HEALTHCARE

KPMG's Washington Healthcare Update

KPMG LLP

Late Summer 2007

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Introduction

The summer vacation season is over and official Washington now turns to matters such as implementing new regulations for programs like Medicare, the subject of the first article in this edition of KPMG's Washington Healthcare Update.

In our lead article, we concentrate on proposed and final regulations that deal with provider reimbursement, particularly the final fiscal 2008 hospital inpatient PPS rule, which may have a very significant impact on the industry. We also will look at proposed and final ambulatory surgical center and outpatient PPS payment changes, as well as an HHS Inspector General's opinion that concerns the sale of a physician-owned ASC to a hospital that could have implications for a number of our readers. We wrap up with comments on several HHS and CMS fraud-fighting initiatives.

Next, we move to Capitol Hill, where we concentrate on legislation passed by the House and Senate concerning the reauthorization and expansion of the State Children's Health Insurance Program (SCHIP). This legislation has received much attention from both houses of Congress and the press, resulting in different solutions that would affect providers in varying ways. It could also make it difficult for the House and Senate to reach a compromise version of the law or prompt the president to veto the bill that is ultimately sent to him.

Our third article looks at matters affecting the pharmaceutical industry, particularly legislation dealing with imports of prescription drugs, the disclosure of gifts to physicians and others, and FDA user fees.

Tax issues continue to have the potential to significantly affect the not-for-profit community and are the subject of this edition's final article. We finish with our End Points, which concentrate on healthcare cost and spending matters.

Press Time Update

Just as we went to press, the president vetoed the SCHIP legislation agreed to by both houses of Congress. If a veto override doesn't occur in the House, we expect both houses to reach an agreement, time period unknown, on a revised bill later this year, and we will provide an update in our next edition. The article in this edition does, in fact, provide background with more detailed information in this area.

AUDIT ▪ TAX ▪ ADVISORY

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"The poet and the politician have this in common: their greatness depends on the courage with which they face the challenges of life."

President John F. Kennedy

HHS/CMS Decisions and Matters Affecting Providers

- **Final Fiscal 2008 Medicare Hospital Inpatient Prospective Payment System (IPPS) Rule**

The summer was a very active period for CMS regarding the publication of rules affecting providers, particularly payment rules. The rule that has garnered the most attention has been the final fiscal 2008 Medicare Hospital IPPS rule, effective October 1. A brief summary of the rule follows. A more descriptive and detailed explanation of the rule's content (and a KPMG Healthcare Advisory briefing paper on the rule, ***Addressing the Impacts on Healthcare Facilities***) can be obtained from KPMG Healthcare Directors Steven Robinson (slrobinson@kpmg.com; 404-614-8676), Nancy Freeman (nfreeman@kpmg.com; 404-222-7210), or Carolyn Scott (carolynscott@kpmg.com; 214-840-6210).

The final fiscal 2008 Medicare Hospital IPPS rule released on August 2 continues the transition, according to CMS, to a more accurate payment system and also promotes quality care for hospitalized patients by providing additional incentives for hospitals to improve quality. The reforms fostered by the 2008 final rule will not only restructure the inpatient diagnosis-related groups (DRGs) to account more fully for the severity of each patient's condition, but also expand the list of publicly reported quality measures, and reduce Medicare payment when a device is supplied to a hospital at no or reduced cost. Despite concerns expressed by the industry, CMS has retained the behavioral offset adjustment that it proposed earlier this year. This provides for an offset or reduction in reimbursements on the assumption that there will be improvements in coding and documentation by hospitals, resulting in a behavioral offset. The agency also has decided to phase in new severity–adjusted DRGs referred to above over two years.

