

KPMG's Washington Healthcare Update

Spring 2008

Contents:

- 1 Introduction
- 2 HHS/CMS Activities and Matters
- 8 MedPAC Advisories
- 9 The Hill
- 12 Other Pharmaceutical Matters
- 12 New IRS Form 990
- 14 End Points

Introduction

The cherry blossoms have bloomed on the Mall, and winter has finally disappeared from the nation's capital. In this spring edition of our *Washington Healthcare Update*, we begin by looking at a multitude of issues that have kept the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) extremely busy. This first article discusses healthcare quality; fraud concerning provider self-disclosure; and Medicare provider payments, including CMS' proposed fiscal 2009 hospital inpatient prospective payment system (IPPS) rule, which also includes proposed rules for the Stark physician self-referral statute.

We then discuss some comments and recommendations from the Medicare Payment Advisory Commission (MedPac) to the Congress, e.g., provider payment updates, and other activities on Capitol Hill that affect the industry.

The next article covers a couple of Food and Drug Administration (FDA) actions involving its presence in China, and draft guidance concerning discussions of unapproved uses of FDA-approved drugs and medical devices in industry scientific journals and articles. We then provide some perspective from KPMG's Exempt Organizations Tax Practice in *hfm* magazine on the new IRS Form 990 before we conclude with our End Points.

"Health is worth more than learning."

Thomas Jefferson

HHS/CMS Activities and Matters

Quality

On April 23 in Washington, DC, HHS Secretary Leavitt told the World Health Congress that HHS is taking steps to spur the development of a healthcare system based on quality and cost comparisons, including standardizing more than 100 quality measures used by HHS agencies, publishing data on top Medicare procedures by cost and volume, and developing a demonstration project in which bundled payments are made for hospital care.

In the secretary's words: "The value of care should replace the volume of care as the most important virtue in the way we pay for healthcare in this country. The unbridled escalation of healthcare costs is the most serious economic threat our nation faces in the decades ahead. Left on auto pilot, I have no doubt that the percentage of our nation's economy devoted to healthcare will march forward until the weight of these expenditures brings our economic system to its knees."

On April 14, as part of the proposed fiscal 2009 Medicare Hospital Inpatient Prospective Payment System (IPPS) rule discussed below, CMS continued to build on its recent efforts to use Medicare payment systems to offer hospitals incentives to improve the quality of their care for Medicare beneficiaries. Such efforts include making hospitals bear the increased costs of treatment of hospital-acquired conditions (HACs) by adding nine more HACs to the list and by adding 43 more quality measures that hospitals will need to report in fiscal 2009 in order to receive the full IPPS payment update in fiscal 2010.

The proposed new HACs include:

- Surgical site infections following certain elective procedures
- Legionnaires' disease
- Extreme blood sugar derangement
- Iatrogenic pneumothorax (collapsed lung)
- Delirium
- Ventilator-associated pneumonia
- Deep vein thrombosis/pulmonary embolism
- Staphylococcus aureus septicemia (bloodstream infection)
- Clostridium difficile associated disease (a bacterium that causes severe diarrhea and more serious intestinal conditions such as colitis)

The new quality measures are in the following areas:

- Surgical care improvement project – 1 new measure
- Hospital readmissions – 3
- Nursing care – 4
- Patient safety indicators developed by the Agency for Healthcare Research and Quality (AHRQ) – 5
- Inpatient quality indicators developed by the AHRQ – 4
- Venous thromboembolism measures – 6
- Stroke measures – 5
- Cardiac surgery measures – 15

For more information, please go to http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

In late March, CMS posted new survey information on its Hospital Compare Web site (<http://www.hospitalcompare.hhs.gov>) that offers consumers more insight about the hospitals in their communities, new information from Medicare patients about their hospital stays, additional information about the number of elective procedures provided to patients, and what Medicare pays for the services. For the first time, consumers/patients will have information regarding three critical elements:

- Quality
- Patient satisfaction
- Pricing for specific procedures

More information can be obtained at www.hcahpsonline.org and http://www.cms.hhs.gov/apps/media/fact_sheets.asp (go to March 28, 2008 HCAHPS Facts) about the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which is the standardized survey instrument and data collection methodology used for measuring patients' perceptions of their hospital experience.

