100 Current State of the Health Care Industry

100.1 The health care industry is constantly changing as providers attempt to reduce costs and provide services more efficiently. Medicare reform, government regulations, reductions in federal funding for states, and the growth of managed care have created a highly competitive market. The implementation of electronic health records—digitizing the nation's mass of paper medical files—is underway and is expected to revolutionize health care delivery, reduce errors, and save money. This effort is being championed by both the U.S. Department of Health and Human Services (HHS) and Congress and has resulted in a financial incentive program for health care providers to adopt and use electronic records. The American Recovery and Reinvestment Act of 2009 included $19 billion for health care information technology investment through the portion of the legislation called the Health Information Technology for Economic and Clinical Health Act, or HITECH Act. Now more than ever, a health care provider's success depends on the ability to anticipate change and respond appropriately. The following paragraphs discuss some of the issues shaping the health care industry today.

Managed Care

100.2 The majority of Americans with health care coverage now receive benefits through some sort of managed care arrangement; however, the much-maligned Health Maintenance Organizations (HMO) have taken a back seat to more popular Preferred Provider Organizations (PPO) and Point of Service (POS) plans. The growth of managed care has changed the health care environment, perhaps more than any other factor. It has led to dramatic changes in health care delivery ranging from how services are reimbursed to when and what medical services are provided. Managed care organizations, which are predicted to become the dominant form of health care delivery throughout the United States, have created nontraditional physician arrangements by shifting the focus of reimbursement from fee-for-service to capitation or some other risk sharing mechanism. In short, purchasers of health care services have come to expect providers to assume some financial risk for treating the growing population of patients.

100.3 In response to increased competition and declining profitability under managed care, health care providers are affiliating in health care systems that include any combination of outpatient, inpatient, and physician services. In some cases, however, health care systems have brought about their own set of problems. They can sometimes be complex and difficult to manage due to the different objectives and concerns of various affiliated health care providers.

Medicare Reimbursement

100.4 Medicare pays for a large portion of the fees charged by many health care providers. It is the largest single payor of all personal health care expenditures. Although the much discussed health care reform effort of the early 1990s did not result in comprehensive health care reform legislation, Congress continued to consider comprehensive Medicare reform. One example of health care reform legislation is the Medicare Legislation contained in the Balanced Budget Act of 1997. That legislation resulted in the overhaul of Medicare managed care through implementation of the Medicare+Choice (now Medicare Advantage) program. Another example is the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (discussed in paragraph 100.9). The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the "Health Care Reform Acts") included major changes for Medicare that are being implemented over a 10-year period (discussed in section 101). Additionally, the Budget Control Act of 2011 required across-the-board cuts in federal government spending, known as sequestration, if expenditure reductions of $917 billion over 10 years were not designated. During 2013, the sequestration process was implemented. Some government programs were exempt from the sequestration process; however, the Medicare program was not exempted and cuts applied to individual payments under Medicare Parts A and B and monthly payments to contracts under Medicare Parts C and D. In any event, Medicare regulations are constantly changing in an effort to reduce long-term spending without reducing benefits or increasing fees to beneficiaries. The end result—providers who provide medical services to Medicare patients will continue to face reduced reimbursement.

Government Regulations

100.5 There are several federal and state laws and regulations that impact the practice of medicine by health care providers. Many of the laws and regulations were established to prevent overuse of services by independent providers in a fee-for-service payment environment. Since the payment structure of services has shifted to risk-sharing methods such as capitation, the financial gain from overusing services has been minimized. However, the laws and regulations have not fully adjusted to the market demand for integration of health care providers. Many of the laws and regulations complicate the ability of providers to integrate with other physicians, hospitals, and managed care organizations.

100.6 The Department of Justice is actively investigating and prosecuting fraud and abuse in the health care industry and has made it a high priority. As an indication of the high priority given to the health care industry, HHS and the Department of Justice created an interagency effort, the Health Care Fraud Prevention and Enforcement Action Team, to combat Medicare fraud through the use of data analysis techniques and an increased focus on community policing. The government's emphasis on health care fraud and abuse is based on estimates that fraudulent and abusive activities cost the national economy $80 billion annually according to the Federal Bureau of Investigation.[1] The enforcement activity related to federal and state government regulations has made the liability for noncompliance substantial.

100.7 **Stark III Regulations** Centers for Medicare and Medicaid Services (CMS) published the final regulations for the Stark III rules in the September 5, 2007 Federal Register. Stark III is the third phase of the rules implementing the physician self-referral law. CMS did not propose any new Stark exceptions in the Stark III rules but CMS did refine the existing exceptions. A significant change in this set of rules was the requirement that a physician "stand in the shoes" of his or her group practice. Consequently,

arrangements previously considered as indirect compensation arrangements are now considered direct compensation arrangements. The following Stark regulations were also clarified by the Stark III regulations:

- Physician recruitment.
- Retention payments in underserved areas.
- Rental of office space and equipment.
- Personal services arrangements.
- Nonmonetary compensation.
- Professional courtesy.
- Charitable donations by a physician.
- Compliance training.
- Fair market value compensation.

100.8 **Medical Information Sharing** The Patient Safety and Quality Improvement Act of 2005 enables the accumulation of more accurate information about medical treatments with the goal of reducing medical errors. To accomplish this, the bill creates a confidential system for voluntary reporting medical errors by health care providers. Because the reports are confidential, the information reported cannot be used against health care providers in civil and criminal proceedings. In November 2008, the Agency for Healthcare Research and Quality (AHRQ) published the Patient Safety and Quality Improvement final rule (Patient Safety Rule) that became effective on January 19, 2009. The Patient Safety Rule establishes a framework for reporting information for analysis of patient safety events, outlines the requirements that entities must meet to become Patient Safety Organizations (PSOs), and establishes the processes for the AHRQ to review and accept certifications and list PSOs.

100.9 **Medicare Reform** On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was signed into law. Some of the provisions of this highly complex legislation include the following: increased reimbursement rates for physicians, incentives to providers for practicing in designated underserved rural and urban areas, expansion of coverage for preventative services, introduction of a voluntary prescription drug plan, and the establishment of Health Savings Accounts for eligible individuals with qualified high-deductible health plans, regardless of age. The MMA also implements a quality initiative with financial penalties for providers that fail to provide data to CMS. Relevant aspects of the law are discussed in Chapters 3-6.

100.10 MMA directed the HHS to establish a demonstration program to determine if the use of recovery audit contractors (RAC) to identify Medicare underpayments and overpayments and recover Medicare overpayments is cost effective. The RAC demonstration program proved to be successful in returning funds to the Medicare trust funds and identified amounts to return to providers. In July 2008, the CMS released an evaluation report showing that nearly $700 million in improper Medicare payments was returned during the demonstration program through March 2008. A CMS report to Congress on "Medicare Payment Policy on Short Hospital Stays" in May 2015 stated that from fiscal year 2010 through fiscal year 2013, the RAC program had recovered over $5.4 billion in overpayments. The RAC program has resulted in many hospitals appealing the RAC assessment of overpayments. In June 2015, CMS settled with more than 1,900 hospitals for $1.3 billion. The Tax Relief and Health Care Act of 2006 made the RAC program permanent and expanded the RAC program that is now implemented in all 50 states.

100.11 **Health Savings Accounts** These accounts operate like IRAs and allow eligible individuals to make a tax-deductible contribution to cover the cost of the deductible of a qualified high-deductible policy. To be eligible to make a contribution, the individual must have a deductible of at least $1,300 in 2016 and 2015 for single coverage and $2,600 in 2016 and 2015 for family coverage. The contribution limit is $3,350 for 2016 and 2015 for single coverage or $6,750 for 2016 and $6,650 for 2015 for family coverage. These amounts are considered for inflation adjustments each year. The individual can take tax-free withdrawals from the account to pay for the deductible when obtaining health care under the insurance policy. Employer contributions are voluntary. They are not subject to employment taxes, nor are they taxable to the employee.

