# Public Hospital District Audit Planning Guide

# September 6, 2022

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*Planning Guide Information*

Supercedes previous planning guide dated June 23, 2021. Please direct questions or suggestions to a Hospital District Subject Matter Expert.

Guidance is based on the extensive research, brainstorming and reviews conducted as part of the planning guide update process. For this update, guidance was also informed by discussion with:

- Association of Washington Public Hospital Districts (AWPHD)

This guide is intended for internal use only as a general resource to help the auditor gain an understanding of hospitals. The guide is not intended to supplant planning for individual audits. While auditors should consider all information in the planning guide, comments provided need to be evaluated in terms of the individual entity under audit and in light of other planning procedures and auditor's judgment. Also, while planning guides are as comprehensive as feasible, auditors must be alert for audit issues and situations not specifically addressed.

**This guide is used by the State Auditor's Office staff as they plan audit engagements. Information presented in this document does not represent policy or legal guidance. State agencies and local governments should contact their legal counsels with specific questions.**

# WHAT'S NEW

Auditors should be aware of the following significant updates:

- Payroll and Personnel – We have seen increases in expenditures for traveling nurses and doctors, stipend pay to retain staff and intern pay as districts look for ways to maintain staffing levels.
- Pharmacy Inventory - Due to an increase in the number of reported pharmacy frauds and losses involving system adjustments in hospitals, auditors should consider system adjustments and segregation of duties over ordering, receiving, inventory, and adjustments when assessing inventory controls.

# REQUIRED RISKS TO ASSESS

The following risks must be documented as risk indicators and discussed during brainstorming to ensure sufficient consideration. They should be prioritized for audit to the extent they are applicable and significant to the Hospital District.

### *EFT Controls*

Payroll and vendor electronic file transfer (EFT) related cyber frauds continue to occur. Accordingly, controls over EFTs is a required risk to assess for all entities we audit. When assessing this area of risk, auditors should talk with the entity about its controls related to changing existing EFT contact information and associated bank account numbers. The approach perpetrators of these frauds use has evolved to include changing contact information for existing EFT transactions before requesting a change to the associated bank account numbers. Previously, entities were encouraged to follow up with the contact information known at the time of the request for changes to bank account information; however, a stronger control is to independently confirm any change to payroll or vendor profile contact information or banking account information. Individuals with the ability to change or add EFT accounts need to have clear guidance on the process to authorize these changes through a proper validation method. A testing strategy is available in TeamMate at Accountability | Expenses | EFT Disbursements | Controls over EFTs. Contact Team IT Audit at SAOITAudit@sao.wa.gov for additional clarification or guidance.

### *Financial Condition*

Financial condition risk will be assessed as a baseline test for accountability audits and as part of our going concern analysis for financial audits. Governments have experienced a wide range of effects as a result of COVID-19, so auditors should be alert for impacts to financial condition and review FYI 2020-01 for expected disclosures.

Over the past several years, several hospital districts have struggled financially even before the restrictions of the COVID-19 pandemic. After the beginning of the pandemic restrictions, in early 2020, hospitals were especially hit hard when elective procedures were cancelled causing a loss in revenues. However, as various federal COVID-19 funding programs became available to hospital districts, many had experienced an increase in revenues and cash on hand.

When reviewing financial information, auditors should look for indicators of an eroding financial condition, poor financial management, or an existing financial crisis. The *Measurement of Financial Health* section of this guide lists some of the common indicators of declining or impaired financial health for hospital districts. When assessing a district's financial condition, auditors should also consider whether bond covenants require the district maintain certain financial requirements. Auditors should also consider performing calculations of current cash sufficiency to help in the financial condition assessment. If a district is experiencing financial difficulty, there is a risk it may not be in compliance with bond covenants.

If there appear to be significant concerns regarding the hospital district's long-term financial health, this should be communicated to the Audit Manager and Program Manager for discussion.

### *Patient Accounts*

Emerging risks over patient accounts at hospital districts include third party receipting, securing patient data when transferring to third parties, monitoring patient billings and adjustments to patient accounts.

Hospitals use third party receipting extensively, including collection agencies. Auditors should consider general third party receipting risks. A TeamMate strategy is available at Accountability | Revenues | Third Party Receipting with specific risks and procedures to consider.

There exists a further risk that hospitals may not be securing patient financial data when transferring the unpaid bills to collection agencies. The hospital may also need to verify Payment Card Industry (PCI) compliance for the collection agency. This can be addressed in the contract between the collection agency and the hospital. See also the Information Technology planning guide for additional guidance. A TeamMate strategy for PCI requirements is available at Accountability | Revenues | Third Party Receipting with procedures to consider.

Hospitals should ensure that there are adequate segregation of duties for reviewing patient billing, and especially with adjustments to patient accounts. Some hospital districts combine with other clinics to allow for two separate processes for reviewing patient billing. If there are other operations or clinics, it is important to verify that all locations have adequate segregation of duties to review patient billings and adjustments.

### *Patch Management*

The health industry has suffered a significant increase in cyber incidents such as breaches and ransomware attacks. Patch management is a front-line defense to ensure operational systems, as well as financial systems, remain strong against known and potential vulnerabilities. A testing strategy is available in TeamMate at Accountability | IT Controls | Patch Management. Auditor's should focus the testing towards key systems that house confidential (HIPAA) data.

## BACKGROUND

Public hospital districts are municipal corporations formed under chapter 70.44 RCW for the purpose of operating hospital and health care facilities and providing hospital and other health care services for the residents of such districts and other persons.

> *Note: Harborview Medical Center is not a public hospital district; it is a county hospital formed under chapter 36.62 RCW and is managed by the University of Washington. As such Harborview must comply with King County Regulations and State RCW's as applicable.*

Districts are governed by an elected board of commissioners and have the option of having 3, 5, or 7 commissioners serve on the board. Commissioners are normally elected to terms of 6 years. The board is required to appoint a superintendent to manage the district.

The largest portion of revenues generated by hospital districts comes from providing medical services to patients and billing for these services. Payments are collected either directly from the patient or from 3rd party payees such as private insurance companies (ex. Blue Cross, Group Health, Kaiser), Medicaid and Medicare. In addition, districts are also authorized to levy property taxes, special levies and bond levies.

### *Measurement of Financial Health*

Common indicators of declining or impaired financial health include:

- Increasing operating losses over prior years
- Declining year-end unreserved cash balances available to pay increasing accounts payable
- Use of registered warrants to pay daily operation expenses
- Declining patient receivables balances where the average number of days receivables outstanding remains the same or increases
- Increasing use of interim or short-term debt like lines of credit secured by inventory and accounts receivable.
- Inability to comply with debt covenants

See also Required Risks to Assess for Financial Condition.

