HEALTHCARE

KPMG's Washington Healthcare Update

KPMG LLP

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Introduction

Our early summer edition begins with a brief report on the Medicare Trustees' Annual Report, which resulted in the Trustees issuing a "funding warning" to the president regarding the Hospital Part A program that will require the president to send a spending-reduction proposal to Congress by next February.

Congress has quite a bit of work on its plate before it begins its summer recess, which is expected to start around the end of July, including a number of matters that could affect the Medicare program and healthcare providers. We will describe them in our second article. The third article addresses some matters affecting the pharmaceutical industry, including user-fee legislation pending on the Hill.

HHS and CMS are especially busy this time of the year, with various payment rules being proposed or finalized. Our fourth article, therefore, focuses on proposed changes to Medicare payment rules affecting home health agencies, inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities, and inpatient psychiatric facilities. The Internal Revenue Service released a May information memorandum that serves as our last article. It addresses rules regarding tax-exempt hospitals and physician incentives involving electronic health records that we believe many of our clients will find of interest. We conclude with our End Points.

To all of you from the members of KPMG's healthcare practice: A pleasant, restful, safe, and fun summer!

AUDIT ▪ TAX ▪ ADVISORY

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"Honesty is the first chapter in the book of wisdom."

Thomas Jefferson

Medicare Trustees Issue Annual Report Including Funding Warning

According to the most recent Medicare Program Annual Report, released by the program's trustees April 23, the financial outlook for Medicare continues to raise serious concerns. A funding warning from the trustees was triggered by the report's finding that, for the second consecutive year, projected general-revenue funding is expected to exceed 45 percent of Medicare's financing within the next seven years. The warning requires the president to submit a proposal to reduce program spending to Congress in early 2008. The president must propose legislation to respond to the warning within 15 days of the release of the administration's fiscal 2009 federal budget, which is expected in early February 2008, and Congress must consider the president's proposals on an expedited basis. Also, while the warning indicates that the level of federal general revenues relative to the Hospital Part A program required to finance the program is an important concern, it does not signify that Medicare benefits cannot be paid currently. The trustees, however, do project that the Part A trust fund will be out of money by 2019.

In a statement released at the same time as the report, HHS Secretary Leavitt stated, "Medicare reminds us of the great dilemma of healthcare—the things that are priceless are not price free. We are making progress toward finding peace between the two—toward addressing long-term solvency while providing up-to-date care. But today's report shows us that we have a long way to go. This report shows once again that we are on an unsustainable course for Medicare spending. If Congress were to embrace the president's budget, we could not only eliminate this funding warning, we could extend the life of the Hospital Insurance Trust Fund (Part A) for four years."

Reforms and initiatives mentioned by HHS and CMS in response to the warning include:

- Implementing reductions in the market basket rate of growth, as proposed in the president's 2008 budget request, including a proposed 0.4 percent reduction in the growth rate of Medicare payments, if Congress does not pass a specific alternative proposal to achieve improvements in sustainability
- Increasing the share of program costs paid by the highest-income beneficiaries as proposed in the 2008 White House budget
- Testing quality and efficiency measures and developing strategies to pay more for better results rather than more services
- Implementing competitive bidding approaches to the delivery of care

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According to the trustees, bringing the Hospital Part A program into actuarial balance for the next 75 years will require an immediate 122 percent increase in the federal payroll tax or an immediate 51 percent cut in program outlays—or some combination of both. Senate leaders said difficult decisions will have to be made. The top Democrat on the Senate Finance Committee, Senator Baucus, said the fund warning "will prompt [the president] only to propose slashing Medicare spending, rather than to focus on the underlying factors driving down costs throughout the health system. Any presidential proposal resulting from this warning should address the fundamental issues plaguing the system as a whole—health coverage and healthcare costs." The committee's ranking Republican, Senator Grassley, said, "The spiraling growth in entitlement spending will require a difficult choice of drastic measures. The longer we wait, the more drastic the measures we will have to take."

The trustees' report may be accessed at: http://www.treas.gov/offices/economic-policy/reports/medicare-report-2007.pdf.

