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KNOWLEDGE-BASED AUDITS OF HEALTH CARE ENTITIES

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PRACTICE AIDS ON CD-ROM

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Preface

The new risk assessment standards, issued by the Auditing Standards Board and taking effect for audit reports issued for years beginning after December 15, 2006, require auditors of health care organizations to depart from the prevalent traditional "checklist-oriented" audit and approach the audit in a more analytical, planned fashion.

This new guidance takes into account a deeper understanding of the client and its internal control environment so auditors can focus on those areas in which the risk of financial statement misstatements is the greatest. Auditors face additional responsibility not only to assure the completeness of disclosures but also to evaluate them in a more qualitative manner. In the new world of auditing, learning about the audit client is not part of planning the audit—it is the audit. The new standards require auditors to address and evaluate materiality more thoroughly; know more about their audit clients; understand their clients' internal controls better than before; conduct a more vigorous risk assessment; as well as document their audit approach and findings.

CCH's Knowledge-Based Audit (KBA) methodology will assist auditors in complying with and implementing the new standards. The KBA is a methodology that (1) facilitates compliance with GAAS (generally accepted auditing standards), (2) encourages more efficient and effective audits, and (3) helps auditors to identify and focus on risks.

The Knowledge-Based Audit consists of a set of integrated procedures, from pre-engagement all the way through evaluating, concluding, and reporting. The results from each audit stage feed into a *Communications Hub*, which enables team members to easily view summaries of significant matters, risks, and findings discovered in the audit. This design ensures that important information is not overlooked or hidden in the details of numerous checklists and forms.

This practical guide explains the KBA approach and provides recommended Knowledge Tools on the accompanying back-of-the-book CD-ROM:

- KBA documents, which contain steps and procedures required by Generally Accepted Auditing Standards (GAAS);
- Audit Programs that guide the auditor through related steps and procedures;

- Practice Aids that help the auditor complete steps or processes outlined in other documents;
- Correspondence document templates for engagement letters and confirmation requests; and
- Auditor's Reports document templates for a variety of sample auditor's opinions on audited financial statements.

This first edition of *Knowledge-Based Audits of Health Care Entities* is current through SAS-112.

The author of *Knowledge-Based Audits of Health Care Entities* welcomes comments, suggestions, and recommendations, which will be considered for incorporation in future revisions of the KBA. Please send your comments to:

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Complying with the AICPA's new Risk Assessment Standards isn't something you have to do on your own. ProSystem*fx* Knowledge Tools from CCH provides a streamlined, easy-to-follow audit methodology for implementing these new standards effectively. In addition, new practice aids and tools make the most of technology to support the new audit process and help your firm achieve optimal results. With ProSystem*fx* Knowledge Tools you can:

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The Audit library covers auditing standards, attestation engagement standards, accounting and review services standards, audit risk alerts, and other vital auditing-related guidance. You'll also have online access to our best-selling *GAAS Practice Manual, Audit Procedures, Compilations & Reviews, CPA's Guide to Effective Engagement Letters,* and *CPA's Guide to Management Letter Comments* and be kept up-to-date on the latest authoritative literature via the *GAAS Update Service.*

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Michael F. Garczynski, CPA, is a Partner in Carbis Walker LLP's Health Care Services Group. With 20 years of experience in public accounting, his background includes providing assurance and advisory services to clients within the health care industry. Mr. Garczynski has also served as the accounting and auditing coordinator for Carbis Walker LLP, which included monitoring the firm's system of quality control.

Mr. Garczynski has extensive experience auditing health care organizations and adding value throughout the audit process specifically relating to complex accounting transactions, financial reporting, and internal controls. He regularly makes presentations to boards of directors and professional groups and has written articles on a variety of topics affecting the health care industry.

Mr. Garczynski is a graduate of Pennsylvania State University with a Bachelor of Science degree in Accounting. He also represents the Firm as a member of the American Institute of Certified Public Accountants (AICPA), the Pennsylvania Institute of Certified Public Accountants (PICPA), and the Healthcare Financial Management Association (HFMA). He is currently serving as the president-elect on the board of directors of the Western Pennsylvania Chapter of HFMA. He is a member of the Firm's Executive Committee, which governs policy and procedure for Carbis Walker LLP.

George Georgiades, CPA
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George Georgiades, CPA, has more than 27 years of experience in public accounting, including seven years as an audit senior manager with a major international firm. He currently has his own firm and consults exclusively with CPA firms on technical accounting, auditing, and financial statement disclosure issues. He has been involved personally in more than 600 audit engagements and related financial statements of both small, closely held companies and large, publicly held enterprises. He has personally conducted more than 75 peer reviews, consulting reviews, and inspections. Mr. Georgiades is also the author of *GAAP Financial Statement*

Disclosures Manual, GAAS Practice Manual, and the *GAAS Update Service.* He is a member of the American Institute of Certified Public Accountants and the California Society of Certified Public Accountants, and previously served on the California Society of CPA's Peer Review Committee.