### *Creation of Other Entities/Joint Operations or Contracting for Services/Partnerships*

Hospital districts may establish separate nonprofit entities under RCW 39.34.030 and RCW 70.44.240. Some examples of these separate entities are limited partnerships and nonprofit corporations. Auditors should be aware of how these partnerships/corporations are being funded. We have seen instances where hospital districts consider the entity or partnership as a completely separate entity or operation, when in fact there is actually funding with public money.

If additional entities are identified, auditors should contact their Audit Manager to get approval to work with their Assistant Director to determine if it should be further evaluated by the Director of Legal Affairs.

Auditors should be alert for other entities requiring an audit when reviewing activity, contracts or agency funds of a hospital. We should ensure that these entities are submitting financial statements in accordance with BARS requirements and receiving audits. Follow the SAO Hub | Auditor Reference Guide | New Entity Creation or Dissolution Form and Instructions in evaluating new or previously unidentified entities.

We are also seeing more hospital districts contract with non-profit healthcare organizations to operate the hospital. The benefits of such a partnership are to improve the hospital district's financial stability, quality of medical care and increased patient volume, as well as other benefits for the hospital district. Auditors should be aware that even if hospital operations are contracted out, the hospital district still exists as a public hospital district with its governing body. Further, the hospital district still collects property taxes owed and may even receive payments from the non-profit organization (depending on the nature of the contract, the non-profit could pay lease payments to the hospital district for use of the facility and equipment). This type of agreement is allowable as public hospital districts have the authority to enter into contracts under RCW 70.44.240. Some examples of existing partnerships include, but are not limited to:

- King County Public Hospital District No. 1 (dba Valley Medical Center) and UW Medicine
- Public Hospital District No. 2 Snohomish County (dba Verdant Health Commission) and Swedish Health Services
- Kennewick Public Hospital District No. 1 (dba Trios Health) and RCCH HealthCare-UW Medicine Healthcare Holdings, LLC

Auditors should be alert to how the hospital districts are spending funds to ensure it is within their statutory authority.

## PLANNING & ADMINISTRATION

### *Training and Additional Resources*

The following recorded webinar is available in the training system and may be helpful when auditing Hospital Districts:

- Know Before You Go: Public Hospital Districts

Additional resources related to hospitals can be found on the SAO intranet site under Audit | Reference Guide | Hospital Resources.

**Please add to the TM file the "Entity Specific" planning step for Hospitals from the Team Store to the Teammate file. There are specific steps addressing the four week notice requirement. In addition, auditors should obtain a specific management representation which will need to be added to the management rep letter for all hospital financial statement audits** (see Representation Letter Resource).

- **Audit Timing** - **Provide four weeks' notice prior to conducting an audit.** RCW 70.41.045 requires a letter (written notification) be sent to the Chief Executive Officer of the hospital district with copies to its Chief Financial Officer (and the primary contact, if not the CFO) **four weeks in advance of starting a hospital audit.** Always use the template letter, which is available in the TeamStore.

- **HIPAA Sensitive Data –**Districts may request auditors sign a confidentiality agreement to review information covered by HIPAA during the audit. Auditors must use the standard confidentiality agreement template on the SAO Intranet. Please see the link to the confidentiality agreement found on Hospital Resource page. A Deputy Director must approve and sign the agreement. Questions or changes to the template or HIPAA requirements should be directed to the Director of Legal Affairs.

- **Hospitals are allowed to submit annual reports up to one month late** – RCW 43.09.230 requires all local governments certify and file annual reports with SAO within 150 days after fiscal year end; however, in 2005, our Office issued a letter to all public hospital districts informing them that we would not consider hospitals reporting one month late (by June 30) to be a significant issue and, accordingly, would not report such late submissions as a management letter or finding. This practice is due to deadlines for Medicare and Medicaid cost reports. In January 2016, our Office issued the special report titled "*Local Governments: Increased Transparency and Accountability",* which identified four hospital districts that had not filed complete and timely annual reports.

  ***For all hospital district audits,*** review EIS to determine whether the district filed its annual report later than June 30th. We have advised hospital districts to file accurate annual reports rather than just filing in order to meet the deadline. If the district **did not file its annual report by June 30th**, contact the Hospital District Program Manager regarding reporting levels. Even though many hospital district financial statement audits are conducted by CPA firms, districts are still required to file their financial statements with SAO.

- **CPA Firm Financial Statement Services** - Many hospital districts contract directly with external CPA firms for financial statement audits. In some cases, we audit hospital districts on a 2 or 3 year cycle for accountability purposes, while a CPA firm performs the annual financial audit. The CPA Audit Report Review is to be performed annually (or as frequently as the external report is issued), regardless of the accountability audit frequency. See the Review Work of Others planning guide for additional information and contact the CPA Audit Coordinator for questions. The following guidelines summarize auditor responsibilities when all or part of a financial audit is performed by an external CPA firm or as part of another SAO audit.

  - When the **entire** financial statement audit of the primary government performed by an external auditor in lieu of an SAO audit, follow Audit Policy 3510, perform a "CPA Audit Report Review" in a separate TeamMate file (available in the TeamStore under Special Engagements | CPA Audit Review) and charge time to project code "CPAP". This TeamMate file must be completed prior to planning the Accountability Audit.

  - When **part** of the audit is performed by an external auditor or as part of another SAO audit, follow Audit Policy 6240, use the appropriate "Rely on Work of Others" audit program (available in TeamStore under Financial Statements | Rely on Work of Others) and charge time to project code "CPAR". This work should be started as soon as possible during planning.

  - When **part** of the audit is performed by an external auditor in lieu of an SAO audit **and** it is **significant** to the primary government, follow both Audit Policy 3510 and 6240, perform a "CPA Audit Report Review" coding time to "CPAP" and use the appropriate "Rely on Work of Others" audit program coding time to "CPAR".

- **Analytical procedures** – When performing analytical procedures, auditors should refer to DOH's website for current financial trend information. Hospital districts are required by law (RCWs 43.70.050 and 43.70.052) to submit their year-end financial data to the Department of Health (DOH). Statistical information can be obtained by clicking on the hospital financial tab, then hospital trends or volume trends. In addition to looking at trends for a specific hospital, go to the Year End Reports by hospital or the other types of reports listed under this webpage.

- **Certificates of Need** - Determine if there are any new Certificates of Need for capital equipment purchases or hospital restructuring for new or expanded services. Hospital districts can request a

Certificate of Need from the Department of Social and Health Services (DSHS) and DOH by submitting a proposal that states there is a "need" for that service to be provided in the geographical location. If approved, the certificate allows the hospital district to provide the specific services outlined in the certificate. This information can be obtained through inquiry, touring the facility, and cost reports. The addition of new specialists to the org chart may also be a good indication that a certificate has been awarded. The certificate must be obtained in order for the expense to qualify for Medicaid/Medicare reimbursement. The risk is providing services without an approved Certificate of Need, in which case Medicaid/Medicare may not reimburse for services.