Capitol Hill

As we prepared this edition for you, congressional Democrats announced their $2.9 trillion fiscal 2008 federal budget resolution, or what some call a "budget blueprint." This was then approved in the Senate by a vote of 52–40 and in the House by a 214–209 vote. This high-level plan in reality is a nonbinding resolution because the implementing legislation for the president's consideration has yet to be drafted and will be subject to the "give and take" of the legislative process that will take place later this year.

One key provision in the plan that is important to the healthcare community is a proposal for a "pay-as-you-go" rule requiring that spending increases in programs such as Medicare and children's healthcare coverage such as SCHIP be financed by spending cuts and tax increases elsewhere in the budget. The White House budget director recently issued a warning to Congress that he will recommend that President Bush veto fiscal 2008 spending bills if they exceed the administration's budget request sent to Congress this past winter.

To give you an idea of how the Democrats in Congress might proceed in putting a fiscal 2008 budget together in the Medicare area, here are some plans they have recently announced:

- House Energy and Commerce Health Subcommittee Democrats said again in mid-April that **Medicare Advantage (MA) plans are overpaid** and that cutting their payments could reduce wasteful Medicare spending. Some members said that tying Medicare payments to the quality of services rendered would better

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assure that federal funds are best spent. Some members said durable medical equipment and imaging services are areas where fraud and abuse is a concern. Representative Pete Stark (D), chairman of the House Ways and Means Health Subcommittee, has announced his intention to introduce legislation in July to cut MA payments, to provide funds to avert a large reduction in physician payments, and to increase beneficiary benefits. Republicans, meanwhile, have countered by saying that people enrolled in MA plans are satisfied and they question the need to modify a program that seems to be working well.

- **Senator Kennedy and Representative Dingell, both Democrats, have unveiled their universal healthcare coverage plan to open the Medicare program to Americans under age 65.** Under their "Medicare for All" plan, Americans could keep their current coverage, enroll in Medicare or join an employee health benefits program. Under the bill, the cost of private coverage would be shifted from businesses to the federal government and add $600 billion a year to federal spending. However, the legislators said they do not believe the federal deficit will be increased by their proposal because payroll taxes would finance the added cost to the tune of an employer rate of 7 percent of payroll, with employees initially contributing at a rate of 1.7 percent.

- **Representative Stark announced in early May that the end may be near beginning in fiscal 2008 with respect to hospitals' and other providers receiving an annual Medicare payment increase based on a full inflation update.** The reason: Because of other federal funding needs in 2008 such as the reauthorization of the State Children's Health Insurance Program (SCHIP) and cancelling a scheduled physician Medicare payment cut.

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In some other healthcare-related news:

- **The American Medical Association and other physician groups are drafting a proposal to permanently replace the existing Medicare physician payment system with a system that would base annual payment updates on recommendations made by the Medicare Payment Advisory Commission.** If the current system cannot be replaced immediately, the draft suggests that short-term payment increase updates be provided from 2008 through 2015.

- **A bipartisan bill (S. 1340) has been introduced by Senators Lincoln (D) and Collins (R) aimed at reforming Medicare's fee-for-service payment system to accommodate patients with chronic conditions and reduce costs by establishing a chronic care coordination benefit.** The bill is a revised version of legislation that has been introduced each year since 2001 by Senator Lincoln. A bipartisan version of the bill also is expected to be introduced in the House. For more information, please go to: http://aging.senate.gov/hearings.cfm.

- **Senators Snowe (R) and Stabenow (D) have introduced the Health Information Technology Act of 2007, which would provide tax incentives and resources to offset the costs of investing in new health information technology.** Among its provisions, the bill (1) would establish a five-year, $4-billion competitive grant program for information technologies and services needed by healthcare providers such as hospitals, physicians, skilled nursing facilities, community health centers, and community mental health centers; (2) includes privacy provisions that would require patients to be informed if their personal health record is inappropriately disclosed; and (3) would accelerate the depreciation of health-related IT software and equipment, and increase Medicare payments to providers who use health-related IT to improve the quality and accuracy of clinical decisions for patients with chronic conditions.

