



GOVERNMENT

# Emerging High-Risk Areas in Government

KPMG LLP

2010 NASACT Annual Conference

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8/9/2010

AUDIT • TAX • ADVISORY

## Agenda

- ◆ KPMG Perspectives on Healthcare Reform
- ◆ Healthcare Reform Impact on States
- ◆ Wall Street Reform and Consumer Protection Act



# KPMG Perspectives on Healthcare Reform

## KPMG's Perspectives on Healthcare Reform

- ◆ **When implemented, the new healthcare reform laws will represent the most significant changes to the delivery and financing of healthcare since the inception of Medicare in 1965.**
- ◆ **These are extremely complex laws that will evolve further over the next decade as rules, technical corrections, and operational details are defined and public policies refined.**
- ◆ **Reform is accelerating the transformation of the U.S. healthcare system. The first regulations following from the new laws are to be issued in 2010.**
- ◆ **Leading proponents of the new laws expect there to be additional changes over time.**
- ◆ **The new laws begin a comprehensive journey towards the common goals of universal access/coverage, better cost management, and better quality outcomes.**

# KPMG's Perspectives on Healthcare Reform (continued)

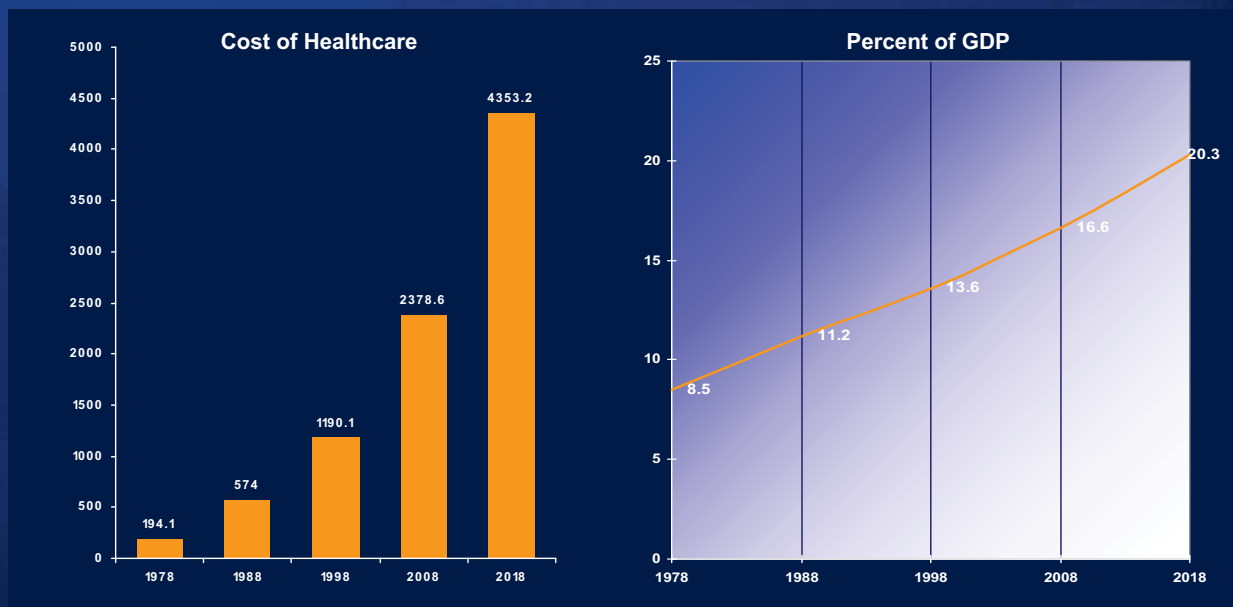
- ◆ The new laws will affect not only the healthcare “ecosystem” but also virtually all companies, all state governments, and all Americans.
- ◆ Analyzing and operationalizing key provisions are critical.
- ◆ Leading companies are reassessing their benefits strategies now:
  - Assessing the potential impacts of reform legislation on their human capital management, e.g. retirement, succession planning, payroll, budgeting, etc
  - Evaluating options to provide for the healthcare of their workforce and to offer competitive salary/benefits packages now and into the future
  - Pressing healthcare insurance providers to proactively discuss their own plans for the future
  - Planning to ensure compliance with the regulations that will be issued
  - Recognizing new options for their consideration are likely to emerge over time



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## Growth in U.S. Healthcare Spending and Percentage of Gross Domestic Product



(Source: Centers for Medicare & Medicaid Services “National Health Expenditures Historical and Projections 1965–2018,” on the Web at [http://www.cms.hhs.gov/NationalHealthExpendData/03\\_NationalHealthAccountsProjected.asp#TopOfPage](http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp#TopOfPage))



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# Healthcare Reform – Major New Laws But Not the Last Words