- **Procurement with Federal funds –** Auditors should inquire during planning whether the district has done any procurement with federal funds. Federal procurement laws are applicable to purchases of equipment with federal funds when state laws are not clear on equipment purchases for hospitals. Auditors should consider this as an accountability risk even if a federal grant audit is not being performed. Please refer to the Compliance Section of the planning guide for additional guidance. Contact the Single Audit Specialist with any identified issues.

- **The Department of Health (DOH) performs audits of narcotics inventories**. These audits are generally based on system design and operation; therefore, a hospital could receive a clean DOH audit report even if there are some missing items. If an auditor identifies this as an area of risk and determines that the system is not operating as designed, auditors should be aware that a recommendation we may give could contradict the clean report a hospital received from DOH. Auditors should ensure audit recommendations emphasize the potential financial impact of inadequate controls increasing the risk of loss of public dollars spent on narcotics and not on the social aspects of missing drugs.

# ACCOUNTABILITY

Under RCW 70.44.171, the County acts as the treasurer of the hospital district unless the commission designates its own treasurer. Most hospital districts have elected to act as their own treasurer.

### *Revenues*

Potential revenue streams at a hospital district may include:

- Patient billings
- Emergency room fees
- Property taxes
- Pharmacy
- Cafeteria
- Decentralized Clinics
- Donations (may be received by a separate foundation or directly by the hospital).
- Gift shop (may be privately operated)
- Patient trust funds – nursing home patients may have trust funds that are accounted for and administered by the district on behalf of the patient. DSHS regulates these accounts and requires monitoring and accountability for these funds.
- Community education program fees
- Revenue for copies of medical records
- Laboratory service fees
- Facility rental fees
- Revenues from joint operations - public hospitals are often involved in joint operations with other hospitals in their area to provide specialty services (ex. hospitals join to establish a cancer center to provide services for cancer patients). Joint operation risks include hospital districts not receiving their portion of revenues generated by the joint operation based on the contract agreement; and hospital districts not disclosing the existence of these operations in the notes to the financial statements.

### *Donations & Fundraising*

RCW 70.44.060(11), gives hospital districts express authority to solicit contributions in support of hospital district services.

If hospital districts perform any fundraising activities, we would expect that the district has:

- A policy in place describing who may approve fundraising activities and provisions for accepting donations with conditions or restrictions.
- Adequate accounting controls for tracking and spending donated funds.
- Adequate cash receipting controls in place over fundraising events.

A step is available in TeamMate for testing fundraising activities in the Accountability | Revenues | Fundraising & Donations folder. If auditors identify any fundraising issues, please contact a subject matter expert for assistance.

***Billing/accounts receivable and cash receipting activities*** at the hospital, such as the cafeteria, and remote locations (doctor's offices) have been the most frequently cited areas for serious control weaknesses. More than any other entity type, auditors should expect to see significant write-offs and adjustments to patient billing due to insurance coverage reimbursement limits and charity care which are routine in a hospital environment. Various IT related risks could also come into play such as reports criteria, data modification and electronic interfacing, plus potential other risks. See the Information Technology planning guide for additional guidance. See also Required Risks to Assess.

### *Third Party Receipting (includes payments made online, in person, by mail or phone using E-check/ACH or credit card)*

Hospitals and clinics might be using third party service organizations for payment processing or bill payer functions. It is also possible that different departments may use different vendors to process payments. To determine if a particular hospital district or clinic uses third parties for receipting, check their website for payment options and inquire with district personnel (typically IT staff need to be involved with the interface so they are a good place to start). A **"Third Party Receipting"** step is available in TeamMate in the Accountability | Revenues | Third Party Receipting folder. See also patient account Required Risks to Assess.

### *Overpayments*

Some hospital accounting software systems allow a district to set up an overpayment threshold where payments received in excess of the amount due, but under the established threshold, are kept as district funds. State law requires the district to consider such overpayments as unclaimed property (Chapter 63.29 RCW). Auditors should gain an understanding of each district's overpayment process and determine if this is a risk.

### *Contracts/agreements for services with Hospital Foundations*

Many Districts contract with foundations to provide services such as fundraising. The contract with the foundation should set out the "deliverables" to be provided by the foundation in return for the resources provided by the District. AGO 1993 No. 18 reviews and approves the basic advice being given about foundations (*note that AGO discusses relationship with universities but the same guidance should be considered for other governments*). Risks include 1) commingling of foundation and public funds, 2) lack of separate bank and GL accounting for the two separate entities, 3) lack of or an outdated written contract when a government provides staff services to the foundation, 4) improper transfer of donations made to the government to the foundation without donor's consent (use of foundation funds is less restricted than public funds, creating motivation for fund transfers), and 5) improper use of donations that are provided by the foundation to the various government's departments.

To determine whether adequate compensation was received for any resources provided to foundations or associations, **consider** the following procedures:

- Identify resources provided to or on behalf of the foundation or association through inquiry, observation, review of contracts or memorandums and review of payments.

  *Auditors should be alert for resources other than direct payments provided by the government. For example: transfers of surplus property, staff time, office space or storage, office supplies, IT support, processing payments or other administrative support or donating revenue streams (e.g. coffee stand or vending machines).*

- Review contracts or other documentation provided by the government regarding compensation provided by the foundation or association.

  *If the government does not have a contract, memorandum or other documentation in place to describe resources and services exchanged between the government and foundation, auditors should consider requesting a written description of the current practices.*

- Consider verifying that contract terms were followed – that the government did not provide more resources and did not receive less resources in return than provided by contract terms.

Auditors should refer to the **Foundations and Association Agreements** step available in the Accountability | Revenues | Fundraising & Donations folder in TeamStore to help evaluate these contracts and perform testing.

### *Expenditures*

- **Payroll -** Special consideration should be given to management's monitoring of over-time, since hospitals operate 24 hours per day. Physician compensation contracts will likely be moving from volume or production based to value or quality based (for more information see CMS's Value-Based Purchasing (VBP) Programs). The contract terms may be harder to measure as they will be based on parameters such as service quality, patient satisfaction and provider satisfaction. The risk is that the Hospital's current data collection systems may not collect metrics to measure the achievement of the contract terms. If you have questions please contact your AIC, AAM or a hospital district subject matter expert.

  We have seen an increasing number of payroll frauds in hospitals. One recurring theme is timecard changes. Many hospitals utilize an automated timekeeping system (similar to punching a timecard, but uses a badge swipe instead). The hospitals have manual processes in place to handle errors, system malfunctions and other unexpected items – usually reflected in a "time entry change report". In some fraud cases, employees are submitting a timecard correction through this process, but the changes are not valid – they are changing the timecard to reflect hours they didn't actually work (and obviously didn't scan in their badge). In another instance, the employee did not clock out at the end of each day. She then used the change process to mark her day-end, but marked a "clock-out" time that was later than she actually left. We would expect hospitals to apply extra scrutiny to any timecard changes.