CMS has also announced:

- Preliminary data indicates that only 16 percent of physicians participated last year in the voluntary Physician Quality Reporting Initiative (PQRI), so CMS is taking steps to encourage physicians and other eligible professionals to take part in the initiative to improve the quality of care rendered to Medicare beneficiaries. The steps include several new reporting options, making it easier for physicians and other eligible professionals to participate and receive feedback on their performance, and adding ways for physician participants to qualify for incentive payments. More information is available at: <http://www.cms.hhs.gov/PQRI>.
- A new rule updates the minimum quality standards for kidney dialysis centers with final conditions for coverage that are more focused on patients instead of

“With the improvements that are being launched..., it’s going to be a lot easier for consumers to access, understand and use the data that tells them more than ever before about the quality, experience, and general cost of care at their local hospitals.”

Deputy CMS Administrator Herb Kuhn

process. The rule, among other things, requires that facilities (1) develop quality assessment and performance improvement (QAPI) programs to track patient health outcomes; (2) conduct a comprehensive assessment of patients' health condition when starting treatment; (3) work with an interdisciplinary team to develop individualized care plans; (4) have a defibrillator so staff can respond to heart attacks; (5) use updated water guidelines and have infection-control procedures; and (6) inform patients of modality choices, including home hemodialysis and transplant options. The rule also drops some requirements, such as a separate long-term care program. More information can be found at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

- CMS has issued a list of poor-performing nursing homes that can be accessed at <http://www.cms.hhs.gov/CertificationandCompliance/Downloads/SFFList.pdf>.

Fraud

An "Open Letter to Health Care Providers," dated April 15, 2008, was issued by the HHS Office of Inspector General (OIG) concerning the Provider Self-Disclosure Protocol (SDP) released in 1998. The letter discusses refinements and clarifications to the OIG's policies that, the agency believes, will increase the efficiency of the SDP and benefit providers who self-disclose. Specifically, the OIG states that the initial submission must contain the following information:

- A complete description of the conduct being disclosed
- A description of the provider's internal investigation or a commitment regarding when it will be completed
- An estimate of damages to the federal healthcare programs and the methodology used to calculate that figure or a commitment regarding when the provider will complete such an estimate
- A statement of the laws potentially violated by the conduct



In addition, to the "Basic Information" described in the SDP, the provider must be in a position to complete the investigation and damages assessment within three months after acceptance into the SDP. The OIG, among other things, indicates that providers who fulfill the requirements in the letter and cooperate with the OIG stand to be rewarded with a chance to walk away without a corporate integrity agreement. For a copy of the letter, please go to <http://oig.hhs.gov/fraud/docs/openletters/OpenLetter4-15-08.pdf>.

Payment

Hospital IPPS. On April 14, CMS issued its proposed Medicare Hospital Inpatient Prospective Payment System rule for the 2009 fiscal year, which begins on October 1, 2008; the final rule is expected on or about August 1. Overall, the agency expects total program payments under the proposal to increase by about \$4 billion and that the average payment per case will increase by \$375 to \$9,519, or 4.1 percent, in fiscal 2009. The proposal includes a 3 percent market basket increase for providers who report quality information in fiscal 2008 and 1 percent for those who do not.

In order to maintain budget neutrality as providers gain experience with Medicare severity diagnosis-related groups (MS-DRGs), CMS adjusts payment rates to take into account changes in documentation and coding practices that do not reflect real changes in patients and the severity of their illnesses; this is expected to reduce 2009 payment rates by 0.9 percent. The proposed outlier threshold is set at \$21,025 versus \$22,185 in fiscal 2008; the 2009 amount could change in the final rule.

Among other changes, the agency:

- Will base relative weights solely on cost and will allow providers to establish a separate cost center in their cost reports for relatively inexpensive medical supplies that will ultimately affect the relative weights under the IPPS and the Outpatient PPS.
- Will apply the post-acute care transfer policy to 273 MS-DRGs as in 2008; of these, 24 MS-DRGs will qualify as special pay post-acute transfer DRGs, approximately the same number as in 2008. The proposal would apply the post-acute transfer policy to discharges to home under a written plan for the provision of home health services that begins within seven days of discharge, if the discharge from the hospital occurred before the geometric mean length of stay for one of the selected MS-DRGs versus the current three-day timeframe.
- Will require applicants to demonstrate that a medical service or technology is new, meets a defined cost threshold, and offers substantial clinical improvement in order to qualify for an additional payment beyond the associated MS-DRG payment.
- Proposes a 2009 average hourly wage that is 4.2 percent higher than in 2008. Based on current information, in 2009, 106 labor markets will have average hourly wages greater than, or equal to, the national average, and 329 will be below.



