since only the top selected diagnostimetric diagnostic tests are used. The same is true for Syncope with a pre-ISD sensitivity value of 15% ((483/(483+2732)), once ISD, is applied sensitivity is 100%. The increase in medical quality occurs because ISD systems educate referring clinicians to order diagnostic tests for a specific disease, not symptoms, this allows for use of ISD tables. ISD tables identify the diagnostic test most likely to confirm the disease in question, in this case Syncope and Esophagitis, and aid clinicians to diagnose disease correctly.

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LET'S CLOSE IT UP AND SEE IF I WAS SUCCESSFUL

- The First item to remember was?
  - "It now cost more to diagnose a disease than it does to treat it."
- The second item to remember was?
  - "Diagnostic cost savings require modification of physician / practitioners behavior."
- *The third item to remember was?*
  - *"Accountants* need tools to measure Effectiveness and Efficiency."
- The fourth item to remember was?
  - "Know the value DEP brings to your medical facility."

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Breakout 24: The CEO/CFO Relationship – What Are They Thinking

Ford Kyes

Ford Kyes

Founding Partner
ActionCOACH Pinellas

As a founding Partner of ActionCOACH Pinellas, Ford has focused on leadership development and growing profitability in companies of all sizes through education and coaching of senior executives and business owners. Ford's firm, ActionCOACH Pinellas, was recently recognized as one of the top ten ActionCOACH firms in the world (#6).

Ford received his undergraduate degree in nursing from Penn State and masters in public management from the prestigious Carnegie Mellon University in Pittsburgh.

Prior to launching ActionCOACH Pinellas, Ford served for six years as President and CEO of St. Anthony's Health Care in St. Petersburg, Florida and Executive Vice President for the 10 hospital BayCare Health System.

The CEO / CFO Relationship – What are they thinking?

Ford Kyes
Partner and Master Coach, ActionCOACH Pinellas
April 27th at 1:00 PM

Seven Key Strategies to Improve Communication:

1. Understand the CEO's customers – What are their WIIFM's

2. Become and expert at communicating by adjusting your style

3. Focus on Revenue, Profitability and Productivity (in the context of Strategy – Hedgehog & SMaC)

4. Provide actionable reports and analysis – give context w/ content

5. Take Ownership of your response → E + R = O

6. Learn to look for the positive (rose tinted glasses)

7. Present Options (but not too many) – be a problem solver vs. problem identifier

7.5 No Surprises – under promise & over deliver

Accounting and Auditing Update

Lynda M. Dennis, CGFM, CPA, PhD

Lynda M. Dennis, CPA, PhD, CGFM

Instructor
University of Central Florida

Lynda M. Dennis, CPA, PhD received her PhD in Public Affairs and her Masters in Public Administration from the University of Central Florida and her under graduate degree in accounting and finance from the University of West Florida. She is a Florida CPA and Certified Government Finance Officer. Lynda has taught as an instructor in the Kenneth Dixon School of Accounting at the University of Central Florida. Lynda is also a CPE discussion leader for the AICPA in the areas of accounting and reporting for governmental and not-for-profit organizations.

Her experience includes serving in a financial capacity, including chief financial officer, in governmental and not-for-profit organizations primarily in Florida. Her experience also includes working as an auditor for local and Big 4 firms with an emphasis in the insurance, government and not-for-profit sectors. Lynda also worked as the Special Projects Manager for the Dallas County Community College District and as a grader of CPA exams for the AICPA.

Lynda actively participates in committee and other volunteer work for the AICPA and FICPA and is a frequent speaker at governmental accounting conferences. She has previously published four CPE courses as well as a book on strategy implementation (both for governmental and not-for-profit organizations) for the AICPA and a public finance primer for the American Public Works Association. In addition, Lynda updated the State and Local Government Accounting and Audit Guide published by the AICPA for 2009 and again for 2010.

Health Industry Conference

Accounting & Auditing Update

Presented by
Lynda M. Dennis CPA, CGFO, PhD
University of Central Florida

Overview

- Accounting update
  - Standard setting for private entities
  - FASB projects
  - Recent ASUs
- Auditing update
  - ASB
  - GAO
  - OMB

Accounting Update

Current Issues

Future of Standard Setting

- 2009
  - FAF forms "blue-ribbon panel" to address how U.S. accounting standards can best meet needs of users of private company financial statements
- January 2011
  - Report submitted to FAF
    - Panel recommendations
      - New separate standard-setting board
      - Modifications to U.S. GAAP to recognize unique needs of private company financial statement users
      - NFPs not in scope of report

Future of Standard Setting

- March 2011
  - FAF completed its review of Panel's final report
  - Announced it was forming a trustee working group to address accounting standard setting for nonpublic entities
  - NFPs in scope