- ◆ **The Patient Protection and Affordable Care Act (PPACA) is now Public Law 111-148.**
- ◆ **The Health Care and Education Reconciliation Act of 2010 (HCERA), which made significant policy and taxation adjustments to PPACA, is now Public Law 111-152.**
- ◆ **Some of Washington’s leading insider magazines have suggested operational and political challenges as the laws take effect:**
  - **“And now for the real health care battle: coordinating states, federal agencies and providers to implement the new law’s sweeping provisions. The clock is ticking.”**

*Source: (CQ Weekly, April 5, 2010; page 814)*



# Healthcare Reform Focuses on Access/Coverage, Cost, and Quality

- ◆ **32 million more American citizens and legal residents are projected to have insurance coverage over 10 years; 94 percent of all legal residents by 2019.**
- ◆ **The net reduction in the federal deficit is projected to be \$143 B over the period 2010–2019.**
- ◆ **The cost, estimated at \$938 B, will be paid largely by the healthcare ecosystem (health insurance, hospitals and other facilities, pharmaceutical and medical device companies) and by taxes on higher-income individuals.**
- ◆ **Healthcare reform contains various provisions for testing changes in the way that healthcare is paid, how it is delivered, and what therapies and practices are more effective.**
- ◆ **Given the scope of the legislation, reform has the potential to impact virtually all companies, all state governments, and all Americans.**



# Sources and Uses of Funds

Health Insurance Coverage (1)		
2010	83%	50 million nonelderly uninsured
2014	91%	31 million
2019	94%	23 million

(1) Source: Congressional Budget Office and the staff of the Joint Committee on Taxation – Table 4. Estimated effects of the Insurance coverage provisions of the reconciliation proposal combined with H.R. 3590 as passed by the Senate (and now the House). Coverage percentages excludes unauthorized immigrants. Number of people without insurance includes unauthorized immigrants.

Sources (3)	
Medicare Tax	\$210B
Market Basket Updates	157B
Medicare Advantage	136B
Pharma & Med. Devices and Insurance Companies Fees and Excise Taxes	107B
Individual/Employer Mandate & Cadillac Excise Tax	150B
Home Health	40B
Medicare Prescription Drug Coverage	38B
Medicare and Medicaid DSH	36B
Other	64B
<b>Total</b>	<b>\$938B</b>

Uses (2)	
Medicaid and CHIP	\$434B
Exchange Subsidies	464B
Small Employer Tax Credits	40B
<b>Total</b>	<b>\$938B</b>

(2) Same as note 1 above.

(3) Source: Congressional Budget Office and the staff of the Joint Committee on Taxation – Table 5. Estimate of the effects of noncoverage health provisions of the reconciliation proposal combined with H.R. 3590 as passed by the Senate (and now the House) and Table 2. Estimate of changes in direct spending and revenue effects of the reconciliation proposal combined with H.R. 3590 as passed by the Senate (and now the House).