- Proposes that an urban hospital seeking reclassification have an average hourly wage that is at least 88 percent of the average hourly wage for the area to which it seeks reclassification compared to 84 percent as currently required. The rural rate would increase to 86 percent versus 82 percent now.

CMS has also proposed revisions to the Stark III physician self-referral rules and hospital conditions of participation.

Regarding self-referral, the new rules would modify the physician self-referral “stand in the shoes” provisions in defining indirect compensation arrangements to (1) accommodate certain financial transactions made between physicians and academic medical centers or integrated healthcare delivery systems, and (2) require a designated health service entity to stand in the shoes of an organization in which it has a 100-percent ownership interest.

Under the Stark III rules, financial relationships between hospitals and other providers of designated health services (DHS), on the one hand, and physician practice groups and other physician organizations, on the other, are treated as if the arrangements have been entered into directly between the hospital/DHS entity and the individual physician. In essence, physicians are deemed to “stand in the shoes” of their respective physician organizations.

In cases where physicians meet any of the three existing Stark exceptions for employment services, personal services arrangements, or fair value market value compensation, they would not be required to “stand in the shoes” of their physician organizations to determine compliance with the law. For compensation arrangements not covered by one of the three existing exceptions, physicians would “stand in the shoes” even if the arrangements met other exceptions.

In addition, the “stand in the shoes” provision would not apply to many arrangements between physician organizations and academic medical centers (AMC). However, CMS has noted that if all of the requirements of the existing exception for services provided to an AMC are not met, physicians would “stand in the shoes” of their physician organization unless they also met one of the three exceptions referred to above. Under the CMS proposal, the provision would not apply in cases where compensation is paid by a component of an AMC to an affiliated physician organization for services required to meet the AMC’s obligations under the Medicare graduate medical education rules.

CMS has also indicated that instead of making changes to the “stand in the shoes” provision, it is considering the development of a new exception that would cover non abusive arrangements between physician organizations, AMCs, and nonprofit integrated health systems.

The self-referral proposal would also:

- Revise the definitions of “physician” and “physician organization”
- Clarify the period of time for which a physician would be prohibited from referring Medicare patients to an entity for designated health services, and for which the entity would be prohibited from billing for such services if a financial relationship

between the physician and the entity failed to satisfy the requirements of an exception to the prohibition on physician self-referral

- Solicit public comments on gain-sharing arrangements and physician-owned implant companies regarding the extent to which such arrangements pose a risk for program abuse
- Solicit comments on a mandatory Disclosure of Financial Relationships Report to collect information about financial relationships between hospitals and physicians
- Expand the existing hospital condition of participation to require disclosure of hospital ownership interests held by physicians and their relatives

Additional information is available at: http://www.cms.hhs.gov/apps/media/fact_sheets.asp then click the April 14, 2008 links for the fact sheets.

On April 21, CMS proposed a rule to improve the accuracy of payments for Medicare services in inpatient rehabilitation facilities (IRFs). Due to statutory requirements in the Medicare, Medicaid, and SCHIP Extension Act of 2007, the proposal indicates that CMS will apply a zero percent increase factor for fiscal 2009 Medicare payment rates. The agency also indicates that the proposal will improve the accuracy of payment by recalculating the rates using more recent information from rehabilitation hospitals about the costs they have incurred in treating patients.

The rule implements previous temporary policies for 2009 by requiring that only 60 percent (instead of 75 percent) of a facility's patient population have 1 of 13 specified qualifying conditions, and by allowing facilities to count patients whose principal reason for needing treatment is not one of the specified conditions, but is complicated by one of these conditions as a secondary diagnosis.

CMS will also update relative weights, revise the cost outlier threshold to \$9,191 from \$7,362 in fiscal 2008, and continue to use the pre-reclassified and pre-floor hospital wage indexes.