Future of Standard Setting

- **October 2011 – "Plan"**
  - **Comment period ended 1/14/12**
  - **No separate standard setting body**
    - **Private Company Standards Improvement Council**
      - **Evaluate if exceptions to US GAAP needed**
      - **11-15 members**
      - **Overseen by FAF Board of Trustees**
      - **Any changes to existing US GAAP subject to ratification by FASB**
      - **Council chairman**
        - **Selected & appointed by FAF Trustees**
        - **FASB member with substantial experience with private companies**

NFP Financial Reporting Projects

- **NFP Advisory Committee - September 2011**
  - **Conclusions re: NFPs**
    - **More similar to public entities (contributions, tax exemptions)**
    - **BOD involved in mission not running business (really users of the NFP FS)**
  - **Project recommendations to FASB**
    - **Net asset classes**
      - **Categories confusing**
      - **More information re: liquidity in classes of net assets**
      - **Disclosing liquidity information**
    - **FS format**
      - **Better disaggregation re: financial performance & operating & nonoperating aspects of it**
    - **MD&A**
      - **Require or encourage**

NFP Financial Reporting Projects

- FASB added two projects to agenda November 2011
  - Standards setting project
    - Net asset requirements
    - Statement & note information re:
      - Liquidity
      - Financial performance
      - Cash flows
  - Research project re: communications

NFP Accounting & Reporting Issues

- EITF issues
  - Issue No. 12-A – Cash flows & gifts of securities
    - Investing vs. operating
  - Issue No. 12-B – Services received from affiliates
    - Receipt of support etc. used to pay employees who than work for affiliates
      - Contributed services vs. separate recognition

Medicare Incentive Payments "Meaningful Use"

- HFMA Issue Analysis
  - Issued December 2011
  - HITECH Act
    - Must meet "meaningful use" criteria to qualify for incentive payments
  - Traditional accounting
    - Contingency model
    - IAS 20 grant model
      - Main focus of issued analysis on grant accounting model
      - Nothing issued by SEC on specific requirements of the contingency model

Statements Effective for Periods Beginning On or After December 15, 2010

Health Care Entities – Charity Care Disclosures

- ASU 2010-23
  - Use of costs as measurement basis
    - Identified as direct & indirect costs of providing charity care
  - Disclose method used to identify or determine such costs
  - If costs cannot be specifically attributed to services provided to charity care patients, management may estimate costs of those services using reasonable techniques

Health Care Entities – Insurance Claims & Recoveries

- ASU 2010-24
  - Clarifies that a health care entity should not net insurance recoveries against a related claim liability
  - Establishes that the amount of the claim liability should be determined without consideration of insurance recoveries

Statements Effective for Periods Beginning On or After December 15, 2011

Goodwill – When to Perform Step 2 of the Impairment Test

- ASU 2010-28
- Modifies Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts
  - Eliminates entity's ability to assert a reporting unit is not required to perform Step 2 because carrying amount is zero or negative despite the existence of qualitative factors that indicate the goodwill is more likely than not impaired
  - Entity is required to perform Step 2 if it is more likely than not that goodwill impairment exists

Goodwill – When to Perform Step 2 of the Impairment Test

- Qualitative factors requiring testing of goodwill of a reporting unit between annual tests
  - Significant adverse change in legal factors or business climate
  - Adverse action or assessment by a regulator
  - Unanticipated competition
  - Loss of key personnel
  - More-likely-than-not expectation that reporting unit or a significant portion of reporting unit will be sold or otherwise disposed of
  - Testing for recoverability as required by Subtopic 360-10 of a significant asset group within a reporting unit
  - Recognition of goodwill impairment loss in financial statements of a subsidiary that is a component of a reporting unit

Reconsideration of Effective Control for Repurchase Agreements

- ASU 2011-03
- Removes both of the following from the assessment of effective control:
  - Criterion requiring transferor to have ability to repurchase or redeem the financial assets on substantially the agreed terms, even in the event of default by the transferee
  - Collateral maintenance implementation guidance related to that criterion
- Other criteria applicable to the assessment of effective control are not changed

Fair Value Measurement – Convergence of Measurement & Disclosures in US GAAP & IFRS

- ASU 2011-04
- Most not intended to change application of existing FV US GAAP
- Common measurement & disclosure between US GAAP & IFRS
  - Wording changes (use of "shall")
  - Clarification of FASB's intent re: application of existing FV measurement requirements
    - Highest & best use for nonfinancial assets only
    - Use perspective of market participant for own equity instruments (reported in SE)

Fair Value Measurement – Convergence of Measurement & Disclosures in US GAAP & IFRS

- Changes to disclosures
  - Level 3
    - Valuation process used
    - Sensitivity to changes in unobservable inputs & interrelationships*
    - Use of nonfinancial asset differing from highest & best use
    - Categorization by level for items not measured at FV in BS but where FV required to be disclosed*
  - Information re: transfers between Level 1 & 2*