The rule also says Medicare will no longer reimburse for the following hospital-acquired conditions beginning in fiscal 2009:

- Objects left in patient during surgery
- Air embolisms
- Blood incompatibility errors
- Catheter-associated urinary tract infections
- Vascular catheter-associated infections
- Mediastinitis after CABG
- Complications from falls such as fractures, dislocations, intracranial injury, crushing injury, burns
- Pressure ulcers and bedsores

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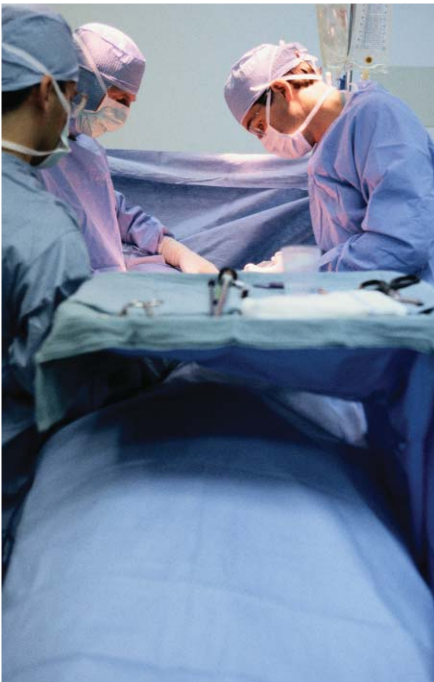
There is a strong likelihood that the following conditions also will not be reimbursed in fiscal 2009: ventilator-associated pneumonia, staphylococcus aureus septicimia, deep vein thrombosis, and pulmonary embolism.

In fiscal 2008, payments to hospitals for inpatient services are expected to increase by an average of 3.5 percent (3.3 percent attributed to the market basket increase), or more than $3.8 billion. Hospitals not reporting quality data will receive a 1.3 percent market basket increase. Urban hospitals are expected to receive a 3.8 increase because they generally treat more severely ill patients.

Adopting DRGs that replace 538 DRGs with 745 new ones that better recognize severity of illness is not expected to result in any net change in Medicare spending, CMS says. The change will result in increased payments to hospitals treating more severely ill and costly patients, with an offsetting decrease in payments to hospitals treating less severely ill patients. CMS also states that by better recognizing the severity of illnesses, fewer cases will be paid as outliers if it did not reduce the fixed amount of loss. As a result, the fiscal 2008 outlier threshold has been reduced by 7.6 percent to $22,635 from $24,485 in fiscal 2007. The agency reports that it set its threshold for high-cost cases so that total outlier payments will equal 5.1 percent of total inpatient payments. (Meanwhile, the American Hospital Directory says the outlier percentage was 4.6 percent in fiscal 2006 and is expected to fall to 3.1 percent in fiscal 2008.)



As for capital-related costs, in response to MedPAC and other parties' comments, CMS indicates that the final rule does not include its earlier proposal to provide a zero-payment update for urban hospitals. Instead, the rule provides a full update for all hospitals, eliminates the large urban add-on payment, and discontinues the teaching adjustments to capital payments over a three-year period. In addition, 2008's indirect medical education and direct medical adjustments will exclude the time residents spend on vacation or on sick leave applicable to the full-time equivalent calculations.

The rule also continues to phase in a change introduced in fiscal 2007 that would better align payments with the costs of care by using estimated hospital costs, rather than list charges, to establish relative DRG weights. Hospitals will be paid during fiscal 2008 based on a blend of one-third charge-based weights and two-thirds hospital cost-based weights. In fiscal 2009, hospitals will be paid solely using cost-based weights.

The rule also requires physician-owned specialty hospitals to disclose such ownership to patients and provide the names of physician owners upon request. These hospitals also are required to have physician owners who are members of the

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hospital's medical staff disclose their ownership to the patients they refer to the hospital. A hospital also must notify all patients in writing if a doctor of medicine or osteopathy is not present in the hospital 24 hours a day, seven days a week, and describe how the hospital will meet the medical needs of a patient who develops an emergency condition while no physician is on site.

The U.S. House of Representatives, as part of the Department of HHS Appropriations Bill (H.R. 3043), passed an amendment that would prohibit Medicare from implementing the behavioral adjustment or offset referred to above. The House also blocked the use of severity-based DRGs (MS-DRGs) by CMS, which the House states will reduce hospital inpatient payments by 2.4 percent. The future of the amendment rests with the House-Senate conference, which is expected to take place within the next couple of months. So stay tuned; we'll keep you informed on future developments.