  With the COVID pandemic, districts are challenged to maintain staffing levels and respond to the changing envinromement. We have seen increased expendituress for traveling nurses and doctors (this may impact financial condition as these costs are higher than payroll costs for district employees). We have also seen increases in stipend pay to retain staff and some districts are also increasing pay to interns, including high school students who may potentially work for the district after graduation. If you have questions about these types of expenses, reach out to the Program Manager.

- **Bonus and Incentive Pay** – Special consideration should also be given to bonus or incentive pay arrangements and executive compensation. These types of payments are relatively common in hospitals; however, in order for them to be appropriate, there must be (1) a board approved policy in place at the time the goals were established or a board signed contract which included the specific goals and how they will be measured, (2) adequately defined goals so they can be measured to determine if accomplished, and (3) adequate documentation to enable an auditor to determine whether the goals were in fact achieved and bonuses approved. Problems have been found and reported in all three of these areas.

- **Compensation of Commissioners –** Under RCW 70.44.050, effective July 1, 2018, the compensation is authorized at a rate of $128 per day up to an annual amount not to exceed $12,288 (see OFM 2018 notice). This rate adjustment period is set once every five years. The Legislature has "fixed" the compensation (per diem increase) of certain commissioners (e.g. fire, hospital, port, and water-sewer districts) by use of the word "shall" in the language of the statute. Consequently,

commissioners from these respective districts do not "fix" their compensation and may receive the midterm increase in their compensation as directed by law.

- **Home Health Program** - Unique to hospital districts is the Home Health Program for homebound patients. Nurses travel to homes to provide healthcare services. Risk is that these employees are not adequately monitored to ensure travel expenses are valid and patient visits were actually performed.

- **Travel Costs for Job Interviews** - RCW 70.44.060(9) authorizes districts to pay actual travel expenses for candidates interviewing for physician, health care practitioner, superintendent or other managerial and technical positions. These costs may only be paid when the board determines that hospitals or other health care facilities are not adequately staffed and that personal interviews are necessary. Travel expenses for family members accompanying the candidate are specifically allowed.

- **Credit Cards** – Hospitals are required to have adequate staffing to serve the patients in their District. As a result, Executives may have broader spending parameters in the area of recruitment. In reviewing credit card purchases auditors should verify that the District's poilicies clearly define allowable credit card purchases and limits and that credit card purchases are adequately reviewed and monitored to determine they are allowable per District policy.

- **Sponsorship/Advertisement Expenditures –** Advertisements to make the public aware of specific services are considered a proprietary purpose of a hospital district. See Hospital District Authority below for additional information on allowable expenditures.

### *Assets*

Hospitals normally have significant sources of valuable assets. In addition to normal office equipment and a significant amount of technology equipment, small and attractive assets typically consist of drug inventories, medical supplies and medical equipment. We would expect all medications for use in treating patients and in the pharmacy (if one is operated by the hospital) – especially narcotics – be secured and subject to continuous inventory controls. Due to an increase in the number of reported pharmacy frauds and losses involving system adjustments in hospitals, auditors should consider system adjustments and segregation of duties over ordering, receiving, inventory, and adjustments when assessing inventory controls.

Misuse, misappropriation or loss of medications, medical supplies or equipment may be much higher when the district allows physicians to use hospital facilities for their private practice.

Recent audits have also identified risks with safeguarding of computers and similar theft-sensitive assets, such as lack of controls to track, monitor and safeguard these small and attractive assets.

### *Compliance Requirements*

General compliance requirements apply to hospital districts, including Open Public Meetings Act, expenditure audit and certification, conflict of interest, insurance / bonding requirements, limitation of indebtedness, authorized investments and budgeting.

#### *Hospital District Authority*

RCW 70.44 authorizes the establishment of public hospitals to own and operate hospitals and other health care facilities and to provide hospital and other health care services for the residents. In 2018, the statute was revised to include facilities and services that "promote health, wellness and prevention of illness and injury" as outlined in RCW 70.44.007. Auditors may see Hospital Districts paying for recreational facilities such as bicycle lanes and trails, school recreational fields, walking paths and fitness room upgrades. Districts may also be paying for services that promote wellness, such as cooking or exercises classes. These expenditures may be allowable if the district can demonstrate how these expenditures meet the definitions of the new statutory authority.

If you have questions about whether expenditures are within a Hospital District's authority, please consult the program manager.

*Creation of New Entities*

We are seeing Hospital Districts create new entities that serve various functions related to patient care (for example, hospice services, or even information technology related to patient care). When a hospital district or a group of hospital districts create a new entity, that entity may be subject to audit. Areas to consider in evaluating whether the new entity is subject to audit include the following: 1) Whether the new entity performs a governmental function. 2) The extent to which the government funds the entity activities. 3) The extent of government involvement in the entity activities. 4) Whether the new entity was created by a government or group of governments. If you see new entities being formed by the District or identified in review of the Notes about joint venture(s), please discuss with your AIC, AAM or Hospital District subject matter expert to determine if legal analysis of the new entity may be needed. Note: If it is determined that legal analysis is warranted, auditors should start the review process by using the Audit Authorizations – Entity Creation SharePoint page. See also instructions for this page here.

*Surety Bond*

Treasurers are required to have a fiduciary bond. RCW 70.44.171 requires that the treasurer of the county in which a public hospital district is located shall be treasurer of the district, except that the commission by resolution may designate some other person having experience in financial or fiscal matters as treasurer of the district. If the treasurer is not the county treasurer, the commission shall require a bond, with a surety company authorized to do business in the state of Washington, in an amount and under the terms and conditions which the commission by resolution from time to time finds will protect the district against loss. The premium on any such bond shall be paid by the district (RCW 70.44.171).

*Executive Session*

Hospitals may conduct executive sessions for quality improvement committee meetings or to discuss the status of clinical or staff privileges (RCW 70.44.062), in addition to general allowable purposes for executive sessions in the Open Public Meetings Act; however, any final actions related to those discussions must be made in an open public meeting.

*Bid Law*

Hospitals are subject to prevailing wage and competitive bidding requirements for public works projects (RCW 70.44.140). See the Bidding & Procurement guide for details. With respect to purchases, competitive bidding is required for materials, but the law does not clearly require bidding for equipment and supplies; *however, if federal money is used to purchase equipment, the Hospital would be required to comply with the Uniform Guidance procurement standards found in 2 CFR 200.318-.327 (assuming these provisions apply to the federal program they are charging the costs to).*. We will take exception to purchases of materials where there is no competitive process. The bid law guide states:

> Materials and supplies include articles which form a part of a finished product, while equipment is used in carrying on the work (such as tools, appliances, etc.). Materials and supplies are entirely consumed in that process and become a physical part of the product, while equipment does neither.