The proposed rule is at <http://www.cms.hhs.gov/InpatientRehabFacPPS/LIRFF/itemdetail.asp?itemID=CMS1209922>

Inpatient Psychiatric Facility (IPF) Reimbursement. The May 7 Federal Register contains a notice announcing that beginning July 1, 2008, the IPF Medicare federal per diem rate will increase from \$614.99 to \$637.78. On the same date, the transition date for certain IPFs will end and all facilities will, therefore, receive 100 percent of IPF PPS payments in the 2009 rate year. Additional information is at: <http://www.cms.hhs.gov/InpatientPsychFacPPS/Downloads/CMS-1401-Ndisplay.pdf>

Skilled Nursing Facilities (SNF) Reimbursement. On May 1, CMS issued a proposed PPS rule that would reduce SNF fiscal 2009 payments by a total of \$770 million, or 3.3 percent. This decrease, however, would be offset largely by a proposed 3.1 percent change in the market basket of goods and services, which would yield total additional payments of about \$710 million, and after considering the proposed recalibration of the case-mix index, total SNF payments are expected to decrease by about 0.3 percent in fiscal 2009.

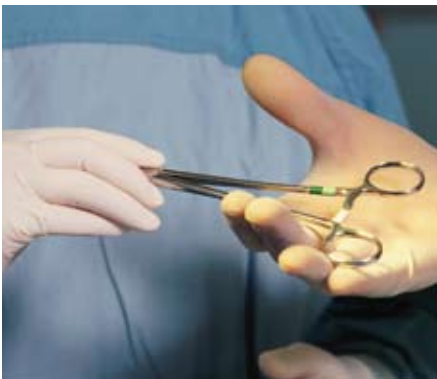


More information is available at: <http://www.cms.hhs.gov/center/snf.asp>.

Long-term Care Hospital (LTCH) Reimbursement. On May 2, the agency issued a final rule for the 2009 rate year that increases the federal standard rate by 2.7 percent from the 2008 rate established by the Medicare, Medicaid, and the SCHIP Extension Act of 2007 (MMSEA). The final standard rate of \$39,114.36 will be applicable to discharges during the 15-month period beginning July 1, 2008 through September 30, 2009. More information is available at: http://www.cms.gov/LongTermCareHospitalPPS/01_overview.asp.

In addition, on May 1, a final interim rule was issued that implements changes to the long-term care hospital PPS required by the MMSEA. This interim final rule is effective this June 5 and delays for three years the application of an option for determining payments for short-stay outlier cases at long-term care hospitals. CMS also indicated that it will address in forthcoming rules implementing MMSEA requirements that pertain to restrictions on the percentage of LTCH admissions from other facilities and a Congressional mandate for a three-year moratorium on the construction of new and expansion of existing LTCHs.

Medicare Advantage. The growth percentage used to calculate payments to private insurance plans will increase by an average 4.24 percent in 2009 versus the preliminary estimate of 4.8 percent. More information may be obtained at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#topOfPage>.



MedPAC Advisories

Earlier this year, MedPAC released its report to Congress entitled Medicare Payment Policy in which it concluded that Congress and CMS need to make changes across a broad front to increase quality, slow the growth in Medicare spending, and address the program's long-term viability. The report focused on policy recommendations that create incentives for greater program efficiency, reward quality, and modify payment rates to private plans and providers to ensure accuracy and equity.

For 2009, MedPAC recommends:

- Updates equal to the hospital market basket for inpatient and outpatient services, implemented concurrently with a quality incentive program
- Part of the funding for the incentive program to come from reducing indirect medical education payments by one point to 4.5 percent per 10 percent increment in the resident-to-bed ratio
- An update equal to the increase in input prices less MedPAC's adjustment for productivity growth for the physician fee schedule
- No payment increases for skilled nursing facilities (SNFs), home health agencies (HHAs), and IRFs
- An update for outpatient dialysis services equal to the projected change in input prices less the Commission's productivity growth adjustment

- A pilot program to test the feasibility of issuing single payments for episodes of treatment that would be shared by the hospital and the doctors delivering care, as mentioned in Secretary Leavitt's comments above

At its early April meeting, the Commission recommended that Congress establish a "medical home pilot project" with participants meeting stringent criteria to:

- Furnish primary care, including coordinating appropriate preventive, maintenance, and acute health services
- Use health information technology for active clinical decision support
- Conduct care management
- Maintain 24-hour patient communication and rapid access
- Keep up-to-date records of patients' advance directives
- Have a formal quality improvement program
- Maintain a written understanding with beneficiaries designating the provider as a medical home
- Have a physician pay-for-performance program

More information regarding the Commission's activities can be found at: <http://www.medpac.gov>.