- **Proposed Revised Payments to Ambulatory Surgical Centers (ASC) and for Hospital Outpatient and ASC Services**

CMS released a final rule in July that modifies the ambulatory surgical center payment system. The change would align ASC payments with ones for similar services furnished in hospital outpatient departments or physicians' offices beginning in calendar 2008. Under the new rule, ASCs are expected to receive almost $3 billion in Medicare payments in calendar 2008. ASCs will be paid for surgical procedures that do not pose a significant safety risk when performed in an ASC and that do not require an overnight stay. The revised payment system will add about 790 ASC procedures for payment and will be implemented using the hospital OPPS relative weights as a guide, according to CMS. The program will make separate payments for covered ancillary services such as radiology, some drugs, and biologics that are considered integral to covered surgical procedures. It would also provide separate payments to ASCs for brachytherapy sources implanted during the treatment of prostate cancer. The system will make payment adjustments for ASC procedures with high device costs. The final ASC payment rates will be published in the OPPS/ASC final rule in November. Some of the rates will be phased in during a four-year transition period. The rates will account for geographic wage variations by applying the wage index to 50 percent of the ASC payment.

The proposed OPPS/ASC rule includes a 3.3 percent inflation update for Medicare payment services in hospital outpatient departments under the OPPS in calendar 2008. CMS projects that hospitals would receive $34.9 billion in calendar 2008 for services provided to outpatients under the proposal. The proposal will cover inpatient rehabilitation services, psychiatric facilities, long-term acute care hospitals, children's hospitals, and cancer hospitals. It also continues a process of reducing beneficiary liability to 26 percent of total payments in 2008,

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ultimately moving to 20 percent in the future, and will reduce annual payment updates by 2 percentage points if hospitals don't report quality information. Among other changes, CMS proposes increasing the size of OPPS payment bundles, and would establish a new type of Ambulatory Payment Classifications (APCs), called a composite APC, through which a single payment would be made for multiple major procedures performed in a single hospital encounter. One is being proposed in 2008 for low-dose prostate brachytherapy and another is being eyed for cardiac electrophysiological evaluation and ablation.

Fact sheets on the rules can be found at:
http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

On the heels of the ASC payments rules, CMS announced a proposed rule in late August revising the requirements that ASCs must meet to receive Medicare payment. The agency plans to revise three existing conditions consisting of: (1) revising the evaluation of quality (now named quality assessment and performance improvement QAPI) that will require ASCs to continuously monitor quality improvement through projects, measure improvement in patient health outcomes, identify barriers to improvement, and work on reducing medical errors; (2) expanding ASC governing body and management's responsibility to include the creation of a QAPI as well as the creation and maintenance of a disaster preparedness plan; and (3) revising the laboratory and radiological services provision by requiring that an ASC meet certain conditions for coverage for portable X-ray services if it is directly furnishing those services. CMS has also proposed to create new conditions concerning: (1) patient rights, which will include a notice of rights, privacy, and safety, and confidentiality of clinical records; (2) infection control; and, (3) patient admission, assessment, and discharge. In addition, an ASC would be required to disclose in writing and provide to a patient prior to a first visit any physician financial interests or ownership in the ASC.

For more information, please go to: http://www.cms.hhs.gov/center/asc.asp.

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- **Final Home Health Agency (HHA) PPS Payment Rule**

CMS issued a final rule governing Medicare payments to HHAs in calendar 2008. The rule released during August maintains a provision in the proposed rule that reduces payments over four years to account for nominal case-mix growth. The specifics are:

- The final 60-Day Episode rate for 2008 will be $2,270.32 in calendar 2008, compared to $2,339 in calendar 2007. This calls for a 3 percent HHA market increase in 2008, compared to a 3.3 percent increase in 2007.
- The market increase is then adjusted for case-mix and wage indexes and for three years beginning in 2008 will be further reduced by 2.75 percent and by 2.71 percent in 2011.

The HHA rule, among other things, implements a new case-mix model intended to account for comorbidities and the differing health characteristics of longer-stay patients. The revised system replaces the current threshold of 10 visits per episode with new therapy thresholds at six, 14, and 20 visits, with graduated payment levels between thresholds.

For a comparison of significant facts and differences between 2007 and 2008, please go to: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

- **Physician Payments Will Drop Significantly in 2008 Without Congress' Intervention**

CMS indicated that Medicare physician payments will decline by 9.9 percent under the proposed 2008 fee schedule. The proposed rule would reduce expenditures by about $5.9 billion in calendar 2008 and provide a total of $58.9 billion in payments to the physician community. The proposal would also: (1) eliminate the exemption for computer-generated faxes from the e-prescribing standards, (2) revise the methodology for calculating the average sales price for Medicare Part B drugs, and (3) implement physician self-referral prohibitions.