Economic Crisis Impact

100.12 Like most industries, the health care industry was impacted by the recent global economic crisis with investment securities declines, liquidity and funding concerns, and payment reductions, as well as increased charity care requests and government scrutiny. The AICPA has issued an Audit Risk Alert, *General Accounting and Auditing Developments*, that while audit-focused, may still enhance the consultant's understanding of issues affecting the health care industry. The AICPA Audit Risk Alert, *Health Care Industry Developments*, also discusses economic and industry developments specific to the health care industry, including the increased implementation of cost containment activities to offset the downward pressure on revenues from payment cuts to Medicare and Medicaid that are required by the Health Care Reform Acts and the Budget Control Act of 2011. These publications are available on Checkpoint to subscribers of the AICPA material, online (electronic or print version) at **www.cpa2biz.com**, or by calling the AICPA at (888) 777-7077.

[1] In an October 2010 white paper, “Combating Health Care Fraud in a Post Reform World: Seven Guiding Principles for Policymakers,” the National Health Care Anti-Fraud Association (NHCAA) estimates the 2008 losses due to health care fraud at $70 billion, or 3% of the U.S. annual health care outlay in that year. The NHCAA also notes that other estimates by government and law enforcement agencies place the annual loss as high as 10%, or over $234 billion. See the NHCAA website at **www.nhcaa.org** for more information about health care fraud.

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101 Health Care Reform Acts

101.1 The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively the "Health Care Reform Acts," "Affordable Care Act," or "ACA") combine to dramatically change how health care is delivered in the United States. Both were enacted in March 2010 and are in the process of being implemented. Many provisions of the Health Care Reform Acts have affected employers and employer-provided health plans and will continue to do so over the next decade. The Health Care Reform Acts have also affected (and will continue to affect) organizations throughout the health care industry in many ways through insurance reforms, changes in Medicare and Medicaid provider payments, quality and transparency initiatives, and delivery system reforms.

101.2 A primary purpose of the Health Care Reform Acts is to provide at least minimum health care benefits to all individuals. These minimum benefits are defined as being equal to 60% of the actuarial value of minimum essential health benefits, which is termed a *bronze plan* under the ACA. In addition to paying the premium, after whatever subsidies are available, the insured individual is also responsible for the 40% of the actuarial value of minimum essential health benefits not covered by the *bronze plan*. The legislation provides for the establishment of qualified health plans that must provide these essential health benefits. The Congressional Budget Office (CBO) originally estimated that about 32 million people would become insured by 2019 with more than 20 million in Medicaid. The CBO also estimated that the Health Care Reform Acts would cost approximately $940 billion over a 10-year period. Numerous changes have taken place since enactment of the legislation that significantly altered these estimates. For example, the CBO estimated that the delay in the employer mandate described below would cost an additional $12 billion. Additionally, as of March 2015, the CBO reduced the number of people expected to be insured by 2019 to 24 to 25 million.

101.3 The Health Care Reform Acts are being funded from new taxes and fees, reduced provider payments that in turn are expected to be offset by revenue from the newly insured, and assumed reduction in fraud in the Medicare and Medicaid reimbursement systems. The reduction in provider payments is discussed beginning at paragraph 101.15 and the impact from eliminating fraud and waste is discussed at paragraph 101.27. New taxes and fees come from a wide variety of sources. A 40% excise tax will be placed on so-called "high dollar" health insurance plans in 2018 (although there is a bipartisan movement in Congress to repeal this tax); practitioners should be aware that because of cost

of living and intensity of service utilization differences, among other factors, this excise tax would fall disproportionately among the states. Medicare payroll taxes paid by the upper middle class and wealthy will be increased and will include both earned and unearned income in the base. The threshold for itemized medical expense deductions increases from 7.5% to 10%. Indoor tanning services have an additional 10% tax that is already implemented. Beginning in 2011, an annual, nondeductible fee on pharmaceutical companies is assessed based on each company's share of the gross receipts of the pharmaceutical manufacturing industry for the prior year multiplied by a fixed amount. In 2013, a 2.9% excise tax took effect on the first sale for use of a *medical device*, as defined in the Federal Food, Drug, and Cosmetic Act or FFDCA. In 2014, an annual, nondeductible fee on health insurance providers [2] took affect that is allocated according to market share within the health insurance sector. The tax deduction for the subsidized portion of retiree Medicare Part D prescription drug payments was eliminated for years beginning after December 31, 2012.

101.4 The tax implications of the Health Care Reform Acts are beyond the scope of this *Guide*. *PPC's Guide to Health Care Reform* is designed to provide tax-related guidance to the tax professional, employer, plan sponsor, and others who must deal with the business and tax aspects of the health care reform legislation.

101.5 The federal health care reform legislation was closely modeled on the Massachusetts reform legislation that was passed in 2006. As such, practitioners who need to advise their clients about the likely impact of federal health care reform on small businesses in particular should consider studying the results in Massachusetts. In September 2010, the nonpartisan Center for Studying Health System Change released a report reviewing the Massachusetts experience that can be obtained at **www.hschange.com/CONTENT/1145/**.

Insurance Reform

101.6 While labeled as health care reform, much of the impact of the Health Care Reform Acts is through changes in the insurance market. Beginning in 2014, most residents of the United States are required to obtain health insurance or pay a penalty, which was upheld by the Supreme Court in June 2012. The tax on individuals without qualifying coverage started in 2014 with a minimal $95 penalty that grows to $695 per year or 2.5% of household income by 2016. The penalty amount remains less than the comparable penalty in the state of Massachusetts upon which the federal reform was modeled. This penalty also will be substantially lower than the cost of obtaining health insurance.

101.7 Businesses with 50 or more Full-time-Equivalent (FTE) employees who *do not* offer coverage pay a nondeductible fee of $2,000 per FTE in excess of 30 employees if they have at least one employee who receives a premium credit through a health insurance exchange starting in 2016. Employers with 100 or more FTEs must offer health insurance to only 70% of their FTEs in 2015 rather than the 95% that is effective in 2016. Businesses with 50 or more FTE employees who offer coverage but have at least one employee who receives a premium credit through a health insurance exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $2,000 for each full-time employee (in excess of 30 employees) starting in 2016; the penalty applies to employers with 100 or more FTEs in 2015 not covering 70% of their FTEs. Employers with more than 200 employees are required to automatically enroll employees into the health insurance plans offered by the employer although the employee may opt out of the coverage. Medicaid was expanded in 2014 to be available to

citizens of electing states who earn less than 138% of the poverty level. (Note: The Health Care Reform Acts actually state that the level is 133% but it is, in fact, 138% because a separate provision in the legislation provides for a 5% *disregard* in the income calculation.) Much of this expansion will be to adults without dependent children who are presently excluded from Medicaid coverage in most states.

101.8 During the first year of implementation, the primary impact on insurers included the following:

• Plans must cover adult dependent children up to age 26.

• A temporary national high risk pool was established for people who are uninsured for at least six months due to pre-existing conditions that has since expired.

• Insurers are precluded from denying coverage to children with pre-existing conditions.

• Insurers are precluded from placing lifetime limits on the dollar value of minimum essential coverage.

• Insurers are precluded from denying or rescinding coverage of insured persons who become sick, except for instances of fraud by the insured.

• All “new” plans will provide first dollar coverage for preventative services and immunizations. As described in paragraph 101.14, existing plans which undergo what may be seen as common changes will be considered “new” under interim regulations issued in June 2010.

101.9 The insurance reforms include the following:

• Group plans must spend a certain percentage [3] of premium dollars on medical services (85% for large plans and 80% for small plans) with rebates to customers of plans that spend less on medical services.

• Health insurance exchanges in each state are supposed to be open to individuals and small employers with up to 100 employees. States that elect not to implement their own exchange will have an exchange run by the federal government on their behalf. Exchanges were modeled on the Massachusetts Health Connector, a web portal where insurers offer health insurance to consumers. The Office of Personnel Management will also contract with insurers to offer multi-state plans. For 2015, 14 states operated state-based health insurance marketplaces (exchanges).