## Healthcare Reform Impact on States

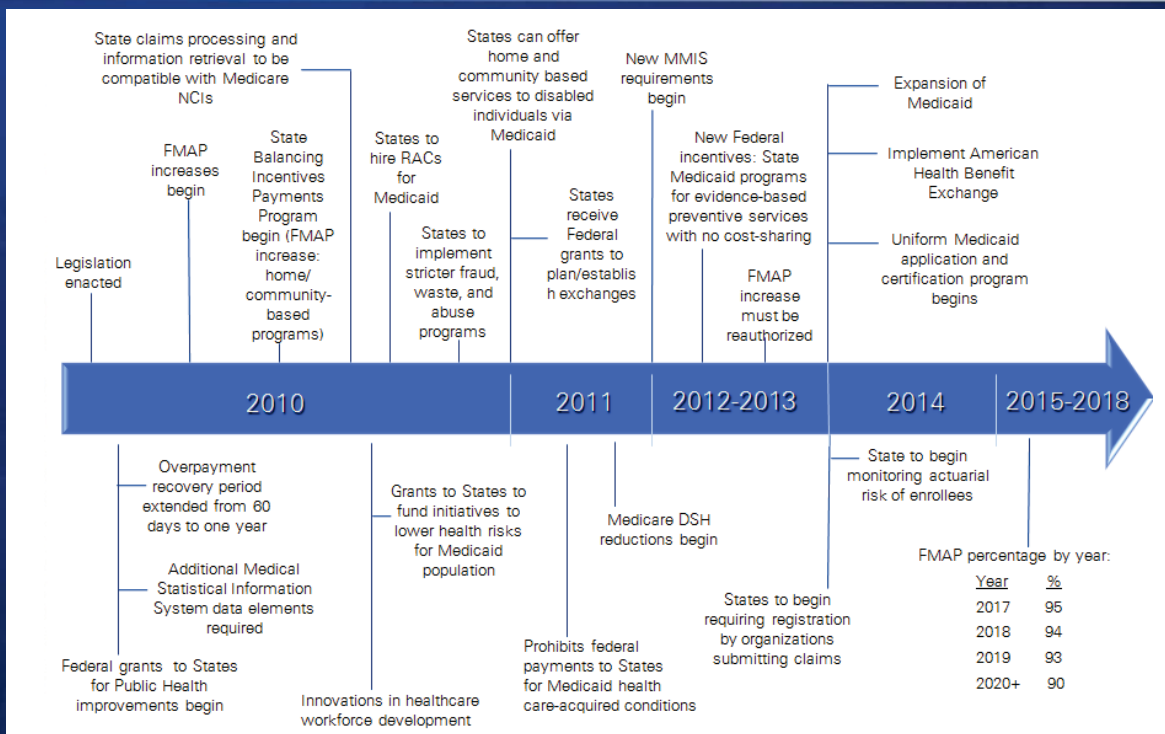
# Thirty Impacts on States

- ◆ Expansion of Medicaid Eligibility Criteria
- ◆ Expanding Medicaid Benefits
- ◆ Changes in Medicaid Eligibility Determination
- ◆ Extension of ARRA Requirements
- ◆ Creation of Temporary High Risk Pools
- ◆ American Health Benefit Exchanges
- ◆ Changes to FMAP/DSH
- ◆ Creation of New Prevention Programs
- ◆ Bundling of Services
- ◆ Accountable Care Organizations (ACOs)
- ◆ Changes to Pharmaceutical Rebate
- ◆ Changes in Higher Education Funding
- ◆ Creation of Workforce Development Initiatives
- ◆ Changes in Student Loan Delivery
- ◆ Changes to MMIS Requirements
- ◆ Public Health
- ◆ Requirements for a Uniform Application for Medicaid/Cross Certification
- ◆ Changes in CHIP
- ◆ Reporting Requirements
- ◆ Study Mandates
- ◆ Audit Requirements
- ◆ Taxes/Revenue Provisions
- ◆ Waivers for Dual Eligibility
- ◆ Expansion of Recovery Audit Contractor (RAC) Program
- ◆ Grant Programs
- ◆ New State Oversight Responsibilities
- ◆ Accountability and Transparency
- ◆ Creation of a CMS Innovation Center
- ◆ Changing Enrollment for Providers
- ◆ Definition of Qualified Health Plans



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# HC Reform Time Line: A Marathon Implementation



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# Five Major Areas for States to Consider

- ◆ Medicaid Expansion
- ◆ Insurance Exchanges, High-Risk Pools, and other Regulatory Changes
- ◆ Health IT
- ◆ Accountability
- ◆ Grants



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# Medicaid Expansion

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# Medicaid Expanded Eligibility

## *How does the ACA affect Medicaid?*

### The Patient Protection and Affordable Care Act (ACA) changes Medicaid in primary ways:

- Mandates changes and standardization to the Medicaid application and eligibility determination process
  - *Goal: Ensure that all applicants are evaluated consistently from state to state*
- ◆ **Expands Medicaid Benchmark benefits**
  - *Goal: Ensure that all recipients receive the same standard of care necessary for treatment and prevention*
- ◆ **Expands Eligibility for Medicaid**
  - *Goal: Make healthcare more accessible and reduce the number of Americans without access to healthcare*



# Medicaid Expanded Eligibility

## *Eligibility Expansion Explained*

- Requires all states to extend coverage to childless adults under the age of 65 with incomes at or below 133 percent of Federal Poverty Level (FPL) or \$14,404 currently
- Provides states the option of providing coverage for adults beyond 133 percent of the FPL
- Requires all states to provide coverage to foster children up to age 26
- Requires a state to use modified gross income as the basis for income and eliminates disregards and asset tests
- Requires a state to terminate individuals or providers from their Medicaid program if they were terminated from Medicare or another state's Medicaid program
- Requires Medicaid agencies to exclude individuals or entities who own or manage an entity that has failed to repay overpayments or has been terminated from a Medicaid program

***Net effect is 17–20 million new recipients***



# Medicaid Expanded Eligibility Time Lines

## 2010

- Current eligibility levels, procedures and methodologies are frozen until December 3, 2013.
- States will be able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available. This will make it easier for states that choose to do so to cover more of their residents. Effective April 1, 2010.

## 2014

- The beginning of expanded eligibility—the federal government pays 100 percent of costs for newly eligible recipients.

## 2015

- The federal government pays 100 percent of costs for newly eligible recipients.

## 2016

- The federal government pays 100 percent of costs for newly eligible recipients.

## 2017–20

- The federal government's matching funds phase down to 90 percent.