* Not required for nonpublic entities

Testing Goodwill for Impairment

- ASU 2011-08
- Option to first assess qualitative factors re: existence of impairment indicators
  - More likely than not (50%+) reporting unit FV < CV
    - Do step 1 of impairment test then step 2 if required
  - NOT more likely than not (50%+) reporting unit FV < CV
    - Not necessary to perform 2-step impairment test

Statements Effective for Periods Ending On or After December 15, 2012

Creditors Determination of Whether Restructuring is a TDR

- ASU 2011-02
- Applies to all creditors that restructure receivables falling within Subtopic 310-40, Receivables—Troubled Debt Restructurings by Creditors
- In evaluating whether a restructuring constitutes a troubled debt restructuring, a creditor must separately conclude that both of the following exist:
  - Restructuring constitutes a concession
  - Debtor is experiencing financial difficulties
- Clarifies guidance on creditor's evaluation of whether it has granted a concession

Health Care Entities – Patient Revenues & Bad Debts

- ASU 2011-07
- Health care entities that recognize significant amounts of patient service revenue at the time the services are rendered (even though they do not assess the patient's ability to pay)
  - Patient services revenue reported net of contractual allowances & discounts
  - Present related bad debts on separate line as deduction from patient services revenue

Health Care Entities – Patient Revenues & Bad Debts

- Additional disclosures
  - Enhanced disclosures – revenue recognition & bad debts
  - Patient service revenue, net of contractual allowances & discounts
  - Qualitative & quantitative information re: changes in allowance for doubtful accounts

Health Care Entities – Patient Revenues & Bad Debts

- AICPA Technical Practice Aid
  - Issued March 2012 to assist health care entities in applying ASU 2011-07
    - At what level is "significance" considered in consolidated financial statements
      - Subsidiary vs. parent vs. consolidated
      - Requires accounting policy election

Multi-Employer Retirement Plan Disclosures

- ASU 2011-09
- Retrospective application required
- Additional disclosures – multi-employer plans
  - Plans employer involved
  - Employer participation in plans
  - Effects of participation in plans on employer cash flows

Statements Effective for Periods Beginning On or After January 1, 2013

Offsetting Assets & Liabilities

- ASU 2011-11
- Differences in IFRS & US GAAP
- Amends current disclosure requirements on offsetting
- Affects all entities that have financial & derivative instruments that are either
  - Offset in accordance with either Section 210-20-45 or Section 815-10-45 or
  - Subject to an enforceable master netting arrangement or similar agreement

Offsetting Assets & Liabilities

- Entities are required to disclose
  - Gross information and
  - Net information
- Gross & net information disclose about
  - Instruments & transactions eligible for offset in the statement of financial position
  - Instruments & transactions subject to an agreement similar to a master netting arrangement

Offsetting Assets & Liabilities

- Required information presented in a tabular format
  - Separately for assets and liabilities
  - The total amount disclosed for an enforceable master netting arrangement or similar agreement shall not exceed net amount presented in the statement of financial position
- Requires entity to provide a description of rights of setoff associated with recognized assets & liabilities subject to an enforceable master netting arrangement or similar agreement
  - Including the nature of those rights
- If information required to be disclosed is disclosed in more than a single note, cross-reference between notes is required

IFRS for Small & Medium Sized Entities

IFRS for SMEs

- IASB issued in July 2009
- Stand alone standards
- Organized by topic
  - More like a reference manual
- Must comply in its entirety
- Includes requirements for development & application of accounting policies
- Changes only once every three years

IFRS for SMEs

- Small & medium-sized entities
  - Publish general purpose FS for external users
  - Do not have "public accountability"
    - Debt/equity instruments traded in public market or in the process
    - Holds assets in fiduciary capacity for broad group of outsiders as one of its primary businesses
      - Banks, credit unions, insurance companies, etc.

Key Differences in GAAP & IFRS for SMEs

- Disclosures are simplified in
  - Leases
  - Pensions
    - Simplified calculation of DB plan obligation
  - Financial Instruments
- LIFO is prohibited

Key Differences in GAAP & IFRS for SMEs

- Simplified temporary difference approach to income tax accounting
- Reversal of impairment charges, if certain criteria are met, is allowed
- Accounting for financial assets & liabilities makes greater use of cost
  - No special accounting for AFS

Key Differences in GAAP & IFRS for SMEs

- Goodwill & other indefinite intangible assets are amortized
  - No useful life = 10 years
- Cost model permitted for investments in associates & joint ventures

Auditing Update

Audit Risks in 2012

- Continuing effect of the Great Recession
  - Collections
  - Revenue recognition
    - Grants
    - Contributions
  - Expense recognition
  - Deterioration of financial condition