Pharma Legislation and Consumer Health Information

- **In May, the Senate approved S. 1082 by a 93–1 vote, reauthorizing key drug and medical-device programs at the FDA.** The FDA Revitalization Act provides the agency with approximately $450 million in drug and device-user fee revenue from those industries in 2008 and would allow a portion of the fees to be used to address drug safety issues at any point during a drug's life cycle. The legislation also clarifies that the FDA can require certain drugs to be approved with a risk evaluation and mitigation strategy (REMS), and legalizes the importation of lower-cost drugs from Canada.

  As the Senate was passing its bill, the House Energy and Commerce Subcommittee on Health heard testimony from the FDA on the safety of the U.S.

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drug supply. In his testimony, the FDA's director of the Center for Drug Evaluation and Research said that the increased user fees would be used to hire additional staff to review and analyze safety information, to enhance agency resources to support other post-marketing safety activities, and to support the agency's ability to detect, communicate about, and act on important safety issues to help improve public confidence in the agency's drug safety efforts.

- **The Food & Drug Administration has launched a new Web site and e-newsletter.** The "Consumer Health Information for You and Your Family" Web site (http://www.fda.gov/consumer) provides comprehensive and timely consumer information from the FDA and the free, monthly FDA Consumer Health Information electronic newsletter (http://www.fda.gov/consumer/consumerenews.html) will alert readers to content on the Web site. The Web site provides links to useful information about various products the FDA regulates, including food, human and animal drugs, medical devices, vaccines, and other biologics. It also provides health information from other U.S.-government sources.

- **The April 26 edition of *The New England Journal of Medicine* contains survey results indicating, among other things, that a majority of physicians have some type of relationship with a pharmaceutical company or device manufacturer which, according to the article, raises concerns that industry codes of conduct may not be doing enough to reduce the influence of industry on prescribing decisions.** According to the survey, 94 percent of physicians reported having at least one relationship with a drug or device manufacturer. These relationships were largely comprised of food in the workplace and prescription samples. However, according to the survey, one-third of physicians were reimbursed for costs associated with professional meetings or continuing education. And more than 25 percent received honoraria for consulting, lecturing, or enrolling patients in clinical trials.

  The survey also found that (1) cardiologists were more likely than other physicians to receive direct payments from companies for consulting and other services, (2) family practitioners and internists were more likely than other specialists to receive industry funds and to meet with industry representatives, (3) pediatricians and anesthesiologists were the least likely to have such relationships, and (4) physicians in group settings or solo practice were more likely than their hospital-based counterparts to have relationships with industry representatives.

  The Senate Finance Committee also has expressed interest in these relationships and other relationships that could be inappropriately affecting physicians' decisions. The *New England Journal of Medicine* article may be found at: http://www.nejm.org, and the Senate Finance Committee report may be found at: http://www.finance.senate.gov/press/Bpress/2007press/prb042507a.pdf.

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Medicare Regulatory Issues

- **Proposed Medicare Fiscal 2008 Inpatient PPS rule changes have been announced by CMS.** The changes include revised relative weights for the DRGs and revised standardized amounts. The standardized amounts will be increased by 18 cents and the outlier threshold will be reduced by $85 to $22,940. Wage indexes also will change slightly. To obtain more information, go to the CMS Web site http://www.cms.hhs.gov.

- **On April 27, CMS proposed payment changes for Medicare Home Health Services.** The proposal contains the first refinements to the Medicare Home Health PPS since 2000 and includes the annual update to the system's payment rates for calendar 2008. The expected net impact in 2008 is a total increase in provider payments of about $140 million. The changes include:

  - A market basket increase of 2.9 percent
  - A provision saying that HHAs which submit required quality data will receive payments based on the full market basket increase of 2.9 percent and that those that do not submit quality data will receive a market basket increase of only 0.9 percent

  To account for changes in case mix that are not related to a home health patient's actual clinical condition, the rule proposes reducing the national standardized 60-day episode payment rate by 2.75 percent per year for three years beginning in calendar 2008. In addition, the proposal calls for replacing the current therapy threshold from 10 visits per episode of care with three new thresholds at 6, 14, and 20 therapy visits.