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INTRODUCTION

The Knowledge-Based Audit (KBA) methodology is designed to help the auditor efficiently and effectively perform financial statement audits of *health care organizations* in accordance with auditing standards generally accepted in the United States of America (GAAS).

This KBA methodology overview only provides brief descriptions of certain auditing matters that are unique to the health care industry. Auditors should refer to the AICPA Audit and Accounting Guide, *Health Care Organizations*, in addition to this overview and applicable audit programs for directives and guidance when determining the nature, timing, and extent of audit procedures relating to these auditing matters.

Also, for nonprofit health care organizations, the AICPA Audit and Accounting Guide, *Not-For-Profit Organizations*, should be consulted for financial accounting and reporting matters unique to nonprofit organizations.

For governmental health care organizations, the AICPA Audit and Accounting Guide, *State and Local Governments*, should be consulted for reporting matters unique to governmental organizations.

There are many types of health care organizations that provide services to patients. Each has its own set of characteristics. Health care organizations can be for-profit or nonprofit, and governmental or nongovernmental entities. The characteristics and structural makeup have a significant impact on the accounting and auditing practices of the organization. Consideration of the structural makeup of the health care organization is important when customizing the audit plan, forming risk assessments, and developing audit procedures to ensure an effective audit in accordance with GAAS. The following are some examples of the different types of health care organizations:

- Health systems;
- Hospitals;
- Nursing homes;
- Continuing care retirement communities;
- Managed care organizations (i.e., HMO and PPO);
- Physician practices or groups;
- Home health agencies; and
- Ambulatory surgery centers.

There are many unique audit differences among health care organizations and commercial companies that must be considered. Auditors must have in-depth knowledge of these differences when auditing health care organizations because they pose the most audit risk. The most common audit differences and areas that represent significant audit risk include patient accounts receivable and net patient service revenues, third-party settlements and contractual adjustments, and malpractice reserves. Following are brief descriptions of these areas.

Accounts Receivable and Net Patient Service Revenues

Health care organizations receive revenues primarily from third-party payors such as governmental programs (i.e., Medicare and Medicaid) and insurance companies, and from patients without insurance commonly referred to as self-pay. They also receive funds through grants and contributions. Third-party payors all have different payment methodologies and pay at rates that are less than or different than what the organization charges for its

services. Therefore, health care organizations must develop methods and systems to calculate the amounts expected to be collected in order for patient service revenues to be stated in accordance with GAAP. Contractual allowances are utilized to record net patient revenue and represent the difference between established billing rates or charges and amounts estimated to be paid under various health benefit agreements. Allowance for doubtful accounts is usually estimated on the basis of the health care organization's historical collection experience of the self-pay balances. Provisions for contractual allowances and bad debts are recorded in the period in which the service is provided. In addition, the health care organization may provide charity care to its patients in accordance with the organization's policy. Charity care represents health care services that were provided to patients who were never expected to pay. Charity care amounts are not recognized and therefore are not recorded as patient receivables or as patient revenue.

Third-Party Settlements and Contractual Adjustments

Health care organizations that receive revenues from government programs such as Medicare and Medicaid are subject to compliance with laws and regulations of various governmental agencies. These laws and regulations are extremely complex and require the health care organization to understand the many risks involved to prevent significant adjustments to net patient service revenue. The impact of these adjustments can be very difficult to quantify and estimate and can differ from one organization to the next. Adjustments may be required when examinations are performed by government agencies or fiscal intermediaries who have differing interpretations of regulations to be followed by the health care organization. There may be differing opinions on the medical diagnosis of a patient, medical necessity, or the proper coding used to determine the billing for a particular service. Changes to government program regulations and requirements to participate in the Medicare and Medicaid programs may impact previous estimates.

Due to differing interpretations, frequent changes in regulations, and the high risk of errors, health care organizations must be cognizant and prepare for possible clinical coding violations. A medical record file is used to document the treatment and care received by a patient while visiting a health care organization. A code (ICD-9-CM or CPT-4 code) is assigned to the record based on review by the health care organization's coding personnel. This assigned code is included on the bill to the third-party payor who uses it to determine the proper payment amount for the service provided. Examples of some of the many kinds of errors that can occur during this process include failure to properly document the appropriate procedure, a misinterpretation of the medical record documentation that leads to

the assignment of an incorrect code, an incorrect payment, and, ultimately, misstated revenue.

Health care organizations must make reasonable estimates based on these and other factors such as the time between when services are provided and settlement of the claims to avoid significant adjustments to patient revenues.

Malpractice Reserves

Health care organizations must protect themselves from significant risk of loss from malpractice claims at a reasonable cost. Different methods can be employed to provide the protection such as purchasing insurance, being self-insured, or forming a risk retentive group. Under each of these methods, the health care organization retains a certain level of risk. Based on the risk retained, the health care organizations must estimate the liability for malpractice claims and the amount of funding, if necessary. They can either use outside actuaries to assist in developing the estimate or calculate the liability and funding in-house.