The Hill

The 2009 Budget. As we prepare this update for you, House of Representatives Budget Chairman John Spratt (D-S.C.) is working with his Senate counterpart, Senator Kent Conrad (D-N.D.), to reach an agreement on a 2009 budget that could be approved by Congress before Memorial Day. In this legislatively-compressed election year, the window of opportunity for such an agreement is rapidly closing.

False Claims Act. The False Claims Correction Act of 2007 was approved by the Senate Judiciary committee in early April. Among its provisions, the Act would:

- Make it easier for whistleblowers to collect money from contractors who defraud the government
- Require government employees to report fraud first to their supervisors
- Prohibit lawsuits based on public information or on the results of investigations by the media or the GAO
- Scuttle a U.S. Supreme Court stipulation that only claimants who originate fraud charges can recover money
- Clarify that government employees may act as whistleblowers once they have reported fraud up the chain of command



S. 1200: Indian Health Care Improvement Act Amendments of 2007. The Senate has approved S. 1200 that, among its fraud provisions, would double the civil fines and, in some cases, quadruple criminal fines. Criminal fines could be as high as \$100,000 per fraudulent Medicare claim compared to \$25,000 in current law. Felony jail time for Medicare fraud and for false statements and felonies related to violations of the anti-kickback statute would increase from 5 years to 10 years. Durable medical equipment (DME) supplier surety bonds would also increase.

Medicaid Changes. In late April, the House passed H.R. 5613: *Protecting the Medicaid Safety Net Act of 2008*, by a veto-proof margin of 349-62. The bill would block seven rules proposed by the Bush Administration designed to curb fraud and abuse and, thereby, cut back on Medicaid payments to the states. The proposed rules would reduce or prohibit Medicaid reimbursements for students at teaching hospitals; narrow Medicaid coverage for outpatient hospital services, rehabilitation hospitals, school-based administrative and transportation services, and case management services; and restrict how states raise funds for Medicaid. The White House has threatened to veto the legislation in the past and reiterated its threat in late April. While House leaders have a veto-proof margin, the recent opposition to the House bill expressed by Republican Senator Grassley and others could muddle the likelihood of a legislative solution anytime soon.

Medicare Physician Payments. CMS has said that unless Congress intervenes, Medicare's physician payments would decrease by 10.6 percent beginning July 1 and by another 5.4 percent in 2009. Senate Finance Committee Chairman Baucus has said that he wants legislation erasing these scheduled cuts to come before the Senate by May. Senate aides have indicated that the favored option at this time is to provide a pay increase in the second half of calendar 2008 through calendar 2009, and then allow a 20 percent decrease in 2010 to keep the cost down. In our opinion, it is too early to predict a cut of that size materializing in 2010. So, for now, stay tuned.

Mental Health Parity Legislation. The House and Senate continue to look for a compromise in their respective versions of mental health parity legislation (H.R. 1424 and S. 558). At this time, both the House and Senate bills would require health plans offering mental health coverage to provide the same benefits for mental illness that they do for other medical conditions and would exempt employers with fewer than 50 employees from the legislation. But other matters need to be resolved, such as the House version contains language that would require employers to cover all illnesses listed in the Diagnostic and Statistical Manual of Mental Health Disorders.

Tax-exempt bonds. H.R. 5720: *Housing Assistance Tax Act of 2008*, has been approved by the House Ways & Means Committee. This legislation, among other things, would allow Federal Home Loan Banks to issue letters of credit for tax-exempt hospital bonds.

Pharmaceutical Industry Matters

- Democrat Representatives Dingell, Pallone, and Stupak have released draft legislation entitled the *FDA Globalization Act of 2008* that would improve the safety

of imported drugs, medical devices, food, and cosmetics by creating a registry of manufacturers and by requiring more frequent inspections by the FDA. Under its provisions, it would allow the FDA to issue fines for violations of drug safety requirements. It would extend current FDA authority to recall dangerous medical devices and to detain unsafe medical devices discovered during inspections to also include drugs. The Act would also allow the FDA to destroy counterfeit or adulterated commercial imports. Drug labels would be required to include the source of the active pharmaceutical ingredient and its place of manufacture while medical devices would also need to indicate the country of manufacture.