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The low-utilization payment adjustment would be modified by the proposed rule and the significant change in condition adjustment would be eliminated. In addition, CMS also proposes revising the way to account for nonroutine medical supplies in the standard 60-day episode payment rate. The CMS' summary of proposed Home Health PPS refinements compared to the current payment system is available at http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=2134.

- **The CMS also announced proposed changes in Medicare payments to skilled nursing facilities** that would increase total program payments by about $690 million in federal fiscal year 2008 as a result of a 3.3 percent increase in payments to facilities that provide certain types of skilled nursing and rehabilitation care. This change is described on the CMS Web site at: http://www.cms.hhs.gov/providers/snfpps.

- **On May 1, the agency released the final rule governing Medicare payments to long-term care hospitals.** While total payments to long-term care hospitals will exceed $4 billion in the rate year beginning July 1, 2007, the final rule decreases Medicare's long-term care hospital PPS payments by more than 3 percent principally due to changes to the high fixed cost outlier amount and revisions to the wage index values. Among the changes were:

  - The standard rate will increase 0.71 percent to $38,356.45 from $38,086.04. This change reflects an adjustment for a market-basket increase and a revision to account for the increase in case mix due to changes in coding practices versus treating more resource-intensive patients.
  - The 2008 high outlier fixed loss amount was increased to $20,738 from $14,887.
  - Wage index values were updated.
  - CMS adopted its proposed rule regarding the "25 percent rule." Under the current policy, if a long-term care hospital-within-a-hospital or a long-term care hospital's satellite discharges that were admitted from its co-located host hospital exceed a given percentage (generally 25 percent) for the cost reporting period, the payment to the long-term care hospital is adjusted downward. The new policy will extend this rule to freestanding long-term care hospitals where more than 25 percent of its discharged patients were admitted from an individual hospital, regardless of whether that hospital was located in the general vicinity of the long-term care hospital.
  - Revisions to graduate medical education (GME) payments. Under the current rule, teaching hospitals may count residents training in nonhospital settings for purposes of calculating their GME payments if the teaching hospital pays all or substantially all of the costs for the training program in the nonhospital setting. The final rule defines that requirement to mean that the teaching hospital pays at least 90 percent of the total costs of training residents in the nonhospital setting.

- **Proposed Medicare payment and other policy changes pertaining to inpatient rehabilitation hospitals in fiscal 2008 were released on May 2.** The proposal is designed to update payment rates and modify policies for services

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furnished to Medicare beneficiaries for discharges occurring from October 1, 2007 through Sept. 30, 2008. As a result of the changes, total Medicare payments for inpatient rehabilitation services are expected to increase by $150 million in federal fiscal 2008. Under the proposed rule:

- The payment's market basket-based rate would increase by 3.3 percent.
- The proposal would continue the existing phase-in to a 75 percent compliance threshold. This rule would require that at least 75 percent of a facility's total inpatient population would have one of the 13 medical conditions for which intensive inpatient rehabilitation services are deemed medically necessary. For the year beginning July 1, 2007, the compliance threshold will be 65 percent, and for the year beginning on July 1, 2008, it will 75 percent.
- The high-cost outlier threshold would be increased to $7,522 in fiscal 2008 from $5,534 in fiscal 2007.
- Wage index methodology would be modified for certain rural areas where no hospitals exist to generate wage index data.

• **CMS issued a notice concerning Medicare payments to inpatient psychiatric facilities,** saying the market basket increase for the 2008 rate year beginning July 1, 2007 will be 3.2 percent, resulting in a base payment rate of $615.99 per day, up from $595.09 in the 2007 rate year. This is the last transition year to a full prospective payment rate for these services beginning during the 2008 rate year where payments will be based 75 percent on federal rates and 25 percent on hospital-specific costs.