• Health insurance regulations are revised to prohibit insurance companies from engaging in discriminatory practices due to an individual's health status (e.g., pre-existing conditions), to limit the ability of insurance companies to charge higher rates due to health status, gender, or other factors, and to only vary premiums on age, geography, family size, and tobacco use based on specific numeric factors. For example, age-based premium differences cannot exceed 3.0, and tobacco use differences cannot exceed 1.5. States can, in fact, choose not to use these rating factors. Some states do not penalize smokers, for example.

• Health plans are prohibited from imposing annual limits on the amount of minimal essential benefits an individual may receive. Practitioners need to be aware and advise clients that *only* minimum essential benefits are affected by the prohibition on annual limits. Limits on policy benefits not covered by the definition of *minimum essential* are allowed.

101.10 The state based health insurance marketplaces and the federally-facilitated health insurance marketplace that is run by the HHS began operation in late 2013 for 2014 enrollment. The federally-facilitated health insurance marketplace had operational issues, particularly with the marketplace website, during its initial enrollment season and the enrollment period was extended to accommodate people who had difficulty enrolling. The HHS periodically issued enrollment reports for the initial annual open enrollment period. The May 1, 2015, report stated that over 11.5 million people selected or re-enrolled in a health plan through the health insurance marketplace in either the state or the federally-facilitated health insurance marketplaces for 2015 coverage.

101.11 For plan years beginning after 2013, insured health plans sold in the small group and individual market that are not grandfathered (generally these are group health plans in existence on March 23, 2010; however, see the discussion at paragraph 101.14) must be qualified health plans. A qualified health plan meets certain certification criteria that will be established by the HHS, provides an essential health benefits package, and is offered by a licensed health insurance insurer that meets certain criteria. Grandfathered plans are deemed to be qualified health plans.

101.12 An essential health benefits package is coverage that:

a. provides minimum essential coverage,

b. limits cost-sharing for the minimum essential coverage, and

c. provides a level of coverage that is actuarially equivalent to 60% (bronze), 70% (silver), 80% (gold), or 90% (platinum).

101.13 The minimum essential coverage that a qualified health plan must offer are the items and services covered in the following categories, the specific terms of which are generally defined by each individual state by reference to a *benchmark* plan that qualifies under federal regulatory guidelines:

- Ambulatory patient services.
- Emergency services.
- Hospitalization.
- Maternity and newborn care.
- Mental health and substance use disorder services, including behavioral health treatment.
- Prescription drugs.
- Rehabilitative and habilitative services and devices.
- Laboratory services.
- Preventive and wellness services and chronic disease management.
- Pediatric services, including oral and vision care.

101.14 The following are examples of the types of changes that can cause loss of grandfathered status:

a. Entering into a new policy, certificate, or contract of insurance after March 23, 2010.

b. Eliminating all or substantially all benefits to diagnose or treat a particular condition (for example, eliminating all benefits for In Vitro fertilization or diagnosis of cystic fibrosis).

c. Increasing the fixed-amount and percentage cost-sharing by more than specified amounts to reflect medical inflation.

d. Decreasing the employer contribution rate for coverage by more than 5%, such as decreasing the employer-paid share of premium from 75% to 65%.

e. Imposing a new or modified annual limit on benefits.

Provider Payments

101.15 According to the Centers for Medicare and Medicaid (CMS), over the 2014-2019 period, changes in the rates-of-increase to Medicare providers will reduce payments to providers by around $384 billion; this compares to the original Congressional Budget Office (CBO) forecast of a $500 billion reduction for the period 2010-2019 or approximately half of the cost of the reform. Practitioners should note that many of these cuts can be legislatively overturned and providers affected by the cuts are actively seeking changes. The yearly updates to Medicare's market basket growth amounts are reduced by varying rates each year for inpatient and outpatient hospital charges, inpatient rehabilitation facilities, long-term care hospitals, and home health outlier and rural add-on payments. Medicare Advantage payments were to be reduced to the level of payments made in fee-for-service plans, but the cuts schedule for 2014 were delayed through an administrative action by the CMS. A productivity adjustment will be introduced with the potential for rates becoming negative.

101.16 Practitioners should be aware that the CBO is required to follow instructions from Congress when *scoring* legislation and those instructions may be counter to the likely outcome. Practitioners will also need to monitor legislative developments as the cost saving provisions used by the CBO can be modified in future legislation, and are likely to be so modified.

101.17 **Medicare Payments to Hospitals** Medicare payment updates incorporate productivity adjustments for prospective payment system hospitals starting in 2010, resulting in a budgeted payment reduction over ten years of approximately $112.6 billion. Medicare payments are also increased for hospitals in counties in the lowest quartile of per capita Medicare spending (generally starting in 2011) and will be decreased for hospitals with high readmission rates (generally starting in 2013) and hospitals with a high rate of hospital acquired conditions (generally starting in 2015). The lowest quartile of hospitals received a 1% reduction in Medicare rates for hospital acquired conditions in 2015.

101.18 Medicare Disproportionate Share (DSH) payments are made to hospitals who serve large numbers of Medicaid and indigent individuals in order to compensate them for the otherwise poorly

reimbursed care. DSH payments will be reduced as the number of uninsured patients is reduced (generally starting in 2014) as Medicaid expansion to presently uncovered populations takes hold. Medicaid DSH payments will also be reduced over eight years beginning in 2014. Individual states' decisions about implementing the ACA Medicaid expansion could impact the allocation of the DSH reductions across states starting in the federal government's 2016 fiscal year.

101.19 **Medicare Payments to Physicians** CMS is directed to increase incentive payments under the Physician Quality Reporting Initiative (PQRI) program and the PQRI program is extended through at least 2014. Beginning in 2015, a penalty will be imposed on physicians who do not participate in the program. The Health Care Reform Acts provide for a 10% bonus payment to primary care physicians (PCP), as well as primary care providing physician assistants and nurse practitioners. A separate provision provides a 10% bonus to general surgeons for select services provided in health professional shortage areas (generally starting in 2011).

101.20 The primary care bonus provision is one of the most significant for practitioners working with physician clients. PCPs are defined as physicians specializing in family medicine, internal medicine, geriatric medicine, and pediatric medicine if at least 60% of total Medicare Allowed Charges are for office, skilled nursing facility (SNF), home, rest home, and other visits specified by CPT Codes. For 2011 through 2015, eligible PCPs will receive a bonus equal to 10% of Medicare payments [4] for these services. CMS originally stated that half of the cost of the bonuses would be offset through an across-the-board reduction in all other services, but lobbying by specialist organizations resulted in this being overturned.

101.21 The relevant CPT™ codes are:

a. Office—new and established patients visits—99201 through 99215 (the most common codes).

b. Nursing facility visits—99304 through 99340.

c. Home visits—99341 through 99350.

101.22 Practitioners should be aware that when physicians and other providers register with CMS they designate their specialty, e.g., internal medicine. Physicians who are not registered with CMS as specializing in family medicine, internal medicine, geriatric medicine, or pediatric medicine will not be eligible for this bonus, even if they meet the other criteria. CMS indicated in the 2011 Proposed Rule released in June 2010 that it will prevent physicians currently designated as other than PCPs from attempting to change their specialty designation in order to be eligible for the bonus payment. CMS also indicated that PCPs located in a Health Professional Shortage Area (HPSA) would be eligible for a 10% payment bonus based upon the regular Medicare fee schedule in addition to the HPSA payment; however, the HPSA payment itself would not be increased by the 10%.

101.23 Medicare will also expand its present coverage for a one-time initial preventive physical when a

beneficiary becomes eligible for Medicare. Effective January 11, 2011, annual preventive medicine visits will be covered which are to include personalized prevention plan services. CMS has developed two new HCPCS G Codes to report the first preventive medicine visit and subsequent visits. Oddly enough, the addition of preventive medicine services, a key primary care service, to Medicare may cause many PCPs to fall short of the 60% threshold required for the 10% primary care bonus. The authors have already seen this occur in many otherwise *pure* primary care practices due to their emphasis on preventive medicine. The 2014 Medicare Physician Fee Schedule Proposed Rule indicates that further expansion of payment for primary care services is being studied by CMS.