RCW 39.04.270, Electronic Data Processing and Telecommunications Systems is an alternative method hospitals can use when making such purchases. However, since hospitals are not required to competitively bid for equipment and supplies, this method is not required.

Purchases for expendable or disposable supplies used in patient care are not subject to bid laws.

Hospitals may use day labor/employees on public works projects that do not exceed their bid threshold (including materials, sales tax, and labor costs).

Please contact the program manager to discuss reporting levels of any issues noted.

*Contracts*

General contracting risks are applicable to hospital districts due to the extent of public-private partnerships and contracting. The risks include 1) not adequately monitoring the contracts to ensure the hospital is not paying more than the contract amount or paying for services not rendered, 2) the contract is poorly written

and doesn't clearly identify the services to be received for the compensation paid or address what happens if the services are not fulfilled or 3) there is no formal contract established.

Two types of contracts that are specifically high-risk are:

- **Physicians using hospital facilities for private practice.** These physicians both work for the hospital for a designated number of hours and hold a private practice using the same hospital facility. The primary risk is whether the contract with each physician is appropriate (no gift of public funds). An example of a contract that would not be considered appropriate would be one in which a physician receives many more benefits (from the use of hospital facilities) than he/she is providing in return to the hospital. In order to properly evaluate the exchange of goods and services between a physician and a hospital, the contract language should be sufficiently specific and clear as to allow management (and auditors) to evaluate and measure the adequacy of the exchange. If it is determined to be appropriate, then the secondary risk is whether hospitals adequately monitor physicians to make sure they are not using unauthorized hospital equipment, supplies and personnel for their private practice. Note: some hospitals prohibit this practice.

- **Subsidy contracts with physicians.** Under the conditions of participation in Medicare and Medicaid, hospitals must have adequate medical staff to provide quality care. Hospitals are dependent on physician providers to satisfy these requirements. Market demand and other competitive factors may make it necessary to pay a physician subsidy in order to entice a physician or physician group to the District's service area or maintain their association with the hospital or health care system.

  A subsidy arrangement is basically an income guarantee that the hospital provides to a physician who is recruited to a hospital's geographic area or is used as an incentive to retain a physician in the area. Typically, the District should have some sort of study, survey, analysis or review to support that there is a need for the physician's service type or specialty. The subsidy should be supported by a written agreement, signed by both parties, that clearly identifies the terms under which the physician will receive the subsidy payment. Over the last several years, we have seen an increased risk that Districts do not monitor the terms of the agreement and require the physician to meet the agreement's expectations or provide any identified supporting documents to support the subsidy payments.

  Auditors should review the subsidy contracts for compliance with the terms of the agreement and the District's monitoring of the terms to ensure they are met prior to payment. The agreement should also include the actions to be taken if a physician does not fulfill the terms of the agreement and the District should be refunded amounts already paid to them. (For example if the agreement gives a subsidy based on the physician working at the District for three years but the physician only stays for two years what District controls are in place to ensure subsidy payments are refunded.)

*Budgetary Requirements*

Hospital districts are required by state law (RCW 70.44.060(6)) to adopt a budget. The budget informs the citizens of the district's best estimate of revenues and expenditures for the ensuing year and must be adopted by the Board of Commissioners. Failure, by entity management, to enact a budget would result in non-compliance with the statutory budget requirements. *If actual expenditures exceed those budgeted, districts are not required to amend the budget.*

# FINANCIAL REPORTING

DOH publishes an Accounting and Reporting Manual that prescribes a uniform system of accounting and required reports for Washington hospital districts in order to accommodate data collection. This manual is available on the DOH website. Districts should also follow the BARS manual.

### *GAAP reporting changes*

All new GASBs are identified and evaluated by the Financial Audit Committee (FAC), as summarized on the GASB Tracker available on the FAC Sharepoint page. When evaluating implementation of new GASBs for Hospital Districts, auditors should specifically consider:

- *GASB 87* (Leases, originally effective FYE 12/31/20, now effective FYE 6/30/22) is expected to have an impact on hospitals and require re-evaluating and changes to reporting for leases, such as leases for equipment or buildings. We would expect this to require significant effort and analysis. We would not expect any early adoption of this GASB. A TeamMate testing strategy workpaper is available in Financial Statement | GAAP | Workpapers.

GASB 95, issued May 8, 2020, delayed the implementation date of certain new standards. Entities have the option to decide whether or not to delay implementation. During planning, as part of Understanding the Entity & Environment, auditors should inquire with the entity and confirm the entity's implementation decisions.

### *Patient Billing*

Since accounting for patient revenues involves a number of estimates, it is key to evaluation of financial health and at higher risk for misstatement if a hospital district is experiencing financial difficulty. Moreover, each hospital district's operating practices related to patient billing can affect financial health. See also Required Risks to Assess. Some issues noted in recent audits include:

- Staff turnover or shortages causing untimely billing for patient services to insurance carriers resulting in unanticipated uncollectible accounts.
- Inadequate staff training in the use of the complex patient billing software to produce accurate billings to patients and insurance carriers. If a district relies on software to calculate patient billings and the auditor determines this is a key control, the auditor should use the "IT Control Testing – Software Calculation" step available in TeamMate in the Permanent File | GAAP folder.
- Journal entries made to patient accounts by numerous employees without review for reasonableness or accuracy or without adequate support.
- Using an inconsistent methodology for calculating the allowance for uncollectible patient accounts.
- Charity care determinations that are not supported or do not comply with district policy.

The following are unique accounting issues related to patient billing (revenues and related receivables and payables). Due to the level of estimation involved with components of patient revenues, receivables and payables, inherent risk would typically be assessed at high for these balances.

- **Cost Report Rates** – At the beginning of each year, Medicare and Medicaid provide the hospital with the rates they will pay for patient care under these programs. These rates are based on the total expenditures reported for these patients in prior years. The difference in the actual costs of service and agreed upon rate results in a "Contractual Adjustment". Auditors should consider gaining an understanding of the cost report preparation and how it may impact the financial statement audit. Auditors should consider controls over the data and preparation if the report is internally prepared. If the report is prepared by an outside CPA firm, auditors should consider using the Reliance on Outside Specialists procedures available in TeamStore when auditing material balances affected by the cost report.

- **Contractual Adjustments** – This is a set amount that is adjusted from the actual patient billings based on a contract that is signed by the hospital with insurance carriers (Medicare, Medicaid, Private pay companies). For example, Medicare may agree to pay for 80% of total charges. Thus, 20% is adjusted off as a contractual adjustment.

- **Third Party Settlements** (may be reported as either a receivable or a payable) – These are amounts which have been calculated by Medicare and Medicaid that either the hospital owes to, or are due from, the insurance program based on the contractual agreement and "Cost Report" prepared annually (due May 31st each year). If the hospital shows expenditures to provide patient care services are higher than used to calculate the rate in the annual cost report, the program will send the hospital the difference (receivable) and if it costs the hospital less money to provide the care than that used to establish the rate, the agencies recoup the money when the hospital pays it back (payable).