• **The agency has also issued guidance on hospital emergency services requirements.** The guidance indicates that nearly all hospitals, including specialty hospitals without emergency departments, must be able to evaluate persons with emergencies, provide initial treatment, and refer or transfer these individuals when appropriate. The rule does not apply to critical access hospitals that are subject to separate regulation. The latest guidance may be obtained at http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage and http://www/cms.hhs.gov/PhysicianSelfReferral/.

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IRS Issues Memo on Tax-Exempt Hospitals that Provide Financial Assistance to Staff Physicians

A May 11 IRS memorandum on tax-exempt hospitals that provide financial assistance to staff physicians states:

> " Many hospitals described in section 501(c) (3) of the Internal Revenue Code (Code) plan to establish interoperable EHR (electronic health records) systems to improve the effectiveness and efficiency of their medical care and to reduce medical errors. Some hospitals believe that their medical staff physicians need a financial incentive to acquire and implement EHR software that would allow the physicians to connect to the hospitals' EHR systems. On August 8, 2006, the U.S. Department of Health and Human Services (HHS) issued regulations… that allow hospitals to provide, within specific parameters, EHR software and technical support services…to their medical staff physicians without violating the federal anti-kickback law…and physician self-referral law…
>
> We will not treat the benefits a hospital provides to its medical staff physicians as impermissible private benefit or inurement in violation of section 501(c) (3) of the Code if the benefits fall within the range of Health IT Items and Services that are permissible under the HHS EHR Regulations and the hospital operates in the manner described below.
>
> A hospital that is otherwise described in section 501(c) (3) of the Code enters into Health IT Subsidy agreements with its medical staff physicians for the provision of Health IT Items and Services at a discount (Health IT Subsidy Arrangements).These Health IT Subsidy Arrangements require both the hospital and the participating physicians to comply with the HHS EHR Regulations on a continuing basis. The Health IT Subsidy Arrangements provide that, to the extent permitted by law, the hospital may access all of the electronic medical records created by a physician using the Health IT Items and Services subsidized by the hospital. The hospital ensures that the Health IT Items and Services are available to all of its medical staff physicians. The hospital provides the same level of subsidy to all of its medical staff physicians or varies the level of subsidy by applying criteria related to meeting the healthcare needs of the community.
>
> This memorandum does not apply to a hospital that allows its earnings to inure to the benefit of one or more medical staff physicians through arrangements that are other than Health IT Subsidy Arrangements, because the hospital would not be considered to be described in section 501 (c) (3)."

Should you have any questions about these matters and/or wish to investigate, explore, or enter into such arrangements, please contact your attorney and tax advisor.

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End Points

- The Congressional Budget Office (CBO) said SCHIP has caused children to leave or lose private insurance, but said the reasons why are unclear. CBO Director Peter Orszag said such movement is unavoidable if Congress hopes to reduce the nation's number of uninsured children. "The uninsured and insured are swimming around in the same pool. It is very hard to sort of reach a little net into that pool and pick out the uninsured. You're almost inevitably going to pick out some of each."

- Medicare has the data and the computer capacity to identify individual physicians who are inefficient compared with their peers and CMS may begin contacting them as soon as mid-2008 to urge them to become more efficient, Herb Kuhn, acting deputy administrator of CMS, said in testimony before the House Ways and Means Health Subcommittee. The evaluation, called "profiling," would involve screening how many tests and procedures a physician orders for a particular type of patient compared to his or her peers while getting the same treatment outcome. Kuhn also said, "It's an ambitious goal, but I think that we need to set ambitious goals if we're moving forward in this important reform area."

- The Government Accountability Office (GAO), in a report called *Nursing Homes: Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents*, states that CMS is not effectively carrying out immediate sanction enforcement mechanisms against nursing homes with a history of harming residents. The report can be found at http://www.gao.gov/new.items/d07241.pdf.

- The Congressional Research Service (CRS) said the uncapped tax exclusion for employer-paid health insurance increases demand for healthcare that, in turn, contributes to rising healthcare costs. It also said that because many people would likely obtain insurance without tax benefits, the exclusions can be an inefficient use of public funds.

"Words may show a man's wit, but actions his meaning."

Benjamin Franklin

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