More information is available at: http://www.cms.hhs.gov/center/physician.asp.

In our next article dealing with The Hill, we comment further on this matter.

- **HHS Inspector General Believes That a Physician-owned ASC Sale to a Hospital Could Result in Sanctions**

The HHS Inspector General (IG) indicated that the sale to a nonprofit hospital of an ASC owned by a company that includes several physician investors (with three orthopedic surgeons owning 94 percent of the equity) could potentially generate prohibited remuneration under the Anti-Kickback Statute and lead to the imposition of administrative sanctions. This decision is included in Advisory Opinion No. 07-05, which can be accessed at http://www.oig.hhs.gov.

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Under the proposed sale arrangement, the orthopedic surgeons would sell 40 percent of the company that owned the ASC for a profit. The HHS IG noted that the hospital is in a position to make or influence referrals directly or indirectly to the ASC or its physician investors, though under the arrangement, any physicians employed by the hospital would be prohibited from making referrals to the ASC. In its opinion, the HHS IG noted that:

- Although a safe harbor exists, for returns on investment in hospital/physician-owned ASCs, the proposed deal does not qualify for safe harbor protection.
- It is not clear that the proposed arrangement is not related, at least in part, to referrals to federal healthcare program arrangements.
- Because the orthopedic surgeons would be the only investors selling their shares, it is possible that one purpose of the hospital's investment is to reward or influence a subset of the investing physicians whose referrals to the hospital could be valuable.
- Even though none of the factors considered either separately or in combination necessarily indicates fraud and abuse, the arrangement increases the risk of fraud and abuse.

- **Medicare Fraud-Fighting Efforts**

CMS in late June announced plans to implement a two-year demonstration project involving the enrollment of suppliers of DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics and Supplies) into Medicare. The project's goal is to strengthen CMS's ability to detect and prevent fraud and will focus on DMEPOS suppliers in Southern Florida and the Los Angeles metropolitan area. According to CMS, the types of fraud committed in these areas have included: billing for services not rendered and billing for services not medically necessary.

The three major components of the demonstration are:

- Each DMEPOS supplier must submit a Medicare enrollment application within 30 days after a request by the National Supplier Clearinghouse (NSC).
- DMEPOS suppliers' Medicare billing privileges will be revoked in the following circumstances: (1) the above application request was not complied with, (2) the supplier failed to report a change in ownership or address at least 30 days prior to the effective date of such change, (3) there was a failure to obtain accreditation from an approved DMEPOS accrediting organization within 90 days of notification from the NSC, (4) the supplier has an owner or managing employee who has a felony conviction within the last 10 years, and (5) the supplier no longer meets every requirement necessary for enrollment as a DMEPOS supplier.
- An enhanced review of remaining DMEPOS suppliers under which the NSC will use a fraud-level indicator for each DMEPOS supplier. In assessing a fraud level, the NSC will consider factors such as: (1) experience as a DMEPOS supplier with other payers, (2) prior Medicare experience, (3) specific supplier location, (4) fraud potential of products and services listed, (5) site visit results, (6) inventory observed and contracted, and (7) accreditation of the supplier.

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HHS also issued a proposed rule that would require all suppliers of DMEPOS to furnish Medicare with a surety bond ensuring that the program can recover erroneous payments up to $65,000 that result from fraudulent or abusive supplier billing practices.

Not only is HHS/CMS looking at fraud regarding DMEPOS suppliers, it also announced an initiative on July 17 to protect Medicare beneficiaries from fraudulent Home Health Agency (HHA) providers in the Houston and Los Angeles areas using basically the same three demonstration components described above. They also require state surveys for any HHA that underwent a change in ownership within the last two years.

HHS also announced on August 20 that it is **taking fraud-fighting actions against inhalation therapy activities in Southern Florida.** At the same time, the federal government charged a Southern Florida company with fraudulently billing Medicare $170 million for infusions of HIV drugs.