- **Write-offs** – Amounts written off by private pay insurance carriers or amounts due personally from the patient that the hospital estimates will not be collected. This amount is an estimate based on the collection history of the hospital.

- **Charity Care –** This is an amount that the hospital has decided to pay for those patients that qualify to receive free services according to hospital policy, usually low income patients. Article 8, Section 7 prohibits gifts of public money except for certain things, including "necessary support of the poor and infirm". As described in Chapter 70.170 RCW and Chapter 246-453 WAC, provision of charity care appears to meet the exception in Article 8 Section 7 regarding the necessary support of the poor and infirm. Hospital charity care policies must provide that all persons receiving hospital-based care with income at or below the federal poverty level are entitled to charity care without charge; all persons with incomes between one hundred and two hundred percent of the federal poverty level qualify for discounts based on the hospital's sliding fee schedule (specified in the charity care policy). Thus, hospital districts are not only authorized to provide charity care, but must do so in a manner consistent with these laws. RCW 70.170.060 and WAC 246-453-070 require hospitals to submit charity care policies, procedures and sliding fee schedules to DOH for review and approval. Links to the policies approved by DOH can be found on the DOH website.

- **Major "Customers" –** Revenues at some hospitals from third-party payers like Medicare and Medicaid can account for a significant portion of patient revenues (70 to 80 percent). It is important to determine the make-up of the patient base in each hospital. Laws and regulations governing insurance programs are extremely complex and subject to interpretation and sudden change. Consider that there is at least a reasonable possibility that recorded estimates could change by a material amount.

- **Concentration of Credit Risk** – A hospital basically grants credit to its patients without collateral. Most are local residents that are covered by third-party insurance or uninsured. Again, the make-up of the patient receivable balance among these various parties can affect the collectability or receivables.

### *Reporting Entity*

RCW 70.44.060 gives hospital districts broad authority to cooperate with a variety of organizations and entity types for hospital operations. Districts routinely create related parties or joint ventures as part of this authority. Auditors should evaluate these cooperative arrangements for adequate financial statement disclosure based on the clarity standards. The Interlocal Agreement Entities planning guide should be reviewed to help evaluate these arrangements to determine if they create a separate municipal cooperation that should receive a separate audit. The Director of Legal Affairs should be contacted to evaluate interlocal agreements, and bylaws etc., if the auditor has questions about the proper reporting of these cooperative agreements.

Auditors should be alert for other entities requiring an audit when reviewing activity, contracts, joint venture note or agency funds of a hospital. We should ensure that these entities are submitting financial statements in accordance with BARS requirements and receiving audits. Follow the SAO Hub | Auditor Reference Guide | New Entity Creation or Dissolution Form and Instructions in evaluating new or previously unidentified entities.

### *Reporting Foundations and Trusts*

GASB 39 requires foundations to be reported as discretely presented component units only if the foundation is significant to the entity. For this analysis, auditors should use 5% of total assets or revenues (parallel to major fund determination) as a rule of thumb for "significance" along with consideration of qualitative factors. For audit purposes, we'd expect entities with foundations that are not reported to have documented analysis to support their conclusion. If not, auditors should perform the analysis with increased professional skepticism and obtain a specific management representation if the auditor determines the foundation is not significant and should not be included (see Representation Letter Resource).

Reported foundations must have an audit conducted by a CPA firm for us to rely on the work of the other auditors. Auditors are required to follow procedures in the "External Auditor performs PART of audit" TM step. Auditors should refer to Policy 6240 for guidance on standards for group audits.

Additional guidance and information on reporting foundations is available in FYI 2016-02.

### *Classification of current versus non-current liabilities*

Some hospital districts are not reporting the current portion of UTGO Bond debt as a current liability on the balance sheet because the repayment is intended to be funded through tax revenue received in the subsequent period. Enterprise funds should categorize assets and liabilities as either current or non-current according to whether they are expected to generate or use cash within 12 months of the end of the fiscal period **NOT** according to the origin of resources used to liquidate the liability. The source of money that will repay the debt has no effect on the current/non-current classification.

### *Classification of Grant Revenues as Operating or Non-operating*

Generally speaking grants are not considered to be an operating revenue source; however, there are some exceptions. GASBS 9, paragraph 17c allows grants to be reported as operating revenue if they are for specific activities that are considered to be operating activities of the grantor government (a grant arrangement of this type is essentially the same as contract for services).

These grants may occur in hospitals. There are certain arrangements often called grants (e.g., trauma grants, etc.) which are more like payments for services performed by hospitals than "traditional" grants. In such cases, when a grant is a result of hospital operations (i.e. it's a form of payment either from the state or federal government), it should be reported as operating revenue. If a grant is generated by hospital operations and resembles a payment for services, it should be reported as operating revenue. What the grant can be spent on – e.g. operations – is not a criterion for classification as operating revenue. Please note that if a grant is used consistently to cover an operating deficit, it should be treated as non-operating revenue.

To determine whether or not the hospital district has correctly classified their grants as operating or non-operating revenues, we can ask the hospital district what the purpose of the grant is, what kind of expenditures are made with the grant and if the hospital district receives the grant every year to help cover their costs.

### *Note Disclosure for Material Exposures*

Auditors should review notes for disclosures unique to hospital districts. For instance, determine if material exposure exists regarding changes in estimates for third-party payments, and if so, is the uncertainty regarding revenue realization disclosed in the notes to the financial statements. In the health care environment, it is reasonably possible that estimates regarding third-party payments could change in the near term as a result of future events such as reimbursement methods changing. For most hospitals with significant third-party revenues, the effect of the change could be material to the financial statements. Where material exposure exists, the uncertainty regarding revenue realization is disclosed in the notes to the financial statements. In order to render an opinion, the auditor's responsibility is to evaluate the reasonableness of management's estimates based on present circumstances and to determine that estimates are reported in accordance with GAAP and adequately disclosed. See AICPA's Statement of Position 00-01 for details which is located on the Hospital Resources page.

## FEDERAL AWARDS, INCLUDING GRANTS

Pre-COVID, most districts did not receive $750,000 or more in federal funding. However, as various federal coronavirus funding programs became available to hospital districts, some may be subject to a single audit that normally were not subject to this requirement.