- **A Drug Tracking bill (H.R. 5839: *To amend the Federal Food, Drug, and Cosmetic Act to improve the safety of drugs*)** has been introduced in the House by Democrat Matheson and Republican Buyer. It would establish a tracking system for prescription drugs sold in the United States. Democrat Schumer will introduce a similar bill in the Senate.
- **Disclosure of Financial Contributions.** In mid-April, Senator Grassley released letters from 15 drug and device companies indicating that they will disclose their financial contributions to continuing education. Senator Grassley said that he does not plan to pursue disclosure legislation separate from S. 2029—the Physician Payment Sunshine Act—that he and Senator Kohl introduced last year. S. 2029 would require manufacturers of devices, drugs, and biologics to disclose the gifts, honoraria, travel, and other payments that they make to physicians. The senator also indicated that he will carefully monitor implementation plans described in the letters and consider alternatives, including legislation, if transparency is not achieved. The letters are available at <http://finance.senate.gov/press/Gpress/2008/prg041108z.pdf>.
- Representative John Dingell (D-MI), Chairman of the House Committee on Energy and Commerce, has been critical lately of the FDA's failure to inspect foreign drug manufacturers. During a meeting of the Subcommittee on Oversight and Investigations, April 22, Rep. Dingell said, "Today, we again explore whether FDA is adequately able to protect American citizens from the unscrupulous or incompetent foreign manufacture of pharmaceutical products. Given the findings of this Subcommittee and the recent disturbing events surrounding tainted heparin, I believe FDA is not up to the task, as it cannot or will not undertake reforms needed to protect Americans from this threat from abroad. At least 80 percent of all active pharmaceutical ingredients are imported, much of it from countries lacking competent regulatory systems such as China and India."

"When it comes to the drug and device industry, the stakes are high for both public safety and the public purse. Making information about financial relationships open to scrutiny is the right thing to do. More transparency can do a lot to build confidence in the system and bring greater accountability."

Senator Charles Grassley



Joe Barton (R-TX), ranking Republican member of the Subcommittee, also said, "The agency needs congressional approval to clarify its jurisdiction to thwart criminal conduct outside the United States that threatens the health and safety of the United States population. Again, that's something I hope we can give the FDA later this year. The FDA needs an inspection program with many, many more full-time inspectors overseas and with the availability to go into these foreign plants and conduct the inspections in overseas plants like they're allowed to conduct the inspections in domestic plants.

Foreign inspections are unfortunately the neglected stepchild of the FDA's drug inspection program and that simply cannot continue."

Among his comments, FDA Commissioner von Eschenbach responded by saying, "FDA must make radical and rapid changes. I have consistently endorsed the fact that this would require additional resources. Globalization, increased product complexity, and other market developments are placing tremendous strains on our import system. We must ensure that quality is built into these products at the source of production and hold all parties accountable."

Other Pharmaceutical Matters

- **FDA Overseas Presence.** In mid-March, the FDA announced that it had received approval from the State Department to establish eight full-time FDA positions at U.S. diplomatic posts in China, pending approval from the Chinese government. The agency plans to hire and place the eight FDA staff in China and also hire five local Chinese nationals by the fall of 2009. More information on FDA international programs may be found at <http://www.fda.gov/oia/overview.html>.
- **In February, the FDA issued draft guidance on "Good Reprint Practices" for the distribution of medical or scientific journal articles and other references that involve unapproved uses of FDA-approved drugs and medical devices.** Some of its principles include ensuring that the article or reference be published by an organization that has an editorial board; that the organization fully disclose any conflicts of interest or biases for all authors, contributors, or editors associated with the journal article; and that articles should be peer-reviewed and published in accordance with specific procedures. In addition, the guidance recommends against distributing special supplements or publications that have been funded by one or more of the manufacturers of the product in the article, or are not supported by credible medical evidence and may be considered false and misleading.

New IRS Form 990

The April 2008 edition of the Healthcare Financial Management Association's magazine *hfm* contains an article entitled "**the new form 990: taking a closer look**" by **Richard A. Spiezman, KPMG LLP partner in charge of the firm's Exempt Organization Tax practice based in Washington, DC.** In the summary,

Rick indicates that the revised Form 990 will allow the IRS to better assess the risk presented by not-for-profit organizations. The form will allow for increased transparency and accountability, and ultimately, the information collected on Form 990 may influence important tax policy changes. He goes on to write that healthcare organizations should keep the varied purposes of the form in mind when making resource allocation and other decisions involving tax compliance.