101.24 **Independent Payment Advisory Board** Starting in 2015, HHS was to establish an Independent Payment Advisory Board to develop and submit proposals to Congress and the private sector with the goals of extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care. The Board has yet to be established, and the President has not offered any nominees. This commission will have Medicare rate-setting authority and proposals will be automatically implemented unless Congress acts in opposition. However, hospitals are exempt from the commission's recommendations until 2020 and other providers with update reductions will also be exempt until 2019.

101.25 See Chapter 3 for additional discussion of the impact of the Health Care Reform Acts on Medicare reimbursement.

Delivery System Reforms

101.26 **Accountable Care Organizations and Medical Home Models** Groups of eligible providers that meet certain statutory criteria, as well as those in the final regulations issued in November 2011, may be recognized as accountable care organizations (ACOs) that are eligible to share in the cost savings, or *shared savings*, expected to be realized by the Medicare program. As of December 2014, there were more than 330 ACOs in 47 states, providing care to more than 4.9 million beneficiaries. To qualify as an ACO, a group of providers must meet the detailed requirements specified in the regulations, including having a minimum of 5,000 Medicare beneficiaries covered by its participants, and have established a mechanism for joint decision-making, risk-sharing, financial responsibility for any losses, and meeting quality performance standards. An ACO may include group medical practices, provider networks, physician-hospital joint ventures, and others. A three-year commitment by the ACO to the shared savings program is required. Two *tracks* are offered in the regulations, with the first track having no risk of loss during the initial three-year commitment and a maximum percentage of shared savings of 50%. In regulations released in June 2015, CMS permitted ACOs to elect to renew for a second three year term under the first track model. The second track requires exposure to losses from the outset of the agreement but has a maximum percentage of shared savings of 60%. Regulations issued in June 2015 provided for an additional version of the second track risk model known as track 3. Special demonstration projects will be established through the Medicaid program to promote the provisions of care by pediatric medical providers and study the use of bundled payments for hospital and physician services. Finally, HHS will award grants to providers for the development of medical home models of care. See further discussion of ACOs in Chapter 6.

101.27 **Bundled Payments** In addition to establishing incentives for the creation of ACOs, HHS had begun to develop a Medicare bundled payment pilot program offering incentives to providers who

coordinate care (generally starting in 2013). The bundled payment is for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to the hospitalization and spans 30 days following discharge. This program is complemented by a four-year demonstration project (from 2012 to 2016) to study the use of bundled payments for hospital and physician services in eight states through the Medicaid program. A report on the initial results can be found at **http://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf**

Quality and Transparency Initiatives

101.28 **Medicare Fraud and Abuse** As a condition of enrollment in Medicare, Medicaid, and/or Children's Health Insurance Program (CHIP), all providers and suppliers who do not already have compliance programs must implement such programs. Basic elements of a compliance program are to be developed by HHS. Medicare and Medicaid overpayments must be reported and returned within 60 days of the identification of the overpayment or the date a corresponding cost report is due, whichever is later. Providers are required to report the reason for the overpayment in writing. A provider's failure to report an overpayment is considered an obligation for the purpose of the False Claims Act, which may result in liability against a provider for retaining an obligation. Increased civil monetary penalties and other forms of sanction will be available to CMS in enforcing fraud and abuse prohibitions, and the Health Care Fraud and Abuse Control Fund will receive increased funding for screening and enforcement activity. Practitioners should note that the 60 day overpayment rule is one of the more dramatic provisions in the legislation and has implications across a variety of accounting disciplines, including valuation, auditing, and financial statement preparation.

101.29 **Quality Initiatives** HHS received additional resources to augment its quality reporting program to aide in the development of new quality measures and to establish national priorities for quality improvement programs through a new Innovation Center and other methods. Existing quality reporting programs have been expanded to include a broader range of service providers and the value-based purchasing program for in-patient hospitals has been expanded. ACOs are the first innovation and include 33 quality measures under which participants are evaluated.

101.30 On July 6, 2015, CMS proposed a new initiative to promote value-based home health care. The model would apply a payment reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. At the date this *Guide* went to press, CMS has not yet acted on the proposal. Practitioners should monitor developments in this area. In March 2012, HHS released a plan on how to move home health and nursing home providers into a value-based purchasing program (VBP) system.[5] Also on October 1, 2012, the program for acute care hospitals transitioned from pay-for-reporting to pay-for-performance and reduced payments to hospitals with high readmission rates begins. A percentage of hospital payment is tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care. In 2013, the actual payment linked to quality outcomes became effective and is funded by an across-the-board cut in every hospital's base payment. If implemented in accord with the legislation, the combination of these pay-for-performance changes with the productivity adjustment described at paragraph 101.17 are estimated to put as much as 6% of a hospital's DRG payment at risk. Quality performance measures starting in 2013

include evaluation of treatment of acute myocardial infarction heart failure, pneumonia, and surgeries, as measured by the Surgical Care Improvement Project and healthcare-associated infections, as measured by the HHS Action Plan to Prevent Healthcare-Associated Infections. As is the case increasingly throughout the Medicare and Medicaid payment systems, measures of patients' satisfaction with the level of care will be measured using the hospital Consumer Assessment of Healthcare Providers and Systems (CAHPS) [6] survey metrics.

101.31 **Prevention and Wellness Initiatives** The Health Care Reform Acts provide for the establishment of the Prevention and Public Health Fund and a Community Health Center Fund. These funds are intended to help finance disease prevention and public health programs, community-based programs that promote healthy lifestyles (particularly in medically underserved areas), patient education and outreach efforts, and develop demonstration programs that may test innovative approaches to reducing chronic diseases. A special ten-state pilot project will test the impact of providing wellness programs to at-risk communities including nutrition counseling, physical activity plans, and smoking cessation programs.

Other Requirements

101.32 **Tax-exempt Hospital Requirements** Beginning principally in 2013, tax-exempt hospitals are required to develop programs designed to assure the aggressive pursuit of their charitable missions. Hospitals must specifically:

- Conduct a community health needs assessment.

- Implement a financial assistance policy for low income patients.

- Limit charges billed to qualifying patients to no more than the amounts generally billed to insured patients.

- Observe certain limits on debt collection practices.

- Include in their annual Form 990 a report describing whether or not they are meeting their community needs assessment and a copy of their audited financial statements.

Failure to comply with these requirements will subject hospitals to a monetary penalty ($50,000).

101.33 **Stark Law Amendments** Physicians or group practices that provide in-office MRI, CAT scan, or PET scan services (and potentially other radiology services) must now inform patients, in writing, that these services may be obtained elsewhere. This written disclosure must be made at the time that the

referral is made, and must be accompanied by a written list of suppliers who furnish these services in the area in which the patient resides. See further discussion of the impact of the Health Care Reform Acts on the Stark laws in section 703.

101.34 **Manufacturers and Nursing Home Disclosure Requirements** Generally starting in 2013, drug companies and device manufacturers have to disclose payments to physicians. Nursing homes have to provide public disclosure of ownership information, develop compliance programs, and implement staff training programs.

101.35 **Rebuilding Primary Care Workforce Incentives** In order to strengthen the availability of primary care with the influx of newly covered patients, the legislation includes incentives to expand the number of primary care doctors, nurses, and physician assistants. The incentives include funding for scholarships and loan repayments for primary doctors and nurses with the intention of increasing the availability of health care services in underserved areas or health professional shortage areas.

101.36 Exhibit 1-1 includes various sources of information on health care reform.

Exhibit 1-1

Sources of Additional Information on Health Care Reform

• CMS Chief Actuary April 22, 2010 “Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended”—**http://www.forbes.com/sites/merrillmatthews/2014/09/30/medicares-former-chief-actuary-speaks-out-about-its-challenges/**.

• Massachusetts Division of Healthcare Finance & Policy— **http://www.chiamass.gov/**.