Audit Risks in 2012

- Unfilled positions
  - Effect on current employee workload
  - Increased opportunities for fraud
- Final ARRA monies
  - "Spend it or lose it"

Overview of the Clarity Project

- Clarity format
  - Introduction
  - Objective
  - Definitions
  - Requirements
  - Application and other explanatory material
  - Other conventions
    - Formatting techniques
    - Special considerations section
      - Audits of smaller, less complex entities
      - Audits of governmental entities

Existing Clarified Standards

- Not superseded with SAS No. 122
  - Effective periods ending after 6/15/10
    - SAS No. 117
  - Effective periods beginning after 12/15/10
    - SAS No. 118
    - SAS No. 119
    - SAS No. 120

Existing Clarified Standards

- Issued after SAS No. 122 & effective with SAS No. 122
  - SAS No. 123
  - SAS No. 124
  - SAS No. 125

SAS No. 122

- Issued October 2011
- Virtual culmination of the Clarity Project
- AU sections renumbered to align with ISAs
  - New number assigned if no equivalent ISA section number
  - During transition
    - Existing SASs still use AU designation
    - SAS No. 122 sections use AU-C designation until effective date completely implemented

SAS No. 122

- Supersedes SAS No. 1-116 and No. 121 except
  - SAS No. 51 (SAS No. 124 – non US GAAP statements)
  - SAS No. 59 (ED outstanding – going concern)
  - SAS No. 65
  - SAS No. 87 (SAS No. 125 – restricted use reports)
- Withdraws SAS No. 26

SAS No. 122

- No substantial changes to
  - Audit documentation.
  - Auditor's communication with those charged with governance.
  - Risk assessment standards.
  - External confirmations.
  - Analytical procedures.
  - Audit sampling.
  - Auditing accounting estimates.
  - Written representations.
  - Subsequent events.
  - Consideration of omitted procedures after the report release date.

SAS No. 122

- Implicit guidance made explicit
  - Determining whether the applicable financial reporting framework (chosen by management) is acceptable.
  - Having management agree to their responsibilities at the onset of the engagement.
  - Applying quality control procedures at the audit engagement level.

SAS No. 122

- Additional Requirements
  - The clarified standards include additional requirements to address
    - changes to the wording of the auditor's reports
      - Words & format
      - Explanatory paragraphs
    - more specific procedures to detect illegal acts
    - opening balances in initial audits.

SAS No. 122

- Most substantially revised requirements
  - Overall objectives of the independent auditor and the conduct of an audit in accordance with GAAS
  - Terms of engagement
  - Special purpose financial statements
  - Audits of group financial statements

Audits of Group Financial Statements

- Applies to audits of group financial statements
- Auditor of the group financial statements (formerly principal auditor)
  - Group engagement partner
    - Decides whether to make reference to component auditor or not
  - Group engagement team
- Component auditor (formerly other auditor)

Audits of Group Financial Statements

New Terms

- Component
- Component auditor
- Component management
- Component materiality
- Group
- Group audit
- Group audit opinion
- Group engagement partner
- Group engagement team
- Group financial statements
- Group management
- Group-wide controls
- Significant component

Audits of Group Financial Statements

- Engagement Acceptance or Continuance
  - Based on whether auditor believe sufficient appropriate audit evidence over the group financial statements will be obtained
    - Predicated on work of group engagement team and any component auditors
  - Decision to assume responsibility or not for work of component auditors
    - Done by group engagement partner

Audits of Group Financial Statements

- **Requirements for all group audits**
  - **Obtain understanding**
    - **Component auditor**
      - **Understands and will comply with relevant ethical requirements**
      - **Professional competence**
      - **Operates in regulatory environment that actively oversees auditors**
    - **Involvement in work of component auditor**
    - **Adequacy of information affecting consolidation process from component auditor**

Audits of Group Financial Statements

- **Requirements when not assuming responsibility for component auditor**
  - **Can not reference component auditor unless**
    - **Financial statements audited by component auditor same financial reporting framework as group**
    - **Component auditor performed audit in accordance with GAAS, GAS, PCAOB, etc. as applicable**
    - **Report of component auditor not a "restricted use" report**

Audits of Group Financial Statements

- Requirements when not assuming responsibility for component auditor
  - Precluded from referencing work of component auditor when
    - Component auditor doesn't meet relevant independence requirements
    - Group engagement team has concerns re: component auditor
      - Understands and will comply with ethical requirements
      - Professional competence

Audits of Group Financial Statements

- Requirements when not assuming responsibility for component auditor
  - Report on group financial statements
    - Clearly indicate component not audited by auditor of group financial statements
    - Include magnitude of portion of financial statements audited by component auditor
  - When naming component auditor
    - Obtain express permission from component auditor
    - Present component auditor's report with auditor's report on group financial statements