While the above areas of risk are the most common throughout all health care organizations, certain types of health care organizations also have some unique accounting areas that must be considered during the planning stages of the audit. Following are brief descriptions of these areas.

Individual Practice Associations (IPA)

An IPA is defined in the AICPA Accounting and Auditing Guide, *Health Care Organizations*, as a partnership, association, corporation, or other legal entity organized to provide or arrange for the delivery of health care services to members of a prepaid health care plan and nonmember patients. In return, the IPA receives either a capitation fee or a specified fee for services rendered. Segregation of duties may be an internal control issue as the finance department or business office may have a small number of employees. A mitigating control may exist if the IPA has an office manager who can exercise a high degree of influence or control over the operations. Revenue of IPAs primarily consists of contracts with managed care organizations that have capitated payments and risk pool settlement terms. Estimates of incurred but not reported claims (IBNR) must be calculated due to these capitated contracts. Risk pool settlements must also be accrued during the contract period. Physician compensation arrangements may use complex formulas or methodologies to determine salary and or incentives.

Single Audit Act

Health care organizations may receive federal monies through grants or loans. If the organization expends federal awards equal to or greater than $500,000 in a fiscal year, the organization is required to have an audit in accordance with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Medicare payments to a non-federal entity for providing patient care services to Medicare eligible individuals are not considered federal awards under OMB A-133. Also, Medicaid payments to a subrecipient for providing patient care services to Medicaid-eligible individuals are not considered federal awards expended under OMB Circular A-133 unless the state requires the funds to be treated as federal awards expended because reimbursement is on a cost-reimbursement basis. The AICPA Audit and Accounting Guide, *Government Auditing Standards and Circular A-133* Audits, provides guidance on the auditor's responsibilities when conducting a single audit or program specific audit in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133. It discusses the auditor's responsibility for considering internal control and for performing tests of compliance with applicable laws, regulations, and program compliance requirements. Further, it provides reporting guidance including examples of the reports required by Government Auditing Standards and OMB Circular A-133.

Managed-Care Organizations

Managed-care organizations (MCO) such as HMOs and PPOs may be subject to risk-based capital requirements if the MCO is regulated by a state insurance department. The risk-based capital (RBC) formula, which was approved by the National Association of Insurance Commissioners (NAIC) in 1998, enables state insurance departments to evaluate the financial health of regulated organizations such as MCOs. The RBC formula takes into consideration the MCO's investment risk, asset risk, underwriting risk, credit risk, and general business risk. Depending on the outcome of the calculation, the MCO may be subject to certain reporting requirements to comply with state insurance department regulations on one of four action levels: company action level, regulatory action level, authorized control level, and mandatory control level. The auditor should check with state law to verify if the MCO is required to comply with the RBC formula.

State insurance departments require MCOs to file audited financial statements on an annual basis in accordance with the applicable

state's prescribed and or permitted statutory accounting practices (SAP). In 1999, in order to provide consistency in the reporting of account balances with in the audited financial statements of insurance organizations, the NAIC approved an accounting practices and procedures manual which codified statutory accounting practices for certain insurance organizations including MCOs. As it is expected that all states will adopt the accounting practices and procedures manual, MCOs and auditors should verify if the state the MCO is located in has made the adoption. Auditors will have to address the impact of the adoption of the manual on the financial statements considering going concern issues and the effect on the organization's RBC.

Continuing Care Retirement Communities

A continuing care retirement community (CCRC) is defined in the AICPA Accounting and Auditing Guide, *Health Care Organizations*, as a legal entity sponsoring or guaranteeing residential facilities, meals, and health care services for a community of retired persons who may reside in apartments, other living units, or, in some cases, a nursing center. A CCRC is sometimes referred to as a residential care facility or a life-care retirement community. A CCRC collects advance fees from its residents in accordance with a signed contract. Nonrefundable advance fees, which represent payment for future services, are accounted for as deferred revenue. The deferred revenue is amortized to income based on the estimated life of the resident or contract term, if shorter. Refundable advance fees are accounted for and reported as a liability. The amount of the liability is based on the contract terms and the CCRCs own refund experience. If the costs to provide future services and use of facilities to current residents are in excess of related unamortized deferred revenue, then a liability must be recorded. Because of the significance and complexity of the estimates involved in the calculation of this liability, an actuary may be needed to assist in developing information about the CCRCs morbidity and mortality experience. CCRCs are also allowed to capitalize costs of acquiring initial continuing-care contracts. These costs are amortized to expense on a straight line basis over the average expected remaining lives of the residents under contract or the contract term, if shorter. After the CCRC is substantially occupied or one year following completion, costs of acquiring continuing-care contracts are expensed when incurred.

Although the KBA approach provides a framework for applying GAAS, it is not a substitute for knowledge of professional standards and the exercise of auditor skepticism and judgment. The auditor may need to refer to additional resources to determine how to apply GAAS to unfamiliar or unique circumstances. In addition to