Information in each of these fraud-related areas can be found at:
http://www.hhs.gov/news

Capitol Hill Update

It has been a busy summer on Capitol Hill, even with a recess during most of August, and a full schedule awaited the members of Congress as they returned after Labor Day. One piece of healthcare legislation that has generated much attention as it awaits final consideration in the House and Senate is the **expansion of the State Children's Health Insurance Program (SCHIP).** The House and the Senate have passed versions of SCHIP legislation that await a conference between both bodies to work out a compromise bill for the consideration of both houses.

The House passed legislation that expands the SCHIP program by $50 billion over five years and adds 7.5 million uninsured children to the current qualifying population of 6 million children. Funding would come from a 45 cent-per-pack increase in the cigarette tax. A savings of $20.4 billion would come from the elimination of bonus payments to states for enrolling more children in SCHIP after five years. An additional $35.7 billion in savings would come over 10 years through cuts in Medicare physician payments. Some Washington pundits say these cuts are unlikely to be retained in a final compromise bill with the Senate, though. In fact, they say, the bill would actually increase physician payments during the first two years.

House Democrats also included in their legislation spending cuts for the Medicare Advantage program and reduced Medicare spending via a freeze in payments to

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providers such as SNFs, HHAs, and long-term care hospitals. They also included a provision saying that hospitals that submit quality data in fiscal 2008 would receive a fee update of the market basket minus 0.25 percentage points, while hospitals that do not supply such data would receive an update of the market basket less 2.25 percentage points.

Among other provisions, the House bill would: (1) provide that inpatient rehabilitation facilities in fiscal 2008 would receive an update of 1 percent, with the adjustment applying for the last three quarters of the fiscal year, and a freeze of the "75 percent rule" at 60 percent; and (2) reduce the period for oxygen rental to 18 months from 36 months, but retain the 36-month rental period for oxygen-generating portable equipment. It would also allow payments for reasonable and necessary servicing and maintenance after the 18-month and 36-month rental period.

The Senate's version of SCHIP legislation would provide coverage for an additional 6.1 million children. The Senate's bill relies on a 61 cent-per-pack increase in the federal cigarette tax, which would create a majority of the $35 billion in new revenue needed to fund the expansion during the first five years. Savings would come from provisions such as reductions in program administrative expenses and letting small businesses band together across state lines to purchase health insurance. There are no Medicare provisions in the Senate's bill.

Reaching a compromise is expected to be difficult because of the significant differences between the two bills and the threat of a presidential veto. The White House has said that the president would veto a bill since it would cost too much, would increase taxes, and increase federal involvement in healthcare; the president wants to spend about $5 billion more on SCHIP, so the difference between the Hill and the Oval Office will be difficult to resolve. A veto override is possible in the Senate, but a key Republican has said that would only occur if House-Senate conference negotiators accept the lower spending amount in the Senate's version. Another possibility would be for lawmakers to offer a smaller SCHIP package of about $25 billion, with about $10 billion for a physician payment fix. Under another scenario, the physician payment increase in 2008 and 2009 included in the House bill could be included in another piece of legislation such as an omnibus spending bill that will be addressed later in 2007. Many lawmakers believe the present Medicare physician cuts provided for in current law will be eliminated. Yet another compromise scenario is that a one- or two-year reauthorization of SCHIP would be passed if the chambers can't reach a compromise agreement or if the president vetoes the bill ultimately sent to him.

In another SCHIP-related development, the Bush administration has announced new requirements regarding enrollment. Under the new policy, a state seeking to enroll a

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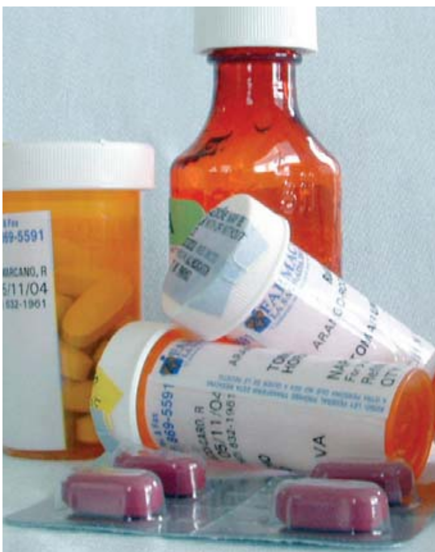
child whose family earns more than 250 percent of the poverty level ($51,625 for a family of four) must first prove that the child was uninsured for at least one year. The state must also demonstrate that at least 95 percent of the children in families making less than 200 percent of the poverty level have been enrolled in the children's health insurance program or Medicaid – a sign-up rate that the Washington Post reports no state has yet managed.