• Commonwealth Fund—**http://www.commonwealthfund.org/topics/affordable-care-act-reforms**

• Kaiser Family Foundation on Reform—**http://healthreform.kff.org/** (general information) and **http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/** (*Summary of The Affordable Care Act*).

• Kaiser Family Foundation Subsidy Calculator—**http://kff.org/interactive/subsidy-calculator/**. This is a tool that enables users to calculate what government subsidy for health insurance is available to an individual or family based upon age, income, and family size.

• Kaiser Family/Alliance for Health Reform Podcast on Private Insurance Changes —**http://kff.org/health-reform/event/aca-101-what-you-need-to-know-2015/**.

• **https://www.irs.gov/Affordable-Care-Act/**. The landing page for the IRS' links to various details of the Affordable Care Act's impact on taxation

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[2] The legislation uses the term *providers* but this can create confusion since health insurance companies subject to the tax are not referred to as *providers* in the healthcare industry.

[3] This percentage is known as the Medical Loss Ratio or MLR.

[4] Since Medicare pays 80% of the Allowed Charge and the beneficiary the other 20%, this results in an 8% overall increase.

[5] See **www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/downloads/Stage-2-NPRM.pdf** for additional information.

[6] Additional information on CAHPS surveys and tools is available at **www.cahps.ahrq.gov/**.

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102 Opportunities for Practitioners

102.1 The health care industry presents many opportunities and challenges for practitioners. It provides a unique and sizable market that can be a highly profitable portion of a firm's practice. Providing the wide range of services health care providers need in an ever-changing industry can be a challenge, however. Health care providers' needs from practitioners may range from traditional tax, accounting, and auditing services to assistance in forming an integrated delivery system or in negotiating a managed care contract. To successfully serve health care providers, practitioners must be able to provide those services timely and at a reasonable cost.

102.2 Many sole practitioners and small firms have successfully developed niche practices by focusing solely on services in which they have specialized knowledge or experience (for example, Medicare reimbursement and reporting). The authors believe, however, that one of the keys to building a successful health care practice is to broadly define the practitioner's role as advisor in a significant number of areas. Health care providers need practitioners who can provide advice in various business aspects of a medical entity. Initially, however, a firm may not have the capability to provide many of the needed services. In that case, the firm may decide to first provide only one or a few services, such as determining a provider's cost structure and analyzing capitation using financial models. The “foot in the door” can then serve as a base for expanding the number of services provided. That approach should be viewed only as an intermediate step to becoming a full-service advisor.

Consulting Services

102.3 Practitioners provide consulting services to help establish and maintain viable health care entities. The nature, timing, and extent of the procedures performed depend primarily on the scope of services requested by the health care provider. Naturally, each consulting engagement differs because of the nature of the service provided and the circumstances of specific clients.

102.4 Health care consulting includes a variety of services that go beyond the traditional CPA practitioner audit, review, compilation, and tax services. They include the following (the list is not all-inclusive):

- Conducting a practice management review.

- Valuing a physician's practice.

- Determining a provider's cost structure.

- Reviewing Medicare/Medicaid billing practices.

- Performing a CPT coding study.

- Designing and installing an information and accounting system.

- Assisting in the purchase and sale of provider practices.

- Negotiating managed care contracts.

- Assessing the performance of discounted fee-for-service or capitation contracts.

- Managing the administration functions of the provider.

- Reviewing fee schedules.

- Assisting in obtaining financing.

- Reviewing the practice's receivables.

- Reviewing compliance with regulations.

- Developing a Medicare compliance program.

- Assisting with strategic planning.

- Selecting the appropriate form of entity.

- Understanding government laws and regulations.

Health care providers have a wide variety of consulting needs, many of which are not apparent to them. Therefore, practitioners need to actively identify service opportunities and inform providers of the variety of services available.

How This *Guide* Helps

102.5 This *Guide* has been designed for use by CPA practitioners, health care industry finance directors, consultants, or others who are considering health care consulting (collectively referred to as *practitioners*). It provides both the technical guidance and practical advice needed to successfully serve health care clients. Its practice aids and illustrative examples (such as listings of health care industry resources, example contracts, checklists, questionnaires, and financial statements) can be used immediately by practitioners. The guidance and practice aids also are excellent tools for training the staff who work for health care consultants or health care providers.

102.6 In providing health care consulting technical guidance and practical advice, this *Guide* draws on the proven excellence of PPC's many other guides on accounting, consulting, financial planning, practice management, and tax matters. However, this book focuses primarily on the considerations unique to health care providers. Specifically, it discusses the following topics:

- *Chapter 2—"Accounting for Health Care Providers"* discusses the application of generally accepted accounting principles to health care entities. Its primary emphasis is on the accounting issues unique to health care providers, such as incurred but not reported (IBNR) claims liabilities, asset transfers between related nonprofit entities, and prepaid payments for health care services. The chapter also provides guidance on financial statement presentation and disclosure issues unique to health care providers including considerations from the September 2014 AICPA Audit and Accounting Guide, *Health Care Entities (2014)*. The appendixes to the chapter include six illustrative financial statements.

• *Chapter 3—"Medicare Reimbursement Determination"* provides an overview of the Medicare program and covers the basics of Medicare reimbursement. It explains how Medicare reimbursements are calculated. The chapter also provides references to the applicable Medicare regulations discussed in each section and to other resources that help to interpret the Medicare laws and regulations. In addition, it provides example payment calculations for Medicare Parts A and B.

• *Chapter 4—"Medicare Reporting and Payment Process"* explains how Medicare program reporting requirements work and how program payments are made to health care providers and suppliers. The chapter also provides references to the applicable Medicare regulations discussed in each section and to other resources that help to interpret the Medicare laws and regulations.

• *Chapter 5—"Procedural Coding and Billing"* addresses one of the most specialized, and often least understood, areas in health care finance. It provides an overview of the current procedural terminology (CPT) codes, guidance on understanding the Explanation of Benefits (EOB), and guidance on performing a coding study. Practitioners who understand the coding area typically find significant consulting opportunities.

• *Chapter 6—"Managed Care Contracts"* focuses on the basics of managed care and how practitioners can help providers evaluate, negotiate, and monitor managed care contracts. Specifically, the chapter discusses the various types of managed care plans, the common reimbursement methods, the Medicare Advantage program, and the risks and rewards under the capitated form of managed care contract. It also provides guidance on negotiating a managed care contract.

• *Chapter 7—"Integrated Delivery Systems—Structures and Legal Issues"* discusses the issues practitioners need to understand before advising health care providers involved in (or about to be involved in) integrated delivery systems. It covers the types of integrated delivery systems common in the health care industry and the related legal, regulatory, and tax issues facing such health care providers. It also provides guidance on how to develop a Medicare compliance program.

• *Chapter 8—"Other Consulting Services"* provides guidance on conducting a practice management review, determining a provider's cost structure, and valuing a physician's practice. The chapter's discussion on practice management reviews focuses on common issues and procedures for evaluating the financial performance of a provider. Its guidance on determining a provider's cost structure addresses the critical requirements of an accounting system and different methodologies for determining costs per procedure. The chapter also discusses why an accurate physician

practice valuation is important to the seller, purchaser, and IRS.

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103 Standards for Consulting Services

Statement on Standards for Consulting Services

103.1 ET 1.310.001.01 of the AICPA *Code of Professional Conduct* (the Code) requires members to comply with the consulting standards when providing consulting services. Because of their authority under the Code, the AICPA's Statements on Standards for Consulting Services (SSCSs) affect consulting practice in the same way that Statements on Auditing Standards (SASs) affect auditing practice.