Audits of Group Financial Statements

- Requirements when assuming responsibility for component auditor
  - Additional procedures required
    - Component materiality
    - Type of work to be performed on component
    - Identify and perform procedures for
      - Significant components
      - Components that are not significant
    - Involvement in work of component auditor
    - Communication with component auditor

Audits of Group Financial Statements

- Requirements for all group audits
  - Establish overall group strategy
  - Develop group audit plan
  - Obtain understanding of group, its components, and environments
    - Including group wide controls
  - Identify significant components
  - Obtain understanding of consolidation process
    - Including instructions from group management to components

Audits of Group Financial Statements

- Significant components
  - Identified by group engagement team
  - Significant due to
    - Individual financial significance
      - Use of benchmarks
    - Nature or circumstances

Audits of Group Financial Statements

- Responding to assessed risks
  - Operating effectiveness of group wide controls
  - Consolidation/combination process
    - Adjustments & reclassifications
    - Consistent accounting policies applied to group and components
    - Adjustments for differing year-ends
  - Subsequent events

Audits of Group Financial Statements

- **Additional Requirements When Assuming Responsibility**
  - **Materiality**
    - **Evaluate appropriateness of performance materiality at component level**
  - **Determine type of work to be performed**
  - **Significant components**
    - **Individual financial significance**
      - **Audit, adapted as necessary**
    - **Nature or circumstances**
      - **Audit of financial information**
      - **Audit account balances, classes of transactions, or disclosures**
      - **Specific procedures related to likely significant risks**

Audits of Group Financial Statements

- **Additional Requirements When Assuming Responsibility**
  - **Components that are not significant**
    - **Analytical procedures at group level**
    - **When additional evidence needed**
      - **Audit financial information**
      - **Audit account balances, classes of transactions, disclosures**
      - **Review financial information**
      - **Specified procedures related to likely significant risks**

Audits of Group Financial Statements

- **Additional Requirements When Assuming Responsibility**
  - **Involvement in work of component auditor**
    - **Purpose - identify RMM in the group financial statements**
  - **Minimum procedures**
    - **Discuss**
      - **Component business activities that are significant to group with component auditor or component management**
      - **Susceptibility of component to material misstatement with component auditor or component management**
    - **Review component auditor documentation of identified significant RMMs of the group financial statements**

Audits of Group Financial Statements

- **Additional Requirements When Assuming Responsibility**
  - **Subsequent events**
    - **Group engagement team required to request component auditor to notify group engagement of certain circumstances**
      - **Events at component that may require adjustment to, or disclosure in, group financial statements occurring between date of component financial information and auditor's report on group financial statements**

Audits of Group Financial Statements

- **Communications With Component Auditor**
  - **Specific communications required in all group audits**
    - **Group engagement team to component auditor**
    - **Component auditor to group engagement team**
  - **Additional communications required when assuming responsibility**
    - **Group engagement team required to evaluate component auditor's communication**

Audits of Group Financial Statements

- **Communications With Group Management & Those Charged With Governance**
  - **Specific separate communications required in all group audits for**
    - **Group management**
    - **Those charged with governance of the group**
  - **Additional communications required when assuming responsibility**
    - **Material weakness or significant deficiencies component auditor brought to attention of group engagement team**

Transitioning to the Clarified Standards

- Become familiar with the clarified standards including the application material, appendices, and exhibits.
- Read the summary of changes between the existing SASs and the clarified SASs.
- Appoint a person or team to be in charge of the transition.
  - Consider establishing small task forces of staff at different levels to develop revisions to the firm's audit methodologies.
  - Include adequate time for training of all audit staff.
- Determine what changes are necessary to audit procedures and training in accordance with firm quality control policies.

Transitioning to the Clarified Standards

- Revise firm guidance and audit programs to refer to the clarified standards.
- Ascertain when the audit software provider expects to have revisions resulting from the Clarity Project made to their software products.
  - Determine when training will be offered and schedule training for all audit staff as soon as possible.
- Discuss pertinent changes with clients (i.e. engagement letter, management representations, new opinion format, group audits, etc.) and financial statement users (new opinion format, group audits, etc.).

Other Clarified Standards

SAS No. 123

- SAS No. 123 *Omnibus Statement on Auditing Standards – 2011*
  - Amends/conforms SAS No. 117 & 118 for SAS No. 122
  - Several amendments to SAS No. 122 for consistency, etc.
- Issued October 2011
- Effective for audits of periods ending on/after 12/15/12

SAS No. 124

- SAS No. 124 *FS Prepared in Accordance with a Financial Reporting Framework Generally Accepted in Another Country*
  - Supersedes SAS No. 51
  - Emphasis of matter paragraph required
- Issued October 2011
- Effective for audits of periods ending on/after 12/15/12