We'll update you in our next edition on the SCHIP expansion and authorization legislation, conference results, and other associated matters.

With respect to some other matters since we last wrote to you:

- The President vetoed S.5 – a stem cell bill – on June 20.
- Senators Baucus and Grassley, the ranking Democrat and Republican on the Finance Committee, have targeted the Medicare Quality Improvement Organization via S. 1947. They say their bill will improve contractor oversight of the quality of Medicare care. A summary of the bill is available at: http://finance.senate.gov/press/Bpress/2007press/prb080207a.pdf.
- House Budget Committee Republicans called for mandated program reforms rather than additional funding to ensure the integrity of federal healthcare programs. Instead of appropriating additional funds, the Republicans said federal agencies and Congress should mandate reforms that ensure federal funds appropriated in the regular process are spent wisely. For more information, please refer to: http://budget.house.gov/hearings.htm.
- A bipartisan long-term care insurance bill has been introduced in the House (H.R. 3363). It would let long-term care insurance be included in employer-sponsored cafeteria plans and flexible spending accounts.

Pharmaceutical Legislation and Other Matters



A new House bill (H.R. 2638) contains a provision that would **allow imports of FDA-approved prescription drugs from Canada.** Another bill (H.R. 3161) contains a provision that would permit drug imports. Both bills, if passed, are expected to be vetoed by the White House.

The Drug Company Gift Disclosure Act was introduced by House Democrats and referred to the House Committee on Energy and Commerce. The legislation (H.R. 3023) would require drug and medical-device companies to disclose certain gifts they make to physicians and other healthcare providers. The bill would require the companies to disclose any marketing or promotional gift worth more than $50 given to a healthcare professional, including managed care drug benefit managers. The information would be made available to the public on the FDA's Web site. The bill's sponsors are Representatives Peter DeFazio, Pete Stark, Maurice Hinchey, and Ben

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Chandler. In the Senate, members of the Special Committee on Aging have expressed misgivings about pharmaceutical companies' gifts to physicians and believe that a national disclosure registry is the solution.

A House bill (H.R. 2900) **authorizing the FDA's collection and spending of drug and medical device industry user fees** would increase the government's net discretionary spending over five years by $181 billion more than a similar Senate bill (S.1082), according to the Congressional Budget Office (CBO). The CBO also notes that the bills authorize different levels of additional user-fee collections for activities related to drug safety. The House bill also increases penalties for drug companies that violate safety norms. The bill would authorize $25 million per year through 2012 to establish a surveillance system for marketed drugs. (The Senate bill would provide $30 million per year through 2012 for a surveillance system.) The House would spend another $25 million on activities related to risk-evaluation and risk-management strategies and for federal initiatives to improve the security of drugs distributed in the United States The House would authorize $30 million annually through 2012 to extend the FDA's grant program for orphan products and other activities, though the Senate bill does not have such a provision. Among the provisions of the two bills, the CBO notes that the House bill would provide six months of exclusivity to all drugs granted pediatric exclusivity, while the Senate bill would limit the period to three months for certain high-selling drugs. The House bill also authorizes the FDA to require that pharmaceutical companies submit television advertisements to the agency for review prior to distribution and to make certain violations related to direct-to-consumer advertising subject to civil monetary penalties. The bill allows a maximum penalty of $250,000 for a first offense involving a false or misleading ad.

The FDA announced a new committee to advise the agency on how to improve communication to the public of risks and benefits of FDA-related products. The committee will:

- Help the FDA understand the public's communication needs and priorities.
- Advise the agency on the development of strategic plans to communicate product risks and benefits.
- Make recommendations to the FDA on what current research suggests about crafting risk and benefit messages, as well as how to most effectively communicate specific product information to vulnerable audiences.

The committee is composed of 15 voting members, including experts and public members not affiliated with the FDA. Experts will include persons knowledgeable in the fields of risk communication, social marketing, health literacy, cultural competency, journalism, bioethics, and other relevant behavioral and social sciences.

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Tax Issues

The IRS released a number of reports and commentaries this summer on matters affecting the tax-exempt healthcare community.