103.2 SSCS No. 1, (CS 100.05) *Definitions and Standards*, defines consulting services as “professional services that employ the practitioner's technical skills, education, observations, experiences, and knowledge of the consulting process.” SSCS No. 1 groups consulting services into the following six categories:

• *Consultations* are completed in a short time frame and based mostly, if not entirely, on the practitioner's personal knowledge. Generally, a consultation is oral advice. Therefore, having no documentation is permissible, but a letter or memo outlining the discussion may be useful. An example consultation includes the client asking the practitioner to suggest software to consider in its search for an accounting system. Many consultations are responses to a client question, but consultations can also be initiated by the practitioner. For example, the practitioner may make suggestions to improve the patient scheduling process. Note that even though the practitioner often is not paid directly for these consultations, the practitioner may be liable for any client actions taken based on the consultation. Liability may be inferred by the wording on any billings rendered to the client during that period of time. Consultations often lead to more formal types of consulting engagements.

• *Advisory services* involve developing findings, conclusions, and recommendations for client consideration and decision making. They often result in a written report of the results of the practitioner's study. The report generally outlines the objectives, approach, information or results obtained, and conclusions and recommendations. An example of advisory services is a practice

management review. Often, a consultation may lead to an advisory services engagement, which in turn may lead to the practitioner providing implementation services.

• *Implementation services* involve putting an action plan or recommendations into effect. The implementation team may involve client personnel as well as the practitioner and staff. Generally, an action plan is prepared and a letter or report is sometimes written to notify the client of the completion of the engagement and summarize its accomplishments. Examples of implementation services are setting up new procedures to implement recommendations from a practice management review or assisting in the implementation of a compensation system to allocate capitation payments.

• *Transaction services* relate to a specific client transaction, generally with a third party. A written report is prepared that documents the practitioner's findings and conclusions. However, the report does not attest to the client's assertions. Examples of transaction services are preparing information to obtain financing (but not preparation of historical or prospective financial statements) and analysis for mergers and acquisitions.

• *Staff and other support services* occur when the practitioner provides staff and possibly other support services to perform tasks specified and directed by the client. Documentation of the practitioner's responsibilities and management's direction is useful. Examples include providing staff for computer programming and serving as controller. Before performing such services, the practitioner should consider whether the firm performs other services that require independence, such as auditing, and whether the staff services would impair that independence.

• *Product services* involve providing a product with associated professional services in support of the installation, use, or maintenance of the product. Examples are sale and delivery of packaged training programs, or sale and implementation of computer software.

103.3 SSCS No. 1 differentiates consulting services from other professional services a CPA may provide. A footnote in SSCS No. 1 states that consulting services do not include—

a. Services subject to other AICPA standards such as Statements on Auditing Standards, Statements on Standards for Attestation Engagements, and Statements on Standards for Accounting and Review Services.

b. Engagements specifically to perform tax return preparation, tax planning/advice, tax representation, personal financial planning, or bookkeeping services; or situations involving the

preparation of written reports or the provision of oral advice on the application of accounting principles to specified transactions or events, either completed or proposed, and the reporting thereof.

c. Recommendations and comments prepared during the same engagement as a direct result of observations made while performing the excluded services.

The previous exemptions are intended to simplify cases where it might be difficult to distinguish whether a discussion is part of tax, accounting, or audit services rather than a consultation type of consulting service. However, as a matter of practice development, a practitioner may wish to treat advice based on observations made while providing other services as a consulting service. That is permissible, but not mandated, and the requirements for performing consulting services are not difficult to meet. Thus, identifying a service as a consultation or other consulting service may have a desirable effect on practice development without creating additional requirements.

General Standards That Apply to All AICPA Members

103.4 All AICPA members must adhere to certain standards when they perform services, regardless of what those services are. Those general standards, which are stated in ET 1.300.001 of the Code, are discussed in the following paragraphs.

103.5 **Professional Competence** A practitioner should not undertake an engagement to provide professional services unless he or she can reasonably expect to complete the engagement with professional competence. The elements of professional competence necessary to perform consulting services include the ability to—

a. Identify and define client needs.

b. Select and supervise appropriate staff.

c. Apply an analytical approach and process appropriate to the engagement.

d. Apply appropriate technical knowledge.

e. Communicate recommendations effectively.

f. Assist in implementing recommendations when required.

103.6 A practitioner does not need to personally possess all the preceding capabilities to perform consulting services. In deciding whether he or she can reasonably expect to complete the consulting service with professional competence, a practitioner may consider all of the following:

• The abilities, education, and experience of the individuals on the staff or otherwise engaged by the firm.

• The skills, education, and experience of client personnel or personnel from other organizations responsible for tasks related to the consulting service.

103.7 **Due Professional Care** The exercise of due professional care in the performance of consulting services includes communicating advice clearly without leading the client to an inappropriate degree of reliance. Even in informal consultations, advice should be given only if the information provided by the client or known to the practitioner provides a basis for the practitioner to give a competent response.

103.8 **Planning and Supervision** The practitioner needs to adequately plan and supervise the performance of consulting services in a manner that provides reasonable assurance that the work is conducted in accordance with:

a. The understanding with the client.

b. Professional standards set forth in SSCS No. 1 and the Code.

c. The CPA firm's own policies and procedures.

103.9 SSCS No. 1 does not comment on the need for a written plan or level of documentation for consulting services engagements. The authors believe that, except for informal consultations, the practitioner should provide the client a written communication at the conclusion of an engagement, however. Even for informal consultations, a letter or memo outlining the discussions with the client would be useful.

103.10 **Sufficient Relevant Data** The practitioner needs to obtain sufficient relevant data to afford a reasonable basis for conclusions or recommendations in relation to any professional services performed. The following techniques may be useful to gather information:

• Interview.

- Observation.

- Review of client documents.

- Research.

- Computation.

- Analysis.

However, SSCS No. 1 recognizes that determining the nature and quantity of information required to develop conclusions or recommendations that fulfill the client's objectives depends on professional judgment. In addition, the extent of the practitioner's procedures can be limited by the client. However, as noted in paragraph 103.17, if the scope of the engagement is limited by the client, the practitioner should notify the client of any reservations about the extent of work. If the information gathered provides adequate support for the conclusions and recommendations communicated to the client based on the understanding with the client, the standard on sufficient relevant data is satisfied.

General Standards That Apply to All AICPA Members for Consulting Services

103.11 SSCS No. 1 (CS 100.07) provides general standards that must be followed by all AICPA members when providing consulting services. Those standards are discussed in the following paragraphs.

103.12 **Client Interest** Practitioners need to serve the client interest by seeking to accomplish the objectives established by the understanding with the client while maintaining integrity and objectivity. ET 0.300.040.03 of the Code describes *integrity* as follows:

> Integrity requires a member to be, among other things, honest and candid within the constraints of client confidentiality. Service and the public trust should not be subordinated to personal gain and advantage. Integrity can accommodate the inadvertent error and honest difference of opinion; it cannot accommodate deceit or subordination of principle.

The standard requiring the maintenance of integrity and objectivity does not require independence. ET 0.300.050.02 of the Code distinguishes between *objectivity* and *independence* as follows:

> Objectivity is a state of mind, a quality that lends value to a member's services. It is a

distinguishing feature of the profession. The principle of objectivity imposes the obligation to be impartial, intellectually honest, and free of conflicts of interest. Independence precludes relationships that may appear to impair a member's objectivity in rendering attestation services.

When the practitioner performs a consulting service for a client and is not independent with respect to a person, product, service, or entity relating to the consulting service, the authors believe that the practitioner should clearly communicate that fact to the client. The authors recommend that the communication, and the client's acknowledgment of it, be in writing.

103.13 **Understanding with Client** The practitioner must establish a written or oral understanding with the client about the responsibilities of the parties and the nature, scope, and limitations of services to be performed, and modify the understanding if circumstances require a significant change during the engagement. To reach an appropriate understanding with the client, the practitioner should consider matters such as the following before undertaking the consulting service:

- Objectives of the consulting services.

- Nature of the services to be performed.

- Scope of services, including areas of client operations to be addressed and limitations or constraints, if any.

- Respective roles, responsibilities, and relationships of the practitioner, the client, and other parties to the consulting service to be performed.

- The anticipated approach, including major tasks and activities to be performed and, if appropriate, methods to be used.

- The manner in which the status of the work and results are to be communicated.

- Work schedule.

- Fee arrangements.