SAS No. 125

- SAS No. 125, *Alert That Restricts the Use of the Auditor's Written Communication*
  - Written communication - one issued by the auditor in connection with engagements conducted in accordance with GAAS
    - Auditor's report – statements and/or SI
    - Communication of deficiencies in internal control
    - Communications with those charged with governance
    - Compliance audits
    - Reports on statements prepared in accordance with special purpose frameworks
    - Letters for underwriters

SAS No. 125

- SAS No. 125, *Alert That Restricts the Use of the Auditor's Written Communication*
  - Addresses auditor's responsibility, when required or the auditor decides, to restrict the use of the auditor's written communication. In an auditor's report
  - Language included in an other-matter paragraph
- Issued in December 2011
- Effective for audits of periods ending on/after 12/15/12

Other ASB Projects

Outstanding Clarified Standards

- **Going concern**
  - ED *The Auditor's Consideration of an Entity's Ability to Continue as a Going*
  - Planned to be effective for audits of periods ending on/after 12/15/12
  - Primary changes
    - Obtaining written representations if conditions or events identified indicating there could be substantial doubt
    - Incorporation of Interpretation No. 1, "Eliminating a Going-Concern Explanatory Paragraph From a Reissued Report"

Outstanding Clarified Standards

- **Internal audit**
  - Task force in process of redrafting AU section 322, *Consideration of the Internal Audit Function in an Audit of Financial Statements*
    - Redraft for clarity format
    - Converge with ISA 610, *Using the Work of Internal Auditors*
  - Task force monitoring IAASB's project to revise IAS 610

Government Audit Standards

2011 Revision to GAS

- Internet version issued late August
  - Pervasive generic nomenclature change Chapters 1-3 to "audit" in lieu of financial audit, attestation engagement, and/or performance audit
- Final version to be issued pending finalization of AICPA Clarity Project
- Effective dates
  - Financial audits/attestation engagements
    - Same as effective date of Clarity Project
      - Audits PE on/after 12/15/12
  - Performance audits
    - Performance audits beginning on/afdter 12/15/11

2011 Revision to GAS Major Changes

- Major Changes Contained in the 2011 GAGAS1A conceptual framework approach for independence to provide a means for auditors to assess auditor independence to activities that are not expressly prohibited
- Specific references to personal, external, and organizational impairments, and overarching independence principles have been removed (the concepts underlying these categories are embodied in the conceptual framework)

2011 Revision to GAS Major Changes

- Requirements for auditors performing nonaudit services at entities they audit, to assess whether management possesses suitable skill, knowledge, or experience to oversee the nonaudit service and to document that assessment
- Guidance on nonaudit services that always impair an auditor's independence with respect to audited entities and on certain nonaudit services that may be permitted under appropriate conditions
- Summary requirements on documentation necessary to support adequate consideration of auditor independence

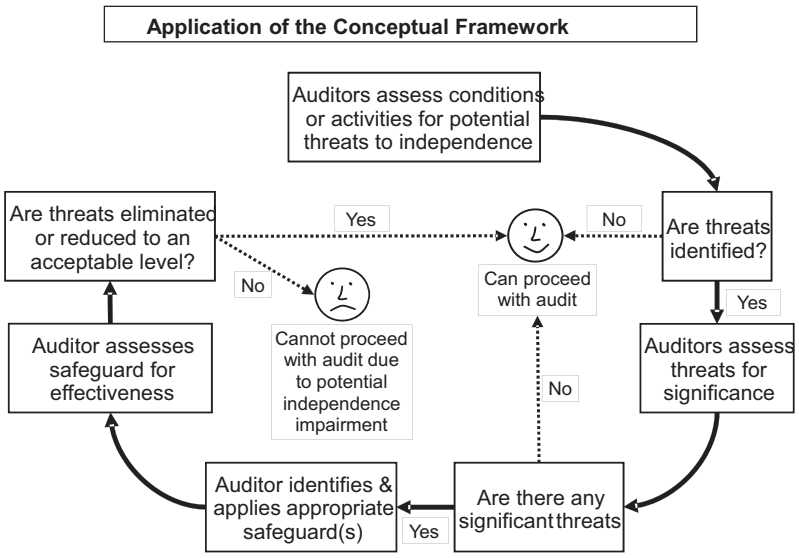
2011 Revision to GAS Major Changes

- Certain requirements in SASs & SSAEs that were repeated in GAS were removed
- Three categories of attestation engagements (examination, review, agreed-upon procedures) are separately discussed. Auditors are not permitted to deviate from the reporting elements prescribed by the AICPA (for attestation engagements).
- Reporting requirement for fraud includes only those occurrences that are significant within the context of the audit objectives for performance audits.