- **The IRS announced plans to redesign the Tax–exempt Entity Form 900. The redesign aims to:**
  - **Enhance transparency to provide the IRS and the public with a more accurate picture of the organization.**
  - **Promote compliance by accurately reflecting the organization's operations so that the IRS may efficiently assess the noncompliance risk.**
  - **Minimize the burden on filing organizations.**

The revised form has been described by some attorneys as a SEC-like disclosure document containing a vast store of readily available information about an organization's activities and the extent to which it engages in insider financial transactions. In essence, the revised form focuses on areas that the IRS has perceived as having the potential for abuse and therefore being subject to possible enforcement action by the government. As a public document, it will be available to state and local government officials, the press, and the public.

The released draft Form 990, which the IRS anticipates using for the 2008 tax year (returns filed in 2009), includes four new schedules with questions on:

- **Noncash contributions** – If an organization receives more than $5,000 in noncash contributions, it would have to report by types of contribution and provide information regarding the donee's valuation method for financial reporting purposes.
- **Hospitals** – Hospitals would be required to report aggregate community benefit for all facilities, and certain information regarding billings, collections, and joint ventures. They also would have to list the facilities and describe the types of services provided at each facility. Policies and activities involving communities served by the organization also must be reported.
- **Tax-exempt bonds** – The form adds requirements for information on the use and investment of proceeds and the organization's relationships with outside financial advisors. The IRS has indicated that it may phase in these questions to give healthcare providers time to adapt.
- **Foreign activities** – Organizations that have a foreign account or office, or have employees or activities outside of the United States, still must report these entities, and the new form adds reporting of exempt and other activities outside the country.

The revised form, among other things, also provides for the provision of information that gives a snapshot of the organization's key financial, compensation, governance, and operational information. It also requires governance information such as the board's composition and other related governance and financial practices.

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The IRS released more than 300 pages of comments on the proposed revisions. Some comments expressed concern about the complexity of the new schedules and asked that the IRS address what they considered repetitiveness in the form and instructions, while others praised the design and approach used by the new form.

Forty-two hospitals urged that Schedule H (on which community benefit, billing, collection, and joint venture information must be supplied) be delayed until 2010 to accommodate the delay the IRS anticipates in issuing instructions, as well as the need to adjust or create systems to capture the required financial information. They also said:

- The full value of the benefits hospitals provide should be included on Schedule H.
- Medicare underpayments should be considered a community benefit.
- Schedule H needs to be streamlined to eliminate questions that are burdensome and confusing or that fail to provide meaningful information to the community.

For more information regarding the IRS's revised Form 990, please go to: http://www.irs.gov/charities/article/0,,id=17126,00.html and http://www.irs.gov/charities/article/0,,id=173113,00.html.

- **The IRS released an interim report on its Tax-exempt and Community Benefit Project.** The report (which can be accessed at: http://www.irs.gov/pub/irs-tege/eo_interim_hospital_report_072007.pdf.) summarizes responses from nearly 500 tax-exempt hospitals to a May 2006 IRS questionnaire. The interim report also contains information relative to certain governance matters and practices, billing and collection practices, medical staff privileges, and ER operations. The IRS indicated in July that it continues to analyze the information it has received.

  According to the report, the IRS states that nearly all hospitals said that they provided various types of community benefit that were the subject of the questionnaire. But no uniform definition of uncompensated care emerged from the 97 percent of the respondents who have a written policy. As a result, the IRS

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indicated that this lack of consistency in classifying and reporting uncompensated care and various types of community benefits often makes it difficult to assess whether a hospital is in compliance with current law. This is one reason the IRS said more analysis is needed. The IRS' project team has recommended that a separate Form 990 schedule for hospitals be developed as a way to address this lack of uniformity. What caught the eye of Senator Charles Grassley, the ranking Republican on the Finance Committee, is that 22 percent of the hospitals spend less than 1 percent of their total revenue on uncompensated care and that 21.6 percent of hospitals reported that they spend less than 2 percent on community benefit as a percentage of their total revenue. As a result, he has been quoted as saying: "The report makes clear that we need to change business as usual at many of our nonprofit hospitals."

Among many findings, the interim report indicated that the treatment of bad debt expenses as uncompensated care received a mixed response: 56 percent of respondents reported that they do not include bad debt expense as uncompensated care, compared to 44 percent who reported that they include some bad debt expense as uncompensated care.