103.14 SSCS No. 1 emphasizes that the CPA's responsibility to the client for a consulting service is defined primarily by the understanding with the client. The understanding may establish constraints or scope limitations on the practitioner's performance of consulting services. For example, based on an agreement with the client regarding limitations on the work performed, the practitioner can accept an engagement even though the engagement omits certain work the practitioner believes is appropriate.

103.15 Although a written understanding with the client is not specifically required, the authors strongly suggest a documented understanding. Even for a consultation, a letter or memo outlining the discussion with the client may be useful. For consulting services other than informal consultations, the authors believe that a practitioner normally should document the understanding with the client in an accepted proposal letter, a confirmation letter, an engagement letter, or a contract. In either oral or written communication, the practitioner should not explicitly or implicitly guarantee results. Any significant change in the services to be performed should also be documented by written modification.

103.16 If the consulting service is performed for an attest client, the understanding with the client must be documented. ET 1.295.040.01 of the Code requires a member performing nonattest services for an attest client to document an understanding with the client regarding the objectives of the services, services to be performed, responsibilities of the client and the practitioner, and any limitations of the engagement. The form of the documentation is left to the judgment of the practitioner (e.g., an accepted proposal letter, engagement letter, or internal workpaper memorandum). See additional guidance at paragraph 103.27.

103.17 **Communication with Client** SSCS No. 1 (CS 100.07) requires the practitioner to inform the client about any of the following:

a. *Conflicts of Interest That May Occur Pursuant to ET 1.110.010 of the Code.* ET 1.110.010 of the Code states that a conflict of interest can occur if a member's relationship with a client could, in the member's professional judgment, be viewed by the client or other appropriate parties as impairing the member's objectivity. The rule does not preclude members from providing consulting services to a client when a conflict of interest exists, however, so long as (1) the member believes he or she can perform the services with objectivity, (2) the relationship is disclosed to the client, and (3) the client's consent is obtained. For example, a practitioner may have a relationship with a vendor whose products are recommended in a practice management review. When a perceived conflict of interest exists, the authors recommend notifying the client in writing about the conflict of interest and obtaining written consent to the consulting services in light of the conflict of interest.

b. *Significant Reservations Concerning the Scope or Benefits of the Engagement.* Communication of significant reservations is required when the practitioner believes that work appropriate for the particular engagement has been curtailed by the client. The practitioner may accept the engagement in that situation, if the responsibilities of the practitioner and the client are clear in the established understanding with the client. However, the practitioner must be certain to communicate his or her reservations about the scope of work or the benefits to be derived from the limited work. Whenever responsibilities for a project are divided between the practitioner and client personnel or others, the practitioner is well advised to communicate the portions for which he or she is not

accepting responsibility.

c. *Significant Engagement Findings or Events.* Communication of significant engagement findings or events normally includes the major facts and assumptions upon which the results are based. Interim communication with the client on lengthy or complex engagements is often helpful.

SSCS No. 1 does not preclude oral communication of the preceding matters. The practitioner's professional judgment determines which communications must be written and which may be oral.

Other Standards

103.18 The standards in the following paragraphs are outside the scope of consulting services discussed in this *Guide*, but may impact certain consulting services (for example, financial forecasts included in budgeting). Therefore, each standard is briefly discussed and reference is made to guides in the Thomson Reuters library that provide additional practical guidance.

103.19 **Attestation Standards**[7] Attestation standards apply only if a practitioner:

• is specifically engaged to examine, review, or apply agreed-upon procedures to a subject matter or assertion about a subject matter that is the responsibility of another party, or

• issues a form of report called for in the standard (that is, an examination, review or agreed-upon procedures report).

The attestation standards establish both performance and reporting standards for attestation engagements. For example, attestation standards provide the authoritative guidance for examination reports about the effectiveness of a client's internal control over financial reporting at a point in time.

103.20 Although the definition of consulting services excludes services subject to other AICPA technical standards, such as Statements on Standards for Attestation Engagements (SSAE), a consulting engagement may include such excluded services or consulting may be performed in conjunction with the excluded services. In such cases, the attestation standards apply to attest services performed as part of consulting services. (See *PPC's Guide to Nontraditional Engagements* for further guidance.)

103.21 **Standards on Business Valuation Services** Statement on Standards for Valuation Services No. 1 (SSVS No. 1), *Valuation of a Business, Business Ownership Interest, Security, or Intangible Asset*, provides guidelines for developing estimates of value and reporting on the results. SSVS No. 1 applies to AICPA members who perform an engagement that estimates the value of a business, business interest, security, or intangible assets for various purposes, including sales transactions, financing, taxation, financial reporting, mergers and acquisitions, management and financial planning, and litigation. SSVS No. 1 applies to an engagement or any part of an engagement that estimates value

when the member:

- applies valuation approaches and methods, and

- uses professional judgment in that application.

103.22 SSVS No. 1 does not apply where:

- The value of the subject interest is provided to the member by the client or a third party and the member does not apply valuation approaches and methods and does not report on the value of the subject interest.

- The member estimates a value as a part of an audit, review, or compilation engagement.

- The value is estimated in internal use assignments from employers to employee members who are not in the practice of public accounting.

- Engagements are exclusively for the purpose of determining economic damages (unless such determination is used to estimate value of a subject interest).

- Mechanical computations do not rise to the level of engagement to estimate value (i.e., where the member does not apply valuation approaches and methods and use professional judgment).

- There is a jurisdictional exemption whereby SSVS No. 1 differs from published governmental, judicial, or accounting authority.

(*PPC's Guide to Business Valuations* discusses the various standards over business valuation engagements in further detail.)

103.23 **Standards on Financial Forecasts and Projections** Standards on financial forecasts and projections establish guidance for a particular type of attestation engagement. They apply to consulting engagements that include reporting on a client's prospective financial information. The guidance includes performance standards, reporting standards, and standards for the presentation of a financial forecast or projection. (Preparing and reporting on forecasts and projections are discussed in great detail in *PPC's Guide to Forecasts and Projections*.)

103.24 **Standards on Reporting on Historical Financial Information** Standards on reporting on historical financial information relate to the three basic services that CPAs in public practice render with regard to historical financial statements—audits, reviews, and compilations. The reporting standards differ for each level of service. Statements on Standards for Accounting and Review Services (SSARS) apply to compilation and review engagements. Compilation and review engagements are discussed in detail in *PPC's Guide to Compilation and Review Engagements*.

103.25 Audited Historical Financial Statements. If the CPA practitioner has audited financial statements included in the consulting report, the authors believe the auditor's report also should be included. Auditing standards are discussed in *PPC's Guide to Audits of Nonpublic Companies*.

Independence and Consulting Services

103.26 AICPA independence standards apply only to attest services (e.g., review and audit of financial statements or examination of prospective financial information). The AICPA standards do not prohibit consulting services engagements for an entity for which the practitioner is not independent. (Note, however, the requirement for objectivity discussed in paragraph 103.12 and the need to communicate conflicts of interest discussed in paragraph 103.17.) In addition, SSCS No. 1 (CS 100.09) specifically states that performing consulting services for an attest client does not, in and of itself, impair independence. Of course, a CPA firm cannot be considered independent, for example, if it performs staff services in a management role or serves as an expert witness in most circumstances. The practitioner should evaluate each consulting services engagement for an attest client and determine whether the consulting services performed might impair independence based on the standards issued by the AICPA, state board of accountancy, state CPA society, Government Accountability Office (GAO), Securities and Exchange Commission (SEC), or regulatory agencies that apply to that client. Professional requirements for the attest services may prohibit certain consulting services.[8]

103.27 In the event that consulting, tax, or other nonattest services are to be provided for an attest client, the practitioner must ensure that the provisions of ET 1.295.040 of the Code are met. There are three general requirements that a practitioner should meet prior to performing nonattest services for an attest client:

a. The practitioner should not assume any management responsibilities.

b. The practitioner should obtain management's agreement to exercise its responsibilities.

c. The practitioner should establish an understanding with the client regarding the nonattest services.