2011 Revision to GAS Major Changes

- Chapters 1 & 2 are realigned & Chapter 1 now includes the foundation & ethical principles of government auditing. The overall discussion on the use and application of GAGAS is now in Chapter 2.
- Chapters 4 & 5 on financial audit performance & reporting, respectively, are combined into one chapter, Chapter 4. In addition, the requirements of AU section 325, ***Communicating Internal Control Related Matters Identified in an Audit*** (AICPA, ***Professional Standards***), are incorporated.

Changes Related to Independence



Applying the Conceptual Framework

- **Should be applied at three levels**
  - **Audit organization**
  - **Audit engagement**
  - **Individual auditor**
- **Process to apply framework**
  - **Identify threats**
  - **Evaluate significance of threats**
  - **Apply safeguards to eliminate/reduce to acceptable level**

Threats to Independence

- **Broad categories of threats**
  - **Self interest threat**
  - **Self review threat**
  - **Bias threat**
  - **Familiarity threat**
  - **Undue influence threat**
  - **Management participation threat**
  - **Structural threat**

Safeguards

- **Consulting an independent third party (professional organization, professional regulatory body, etc.)**
- **Discussing independence issues with those charged with governance**
- **Disclosing nature of audit & nonaudit services provided to those charged with governance**
- **Involving another audit organization to perform or reperform part of the audit**
- **Having a professional staff member, not a member of the audit team, review the work performed**

Safeguards Within the Audited Entity

- Entity requirement that persons other than management ratify or approve the appointment of the auditor to perform an audit
- Internal procedures at the entity ensure objective choices in commissioning nonaudit services
- Governance structure at the entity provides appropriate oversight and communications regarding audit organization's services

Application of the Conceptual Framework

- Created when
  - Start of a new audit
  - Assignment of new staff to an ongoing audit
  - Acceptance of a nonaudit service at an audited entity
  - Other based on facts & circumstances
- Use professional judgment to determine if event warrants use of conceptual framework
  - Should use framework when relevant new information about a threat comes to attention of auditor during the audit
- Should evaluate threats individually & in the aggregate

Additional Issues

- When to decline prospective audit or terminate audit in progress
  - Certain conditions that are so significant, they can't be eliminated or reduced to an acceptable level by applying the safeguards

Period of Independence

- Should be independent during the
  - Audit period
    - Any period of time within the scope of the audit
  - Period of professional engagement
    - Starts earlier of when sign
      - Initial engagement letter (to perform audit)
      - Agreement to start work (on audit)
    - Lasts entire time of professional relationship
    - Ends earlier of
      - Formal or informal notification of termination (by either party)
      - Issuance of report

Specific Nonaudit Services

- Management responsibilities
- Preparing accounting records & financial statements
- Internal audit assistance
- Internal control monitoring
- Information technology systems
- Valuation services
- Other

Selected Activities That Would be Considered a Management Responsibility

- Reporting to those charged with governance on behalf of management
- Accepting responsibility for management of an entity project
- Accepting responsibility for designing, implementing, or maintaining IC
- Providing services intended to be used a management's primary basis for making decisions that are significant to the subject matter of the audit
- Serving as a voting member of an entity's management committee or board of directors

Management Responsibilities for Nonaudit Services

- Auditor provision of nonaudit services impairs independence when
  - Entity does not have individual with suitable skill, knowledge, or experience to oversee the nonaudit services provided
  - Entity is unwilling to perform such functions due to lack of time or desire

Routine Activities

- Providing advice & responding to questions as part of an audit – NOT considered nonaudit services
  - Provide advice/assistance on informal basis as part of an audit
    - Insignificant in terms of time incurred or resources expended
    - Generally do not result in
      - Specific project or engagement
      - Report/other formal work product

Routine Activities

- Considered nonaudit services under GAS
  - FS preparation
  - Cash to accrual conversions
  - Reconciliations
- Evaluate these nonaudit services using the framework

Specific Nonaudit Services Preparing Records & Statements

- Always impair
  - Determining/changing JEs, account codes, classifications for transactions, or other accounting records without obtaining management's approval
  - Authorizing/approving transactions
  - Preparing/changing source documents (providing evidence transactions have occurred) without management approval
    - Includes general ledger & subsidiary records or their equivalent

Specific Nonaudit Services Preparing Records & Statements

- Assistance in drafting FS
  - Auditor acceptance of responsibility for preparation & fair presentation would impair independence

Specific Nonaudit Services Preparing Records & Statements

- May be able to provide certain nonaudit services if
  - Specific nonaudit service is not expressly prohibited
  - Requirements re: performing nonaudit services met
  - Threats eliminated/reduced through application of safeguards

Specific Nonaudit Services Preparing Records & Statements

- Nonaudit services auditor may be able to perform
  - Recording transactions management has determined/approved account, classification, or posting coded transactions to GL
  - Preparing FS based on TB information
  - Posting entries approved by management to the TB
  - Preparing reconciliations identifying items for management to evaluate
  - Proposing standard, adjusting, or correcting JEs or other changes to management provided
    - Management reviews & accepts AND
    - Auditor is satisfied management understands the nature of the proposed entries & their impact on the FS