- **As Labor Day approached, the IRS released revised Form 13907, Tax-exempt Bond Financings Compliance Check Questionnaire, and other documents explaining the compliance checklist process. The IRS said it will be sending the documents to Section 501(c)(3) organizations that reported an outstanding balance of tax-exempt financing on their 2005 Form 990.** The purpose of this action is to check whether tax-exempt organizations that finance capital expenditures through exempt bonds are in compliance with the bond rules; for example, whether such organizations are adhering to recordkeeping and information reporting requirements and whether their activities are consistent with their stated exempt purpose. The questionnaire looks at areas such as: general compliance after the issuance of bonds, general recordkeeping, investments and arbitrage compliance, expenditures and assets, and private business use. The IRS also said that while this is not an examination activity and does not directly relate to determining a tax liability for any particular period, the failure or decision of an organization to not complete the questionnaire could result in an IRS examination.

  For a copy of the questionnaire, please go to:
  http://www.irs.gov/charities/article/0,,id=173245,00.html.

- **If you have a continuing interest in healthcare-related tax issues, you should periodically check the KPMG Web site at http://www.us.kpmg.com/microsite/taxnewsflash/exempt/body.html for updates on significant issues. For example, the site contains information dated July 19 regarding a Senate Finance Committee minority staff discussion draft of tax-exempt hospital reforms that, if implemented, could have a significant effect of an organization retaining its exempt status, and a June 22 release covering IRS Q&As on hospitals' health IT subsidy arrangements with medical staff physicians.**

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End Points

- According to a poll conducted by the American Institute of CPAs, 99 percent of approximately 230 financial executives (CFOs or controllers) at a professional conference are concerned about rising employee healthcare costs, and 81 percent said that their healthcare costs have risen in the past year from as little as 5 percent to more than 20 percent.
- The National Governors Association in its Fiscal Survey of States indicates that Medicaid accounts for about 22 percent of state spending, and total healthcare spending accounts for 32 percent of state spending – the largest single budget category.
- Hewitt Associates LLC reports that information gathered from nearly 160 large companies representing more than 1 million employees shows that initial 2008 HMO rate increases are averaging 14.1 percent, compared to 11.7 percent in 2007 and 12.4 percent in 2006.
- The director of the Congressional Budget Office reported in testimony to Congress that the United States could save $600 billion of what it spends on healthcare annually by adopting national best medical practices used in states with low Medicare healthcare costs. Among other things, he said reducing Medicare and Medicaid spending can't be done in a vacuum and that spending in these programs is linked to inflation in the entire healthcare system. He also said that a prime driver of healthcare inflation is the use of technology, which has improved healthcare services but is often overused. MedPAC in its report entitled *Promoting Greater Efficiency in Medicare* recommended that Congress should create an independent entity to sponsor and disseminate information on comparative effectiveness.
- An early review by a contractor of a major CMS pilot program called the Chronic Care Improvement Pilot indicates that, so far, the voluntary program is not achieving substantial health improvement or saving money during the first six months of its three-year time period. However, the contractor also recognized that the results are very preliminary and said conclusions on the impact on quality of care or health outcomes should not be drawn. Please go to http://www.cms.hhs.gov/Reports/Downloads/McCall.pdf. if you would like to read the report.

"The most successful politician is he who says what the people are thinking most often in the loudest voice."

President Theodore Roosevelt

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us.kpmg.com/healthcare

For more information, please contact:

Ed Giniat
National Sector Leader – Healthcare & Pharmaceuticals
312-665-2073
eginiat@kpmg.com

Bill Baker
Advisory Sector Leader – Healthcare
214-840-2519
billbaker@kpmg.com

Mark Drozdowski
Audit Sector Leader – Pharmaceuticals
973-912-6640
mdrozdowski@kpmg.com

John Fitzgibbon
Segment Leader – Managed Care
415-963-7008
jfitzgib@kpmg.com

Frank Mattei
Tax Sector Leader – Pharmaceuticals
267-256-1910
fmattei@kpmg.com

Sam McGarr
Tax Sector Leader – Healthcare
404-222-3033
smcgarr@kpmg.com

Marc Scher
Audit Sector Leader – Healthcare
314-444-1430
mscher@kpmg.com

Or contact your local KPMG Healthcare partner

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