### *Paycheck Protection Loan Program (ALN 59.073)*

The Paycheck Protection Program (PPP) is one of the four largest federal funding programs established by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. PPP loans are awarded by the Small Business Administration through participating banks and other lenders. The loans can be forgiven under certain conditions and if used for certain purposes. They are targeted to small businesses and non-profits to help pay for payroll and other specific expenses, such as utilities and rent, due to the decrease in business caused by the shutdowns during the pandemic. As of the date of this planning guide, hospital districts are the only known government entity that may be eligible for this program per the US Treasury Interim Final Rule. **This program is excluded from 2 CFR 200 Uniform Guidance, therefore it is not subject to single audit (expenditures are not reported on the SEFA).**

### *Provider Relief Fund (ALN 93.498)*

The Provider Relief Fund (PRF) is one of the four largest federal programs funded by the CARES Act, the Paycheck Protection Program and Health Care Enhancement (PPPHCE) Act, and the Coronavirus Response and Relief Supplemental Appropriations (CRRSA) Act. The PRF supports eligible healthcare providers in the battle against the COVID-19 pandemic. Eligible providers may receive PRF payments for health care related expenses or lost revenue attributable to coronavirus. **2 CFR 200 Uniform Guidance is applicable to this program, therefore, federal expenditures must be reported on the SEFA. However, there are special rules for SEFA reporting. See ALN Notes for special SEFA reporting requirements.**

### *ProShare*

Many rural public hospital districts receive supplemental Medicaid payments which are referred to as "ProShare". **ProShare payments should not be reported on the SEFA**, as these payments are considered a payment for provider services and not a grant.

### *Meaningful Use*

The Centers for Medicare and Medicaid Services (CMS) established an incentive program using American Recovery and Reinvestment Act (ARRA) funds to encourage eligible providers and hospitals to adopt and use certified Electronic Health Record (**EHR**) technology. One goal of ARRA is to increase the Meaningful Use of EHR technology among medical providers.

Hospitals and eligible providers, such as County Health Districts, who participate in the CMS EHR Incentive Program and receive Medicaid Incentive funds **do NOT report these on their SEFA**. These funds are **NOT** a grant or a loan, but a federal payment for using federally certified EHR.

### *Hospital Disproportionate Share Program*

DSHS-Medical Assistance Administration (MAA) gives a "disproportionate share hospital (DSH) payment" to hospitals that serve a disproportionate (large) number of low-income patients. These payments are not considered a grant and should not be reported on the SEFA.

### *Federal Capital Financing Programs for Hospitals*

The Departments of Agriculture, Commerce, and Housing and Urban Development have grants and loans available to assist hospitals in their capital financing needs. Be alert for these types of awards as there is a risk that the hospitals may not be reporting these on the SEFA.

The following are the most common federal awards received by hospital districts:

### *Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (ALN 93.918)*

This program provides extra services and care related to the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS). The program is primarily administered at the Federal level by the HIV/AIDs Bureau and Health Resources and Services Administration (HRSA). Grants are awarded to public and non-profit private entities, including federally qualified health centers. Services may be provided directly by the grantee or through contractual agreements with other service providers. The funding for this grant allows grant recipients to provide disease-specific care and treatment services.

### *Childhood Immunization Program (ALN 93.268)*

This is a HHS program administered by the WA Department of Health (DOH). Funding can be awarded in the form of discretionary Section 317 immunization funding (cash grants) and Vaccines for Children (non-cash assistance-vaccines). The discretionary grants are awarded for activities such as research, public information, education and training. The vaccine program supplies immunizations for children. Both forms of assistance must be reported in the SEFA.

### *Medicaid (ALN 93.778)*

The Medicaid program is administered by WA DSHS. The majority of Medicaid funds are paid to medical providers for services rendered to individuals.

Per Uniform Guidance in 2 CFR 200.502(i):

(i) *Medicaid.* Medicaid payments to a subrecipient for providing patient care services to Medicaid-eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

DSHS enters into various contracts with hospitals, health districts, schools, areas on aging, etc., to perform tasks that may not fall under the "patient care services to Medicaid eligible individuals" classification. A majority of the activity for this grant is often fee-for-service revenue, while a smaller portion of the grant is on a cost-reimbursement basis. DSHS typically considers the auditee to be a vendor with regards to activities funded on a fee-for-service basis (**see note below on "fee-for-service"**), but designates them as a subrecipient with regards to activities funded on a cost-reimbursement basis. Accordingly, only the portion received on a cost-reimbursement basis is considered a grant and should be reported on the SEFA.

**NOTE: not all "fee-for-service" type revenues are excluded from SEFA reporting!** DSHS has clarified that the "service type" is the defining factor. For example, if the fee-for-service is considered administration, then the federal portion must be included on the SEFA, whereas patient care services are not reported. Use the following chart as a guide:

***Federal Medicaid (Title XIX) & Money Follows the Person (MFP) Funds received by the auditee that should be included in the SEFA***

| *Funding Source* | *Service* | *Reimbursement Type* | *Service Type* | *Include on the SEFA?* |
|---|---|---|---|---|
| *TXIX & MFP* | *Health Insurance or Caregiver Training* | *Cost Reimbursement* | *Patient Care* | *No* |
| *TXIX & MFP* | *TXIX & MFP Contract Management (federal portion only)* | *Cost Reimbursement* | *Administration* | *Yes* |
| *TXIX & MFP* | *TXIX & MFP Case Management/Nursing Services (CMNS)** | *Unit Rate/Fee for Service* | *Administration* | *Yes ** |
| *TXIX & MFP* | *TXIX Nursing Services, e.g. DDD or HCS (federal portion only)* | *Cost Reimbursement* | *Administration* | *Yes* |
| *TXIX & MFP* | *TXIX Information and Assistance (federal portion only)* | *Cost Reimbursement* | *Administration* | *Yes* |

* CMNS is paid based upon a unit rate. The auditee must report the federal only portion of the unit rate on the SEFA and not their actual expenditures.

### *Women, Infants and Children (ALN 10.557)*

This is a USDA program administered by the WA Department of Health (DOH). DOH uses both federal and state funds to provide supplemental nutritious foods, nutrition education, and referrals to health care for low-income women who are at nutritional risk and who are pregnant, who have just given birth, or who are breastfeeding. The program also serves infants and children up to age five who are determined to be at nutritional risk.

About 75 percent of the WIC Program's annual appropriation is used to provide WIC participants with monthly food package benefits. The remainder is used to provide additional services to participants and to manage the program. Additional services provided to WIC participants include nutrition education, breast-feeding promotion and support activities, and client services, such as diet and health assessments, referral services for other health care and social services, and coordination activities.

DOH contracts with subrecipients to determine eligibility and to enter eligibility data electronically into the DOH Client Information Management System (CIMS). The subrecipients also print and deliver checks to recipients from CIMS. A primary risk in the WIC program is payments of duplicate benefits. This can occur when a participant enters the program and payment system at more than one location (only if the name documented is different). Staff is trained to ask for identification such as driver's license prior to documenting name in

CIMS so this process should minimize duplicate payments. Checks that are declared stolen can be replaced only with a police report. Checks that are destroyed in a fire can be replaced only with a fire report. If duplicate payment is discovered it is investigated. Checks that are lost are no longer replaced.