Specific Nonaudit Services Valuation Services

- Definition
  - Comprises making assumptions with regard to future developments, application of appropriate methodologies & techniques, & combination of both to compute a certain value/range of values for an asset, liability, or entity as a whole
- Independence impaired
  - Valuation havs separate/aggregate material effect on FS or other information AND
  - Valuation involves significant degree of subjectivity

Grant Compliance & Auditing

OMB Proposed Reforms

- **Why done**
  - **Executive Order 13520 November 23, 2009**
    - **Reducing Improper Payments**
  - **February 28, 2011 Presidential Memorandum on *Administrative Flexibility, Lower Costs, and Better Results for State, Local, and Tribal Governments***
    - **Directed OMB to work with Executive Branch agencies; state, local, & tribal governments; & other key stakeholders to evaluate potential reforms to Federal grants policies**

OMB Proposed Reforms

- Advance notice February 24, 2012
  - Comments due March 26
- Why done
  - Executive Order 13520 November 23, 2009
    - Reducing Improper Payments
  - February 28, 2011 Presidential Memorandum on *Administrative Flexibility, Lower Costs, and Better Results for State, Local, and Tribal Governments*
    - Directed OMB to work with Executive Branch agencies; state, local, & tribal governments; & other key stakeholders to evaluate potential reforms to Federal grants policies

OMB Proposed Reforms

- Three areas of proposed reforms
  - Single Audit requirements
  - Cost principles
    - A-21
    - A-87
    - A-122
    - Hospitals under DHHS (45 CFR Part 75, Appendix E)
  - Administrative requirements
    - A-102
    - A-110
    - A-89

OMB Proposed Reforms Single Audit

- Increase threshold from $500,000 to $1,000,000
- More focused Single Audit for over $1,000,000 to $3,000,000
  - Review only 2 compliance requirements for major programs
    - Allowed and unallowed
    - One at discretion of funding agency
      - Should be one that best targets risk of improper payments & fraud, waste, & abuse
- Full Single Audit for over $3,000,000

OMB Proposed Reforms Single Audit

- Compliance requirements in A-133
  - Emphasize improper payments; fraud, waste, & abuse; & program performance
  - Streamline others
  - Subset of certain requirements for increased testing, larger sample size, & lower materiality
    - Allowed/unallowed activities & costs
    - Eligibility
    - Reporting
    - Selecting subrecipients & monitoring
    - Period of availability
    - Suspended & debarred vendors

OMB Proposed Reforms Cost Principles

- One document for all entities
  - Limited differences by entity type
- Indirect costs
  - Use of flat rate vs. negotiated rate
    - Recipient option
    - Flat rate = discount existing negotiated rate
      - Discount factors to be developed by entity type

OMB Proposed Reforms Cost Principles

- 16 other recommended reforms
  - Maximum residual supplies $5,000
  - Eliminate specific “help wanted” ad specifications
  - Allow budgeting of contingency funds for certain awards
  - Provide examples for NFPs
    - Certificate of Indirect Costs
    - Indirect cost proposal documentation requirements

OMB Proposed Reforms Administrative Requirements

- Consolidate uniform set of requirements
  - Replace A-102 (Common Rule - SLGs)
  - Revise A-110 (higher ed, hospitals & NFPs) & A-89 (CFDA)
  - Continue to include limited exceptions by type of recipient
- Agency pre-award considerations to affect award decisions
  - Proposal merit
  - Applicant's financial risk
    - Specific indicators identified
    - Required considerations established

OMB Proposed Reforms Administrative Requirements

- Agencies required to provide 90-day notice of funding opportunities
  - CFDA to be replaced with CFFA (Catalog of Federal Financial Assistance)
    - Domestic & international funding priorities
      - Grants
      - Loans
      - Insurance
      - Other
- Standard format for funding announcements

Other Things of Interest

NFP Accounting & Audit Guide

- Comprehensive overhaul expected 2013
- Release for review & comment late 2012
- Enhancements expected

NFP Accounting & Audit Guide

- **Enhancements expected**
  - Greatly expanded section in chapter 3 about reporting relationships with other entities
  - New sections in chapter 5 about reporting & measuring noncash gifts
  - New chapter on program-related investments & microfinance loans
  - Greatly expanded section in Chapter 10 about municipal bond debt

NFP Accounting & Audit Guide

- **Enhancements expected**
  - New guidance in Chapter 11 for reporting expiration of donor-imposed restrictions
  - Greatly expanded discussion in Chapter 15 about the NFP legal and regulatory environment
  - For assets & liabilities unique to NFPs, suggestions for audit procedures an auditor might consider as a supplement to the risk assessment procedures

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