103.28 Practitioners are urged to refer to the Code for specific guidance. *PPC's Guide to Write-up Services* and *PPC's Guide to Compilation and Review Engagements* also include expanded discussions on this topic.

Quality Control and Peer Review Standards

103.29 Consultants may wonder whether the AICPA's quality control standards apply to consulting services, that is, services performed under the AICPA's Statement on Standards for Consulting Services. The short answer is “no.” However, the consultant must consider the requirements of the AICPA's quality control standards if any consulting services include a component to which the AICPA's audit, attestation, or accounting and review standards apply.

103.30 Statement on Quality Control Standards No. 8, (SQCS No. 8) *A Firm's System of Quality Control*, establishes standards and provides guidance for a CPA firm's responsibilities for its system of quality control. QC 10.01 [9] states—

> This section addresses a CPA firm's responsibilities for its system of quality control for its accounting and auditing practice. . .

103.31 The standard defines an accounting and auditing practice as audit, attestation, compilation, review, and other services for which standards have been established by the AICPA Auditing Standards Board (that is, SAS and SSAE) or the Accounting and Review Services Committee (that is, SSARS). Services performed under the AICPA's consulting standards are not covered by the AICPA's quality control standards, but the quality control requirements would apply to the portion of a consulting engagement to which SASs, SSARS or SSAEs apply.

103.32 Consultants may also wonder whether the AICPA's peer review requirements apply to services performed under the AICPA's Statement on Standards for Consulting Services. Similar to the quality control requirements discussed previously, the short answer is “no.” The *AICPA Standards for Performing and Reporting on Peer Reviews* (PRP§ 1000.05 and 1000.06) (PR 100.05 and 100.06), [10] describe the scope of peer review engagements as follows:

> Firms (and individuals) [11] . . . enrolled in the program have the responsibility to . . . Have independent peer reviews of their accounting and auditing practices . . . An *accounting and auditing practice* for the purposes of these standards is defined as all engagements performed under Statements on Auditing Standards (SASs); Statements on Standards for Accounting and Review Services (SSARS); Statements on Standards for Attestation Engagements (SSAEs); *Government Auditing Standards* (the Yellow Book), issued by the U.S. Government Accountability Office; and engagements performed under PCAOB standards . . . .

Thus, the peer review requirements do not apply to services performed under the AICPA's consulting standards—only to those services qualifying as accounting and audit practice described in paragraph 103.31.

103.33 This *Guide* should help consultants meet the responsibilities under the AICPA's consulting standards. *PPC's Guide to Quality Control* provides guidance for establishing a quality control system to assure compliance with peer review requirements. That *Guide* recommends that firms cover special budgets, internal use, and attestation engagements in their quality control systems, even though those engagements may not be subject to peer reviews.

Outsourcing to Third-party Service Providers

103.34 Members who outsource client work to third-party service providers are subject to specific requirements, which are detailed in three ethics interpretations. The authors suggest a careful reading of the interpretations to ensure compliance.

103.35 With regard to confidential client information, ET 1.700.040 of the Code requires that before engaging the services of a third-party service provider, members should enter into a contractual agreement with the third-party service provider requiring confidentiality of client information. In addition, members should obtain reasonable assurance that the appropriate procedures are in place at the third-party service provider to prevent the unauthorized release of confidential information to others. If the accountant does not enter into a confidentiality agreement with a third-party service provider, specific client consent should be obtained before the member discloses confidential client information to the third-party service provider (ET 1.700.040 of the Code).

103.36 ET 0.400.47 of the Code defines a third-party service provider as “an entity that the member does not control, individually or collectively with his or her firm or with members of his or her firm, or an individual not employed by the member who assists the member in providing professional services to clients. . . .”

103.37 Professional services include bookkeeping, tax return preparation, consulting, or attest services, including related clerical and data entry functions. ET 1.150.040.03 of the Code states that a member is not required to inform the client when using a third-party service provider to provide administrative support services, such as record storage, software application hosting, or authorized e-file tax transmittal services.

103.38 The Code also provides the following guidance related to third-party service providers:

- When using a third-party service provider to provide *professional services* for a client, the accountant has a duty to inform the client, preferably in writing, of the use of such a provider prior to sharing confidential client information with that provider. If the client objects to the use of a third-party service provider, the engagement would have to be performed without using third-party service providers, or the firm should decline the engagement (ET 1.150.040.02 of the Code).

- The accountant is responsible for all work performed, including the work performed by third-party service providers, and for ensuring that the services meet the general standards and all other applicable technical standards (ET 1.300.040.01 of the Code).

Disclosure of Client Information to Third Parties

103.39 ET 1.700.060 of the Code addresses the disclosure of client information to third parties and applies when a member receives a request from a third party (for example, a trade association, member of academia, or surveying or benchmarking organization) to disclose client information or intends to use client information for the member's own purposes (for example, publication of benchmarking data or

studies) in a manner that may result in the client's information being disclosed to others without the client being specifically identified. A member who complies with such a request would be in violation of the "Confidential Client Information Rule" (ET 1.700.001 of the Code) if the information is considered to be confidential client information, unless the member has the client's specific consent, preferably in writing, for the disclosure or use of the information. This does not apply to the disclosure or use of information that is available to the public. Therefore, practitioners should be cautious in the disclosure or use of client information so as not to go beyond what is available to the public or what the client has agreed may be disclosed. For information not available to the public, practitioners should obtain the client's specific consent, preferably in writing, about the nature of the information that may be disclosed, the type of third party to whom it may be disclosed, and its intended use.

103.40 A member is not prohibited from marketing his or her services or advising third parties, such as current or prospective clients, based on expertise or knowledge gained from experience with clients (for example, the nature of services provided to other clients or common practices within a client's industry). However, when information communicated may be identifiable to one or more clients, specific consent, preferably in writing, should be obtained from the client(s).

103.41 In addition, practitioners should consider whether a contractual agreement with the third party is necessary to maintain the confidentiality, or limit the use, of the client information. Practitioners should also consider whether federal, state, or local statutes, rules, or regulations related to confidentiality of client information may be more restrictive than the requirements contained in ET 1.700.060 of the Code.

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[7] The Attestation Recodification Task Force of the AICPA's Auditing Standards Board (ASB) is continuing to work on its project to redraft the attestation standards to apply drafting conventions similar to those used in the recently issued auditing standards and to evaluate whether and how to converge, where possible, the attestation standards with the analogous international standards. In 2013 and 2014, the ASB issued several exposure drafts on the clarified attestation standards. Based on the most recent discussions of the ASB, the effective date would be no earlier than for reports dated on or after May 1, 2017. Future editions of this *Guide* will update the status of this project.

[8] The Sarbanes-Oxley Act of 2002 (Sarbanes-Oxley) generally applies to public companies and their auditors. It restricts the nonaudit services an audit firm may provide to public company audit clients, including prohibitions against bookkeeping or other services related to the accounting records or financial statements of the client; the internal audit function; the design and implementation of financial information systems; appraisal, valuation, or actuarial services; management or human resources services; broker or dealer, investment adviser, or investment banking services; legal services; and expert services unrelated to the audit. Certain services, including tax services, may continue to be provided, but they must be approved in advance by the client's audit committee. In addition, the GAO has rules that restrict certain nonaudit services for a governmental client.

[9] Among other things, the quality control standards require a firm to document its quality control policies and procedures. The extent of the documentation is based on the size, structure, and nature of the firm's practice. The quality control standards also require a written confirmation of compliance with

independence requirements from all firm personnel at least annually.

[10] The latest Peer Review Program Manual is available on the AICPA website at **www.aicpa.org/interestareas/peerreview/resources/peerreviewprogrammanual/pages/default.aspx** or on Checkpoint. The Peer Review Standards and related Interpretations are found in Sections 1000 and 2000, respectively.

[11] Interpretation No. 3-1 of the AICPA's *Peer Review Standards* states that individual CPAs practicing in a non-CPA owned firm are required to enroll individually in a practice monitoring program.

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