### *Homeland Security Property*

Many entities receive equipment and supplies that are funded by the Department of Homeland Security. Typically, this property is awarded to the State of Washington Military Department and then distributed to various counties and then further distributed to cities, towns, and special-purpose districts. If the district has received Homeland Security equipment or supplies, this is considered a non-cash award that must be reported on the SEFA. The amount to be reported is the fair market value (or other amount designated by the grantor) on the date it is received by the entity.

### *Hospital Cost Principles*

Hospitals do not follow the 2 CFR 200 Uniform Guidance Cost Principles (Subpart E). Per Appendix IX to Part 200 – Hospital Cost Principles: Until such time as revised guidance is proposed and implemented for hospitals, the existing principles located at 45 CFR part 75 Appendix IX, entitled "Principles for Determining Cost Applicable to Research and Development Under Grants and Contracts with Hospitals," remain in effect.

# APPENDIX: Glossary of Healthcare Terminology

**Diagnosis Related Groups (DRGs):** patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed, that provides a framework for specifying hospital case mix, and that identifies a number of classifications of illnesses and injuries for which Medicare payment is made under the prospective pricing system

**Ambulatory Patient Group (APG), Ambulatory Payment Classification (APC):** institutional outpatient reimbursement system based on the methodology developed by 3M for HCFA; APCs/APGs are to outpatient visits/services what DRGs are to inpatient hospital admissions; the payments are based on categories or groupings of like or similar services requiring like or similar professional services and supply utilization; may be used by other payers

**Bundling:** practice of combining services into one provider's claim to a payer; for Medicare, it includes combining services of non-physician providers inside and outside of a facility into the facility claim

**Case Mix:** (1) clinical composition of a provider's population among various diagnoses used as a factor in determining cost of service and rate setting (2) mix of patients who have different third party payers for their medical bills (i.e., Medicare, private insurance, workers' compensation)

**Case Mix Index:** measure of the relative costliness of patient treated in each hospital or group of hospitals

**Case Mix Severity:** level of illness or disability within a particular case-mix grouping

**Current Procedural Terminology, Fourth Edition (CPT V.6.0):** set of 5-digit codes developed by the American Medical Association (AMA) that are used for reporting medical services performed by physicians and other health care providers. Their purpose is to provide a uniform language that will accurately describe medical, surgical and diagnosis services. This system of coding terminology is the most widely accepted nomenclature for the reporting of medical services under government and private health insurance programs.

**Disproportionate Share Hospital (DSH):** a designation given to a hospital that meets HCFA criteria for care given to indigent and/or state healthcare related program patients

**DRG Creep:** systematic coding of a patient's diagnosis to maximize hospital reimbursement, often inappropriately used to refer to natural growth in case-mix severity and efforts to provide more accurate and descriptive coding

**DRG Rate:** fixed dollar amount reimbursement based on averaging of all patients in that diagnosis related group

**DRG Validation:** review by a peer review organization of medical records to ascertain that the DRG assignment was substantiated and that the admission was medically necessary and appropriate

**DRG Weight:** index number that reflects the relative resource consumption associated with each diagnosis related group

**Fiscal Intermediary (FI):** public or private insurer agency selected by HCFA providers to pay institutional claims under Medicare

**Health Care Financing Administration:** a federal agency within the U.S. Department of Health and Human Services. Although it still exists HCFA was renamed to Centers for Medicare and Medicaid Services (CMS)

**Healthcare Common Procedure Coding System (HCPCS):** set of codes that were established to cover a variety of services, supplies and equipment not identified by the CPT codes. The HCPCS is divided into two

subsystems, referred to as level I and level II. Level I is the CPT codes and are identified using 5 numeric digits and level II are services such as ambulance, durable medical equipment, injections, etc. and consist of a single alpha letter and 4 numeric digits. Level III codes were eliminated with the advent of HIPAA.

**Health Insurance Portability and Accountability Act of 1996 (HIPPA):** multi-faceted law whose primary purpose is the protection of patients from loss of healthcare coverage due to pre-existing conditions when changing jobs. It also provides for security and privacy of health data and standards for electronic health information transactions.

**Integrated Delivery System (IDS):** a system of healthcare providers organized to deliver a broad range of healthcare services. Other terms include integrated healthcare delivery system (IHCDS), integrated delivery network (IDN), and integrated delivery and financing system (IDFN)

**Joint Commission on Accreditation of Healthcare Organizations (JCAHO):** private, not-for-profit organization composed of representatives of the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and American Dental Association whose purpose is to establish standards for the operation of health facilities and services, conduct surveys, and award accreditation

**Joint Venture:** arrangement involving risk and benefit sharing between a hospital and one or more other entities, with rights and obligations specified in contractual terms for a specific purpose

**Major Diagnosis:** diagnosis accounting for the greatest resource consumption during a patient stay

**Major Diagnostic Category (MDC):** grouping of patients into major clinical categories based on organ systems and disease etiology

**Medicaid (Title XIX):** federally aided, state-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care; benefits, program eligibility, rates of payment for providers, and methods of administering determined by the state subject to federal guidelines

**Medicare (Title XVIII):** U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis; consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B)

**Medicare + Choice:** Medicare Part C program created by the Balanced Budget Act in which the Medicare program contracts with private health plans, provider sponsored organizations, private PPS plans, and medical savings accounts to provide beneficiary health care. It offers expanded benefits over Medicare Part A and B for a fee. An individual must be enrolled in Medicare Part A and B to qualify.

**Medicare Economic index (MEI):** index used to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expense factors including malpractice, personnel costs, rent, and other expenses

**Medicare Geographical Classification Review Board (MGCRB):** board established by HCFA to review applications by facilities for modification of their wage index under the prospective payment system

**Medicare Loss Recapture**: the Medicare reimbursement provision by which, when a Medicare-participating hospital is sold at a loss within a year after the owner stops participating in the program, Medicare reimburses the selling owner for Medicare's percentage of the loss

**Medicare Part A:** hospital insurance program portion of Medicare, which automatically enrolls all persons aged 65 and over entitled to benefits under the Old Age, Survivors, Disability and Health Insurance Program or railroad retirement; generally pays for institutional care

**Medicare Part B:** voluntary portion of Medicare, which generally covers physician services; requires enrollment and the payment of a monthly premium

**Medicare Part C:** Medicare + Choice above

**Medicare Part D:** drug benefits plus coverage for preventive screenings and tests. Part D came with the passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

**Medigap:** a health insurance policy sold by private insurers to fill the gaps in Medicare parts A and B. There are 10 standardized Medigap plans and each offer a different set of benefits. An individual cannot have both Medigap and Medicare + Choice.

**Prospective Payment System (PPS):** method of payment by which rates of payment to providers for services to patients are established in advance for the coming fiscal year. Providers are paid these rates for services delivered regardless of the costs actually incurred in providing these services

**Upcoding:** also called upcharging, is exaggerating or falsely representing what medical conditions were present or what services were provided to a client in an effort to obtain more money than the actual services that were rendered would provide.