Rick also notes that for most tax-exempt hospitals and other healthcare providers, the new form will result in increased complexity and administrative burden, particularly once it is fully implemented. Form 990 filers should begin now to develop a plan to ensure that they are able to collect and provide the information required in a manner that puts the organization in the best possible light. In particular, organizations should consider the following actions:

- Educate relevant members of staff, management, and the board about the new requirements
- Establish a task force with representatives from relevant parts of the organization, e.g., finance, legal, human resources, appropriate outside advisers, to evaluate the new form and to identify shortcomings in the organization's ability to comply with its requirements
- Determine whether the organization should adopt changes in its policies and procedures in response to the policy and procedure questions on the form, including those for which there is no relevant tax law requirement, and to which the organization cannot currently provide the "correct" answer as likely viewed by the government, the general public, and other interested parties
- Determine whether the organization has the personnel and systems in place to provide the new information required by the form, and make corrections or add resources as necessary



- Consider the extent to which the Form 990 should be reviewed by upper management and the board before it is filed

Among his closing comments, Rick observes that, "The next shoe to drop may be a change in the IRS's position on the requirements for tax-exempt status. Alternatively, there could be a legislative 'solution.' Perhaps it would be appropriate to add to the rationales for changing Form 990... that this is partially an exercise in determining whether the tax law standards should be changed. This is yet another thought to bear in mind when pondering the consequences of the new Form 990."

If you would like more information regarding the new IRS Form 990 or would like to subscribe to *KPMG's TaxNewsFlash-Exempt Organizations* (electronic newsletter), please contact Rick Speizman at rspeizma@kpmg.com.

The *hfm* article can be accessed at http://www.hfma.org/hfm/2008archives/month04/feature_990.htm

End Points

- Four former Senate Majority Leaders, Republicans Howard Baker and Robert Dole and Democrats Tom Daschle and George Mitchell, have launched the Bipartisan Policy Center's Leaders' Project on the State of American Healthcare. The project will host four forums during 2008 and 2009 on (1) preserving and improving the quality and value of care; (2) providing affordable, accessible coverage choices in a reformed insurance market; (3) ensuring and promoting a strong individual role in healthcare coverage and costs; and (4) securing a workable financing mechanism for healthcare. The expectation is that the project will ultimately produce politically viable policy recommendations in each of these four areas.
- An Institute of Medicine report, *Retooling for an Aging America: Building the Health Care Workforce*, concludes that without improved training and better pay for providers of geriatric care, the health system will be ill-equipped to care for the nation's baby boomers. For more information, please go to <http://www.iom.edu/agingamerica>.
- A study by HealthGrades, Inc. indicates that medical errors cost the Medicare program \$8.8 billion from 2004 to 2006 and have resulted in 238,337 potentially preventable deaths. The study is available at <http://www.healthgrades.com>.
- The Dartmouth Atlas of Health Care (<http://www.dartmouthatlas.org/>) reports that Medicare could save tens of billions of dollars annually if the U.S. healthcare system were focused on increasing care coordination for chronically ill patients and curbing overuse of acute care hospitals.
- According to the Federation of State Medical Boards' Summary of 2007 Board Actions, the number of disciplinary actions taken against physicians by state medical boards fell for the second straight year to 5,319 in 2007 compared to 5,574 in 2006 (http://www.fsmb.org/pdf/2007_SummarBoardActions.pdf).

"Yes, we have to divide up our time like that, between our politics and our equations. But to me our equations are far more important, for politics are only a matter of present concern. A mathematical equation stands forever."

Albert Einstein



For more information, please contact:

Ed Giniat
National Line of Business 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
National 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 partner from KPMG's Healthcare practice.



The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation.

© 2008 KPMG LLP, a U.S. limited liability partnership and a member firm of the KPMG network of independent member firms affiliated with KPMG International, a Swiss cooperative. All rights reserved. Printed in the U.S.A. 19431NSS

KPMG and the KPMG logo are registered trademarks of KPMG International, a Swiss cooperative.