# *Health Insurance Exchanges, High-Risk Pools, and Other Regulatory Changes*

# Insurance Exchanges – Requirements

- ◆ **Entity established by the state**
  - Can be existing government agency, new authority, or non-profit
- ◆ **Must be operational by January 1, 2014**
  - Demonstrate capability by January 2013 or HHS can take over operations
- ◆ **Many required functions with elective options**
  - Rules are still being written, but a lot is already known



# Insurance Exchanges – Requirements

- ◆ **Provide subsidized coverage for all families below 400% of federal poverty level**
- ◆ **Serve individuals and small businesses**
  - Choice exists to combine both into single exchange
- ◆ **Establish Small Business Health Option Programs**
  - Facilitates small business purchase of insurance
- ◆ **Certify and offer only “Qualified” health plans**
  - According to federal certification guidelines TBD
- ◆ **Offer “multistate” plans starting in 2016**
  - Regulated primarily by one state, but required to meet consumer protections of all participating states and certain federal plan standards
- ◆ **Submit report to the federal government annually**
  - Accounting of activities, revenues, and expenditures
- ◆ **Coordinate enrollment with Medicaid Program to improve efficiency and continuity of care**
- ◆ **Accept employer “Free Choice” vouchers towards premium payment**
  - allows low income (<400% FPL) employees to use employer contribution towards any qualified exchange plan



# Insurance Exchanges -- State Planning & Establishment Grants

- ◆ Applications due September 1<sup>st</sup> / Award date September 30<sup>th</sup>
- ◆ Application requirements
  - Project Narrative addressing nine project attributes:
    - Background Research
    - Stakeholder Involvement
    - Program Integration
    - Resources and Capabilities
    - Governance
    - Finance
    - Technical Infrastructure
    - Business Operations
    - Regulatory or Policy Actions
  - Timeline
  - Budget (\$1M maximum)
  - Online application process
  - Governor letter of support endorsing application and proposed planning activities

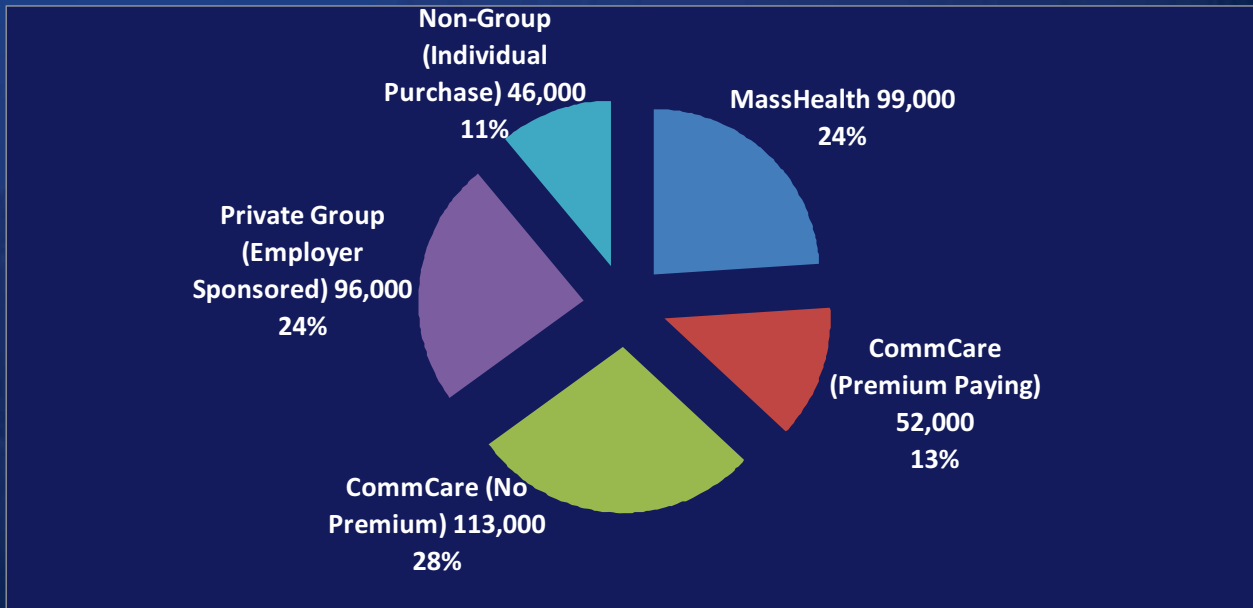


## What does an Exchange look like – The Massachusetts Health Connector Example

- ◆ Over 400,000 newly insured
- ◆ State's uninsured reduced to 2.7%
- ◆ Thirty-five percent of newly insured are private pay
- ◆ No sign of private insurance crowd out
  - employer plans increased from 69% to 72% versus national reduction
- ◆ Public surveys indicate strong support from public and physicians
- ◆ Health safety net users decline by 36% in first 6 months
- ◆ Coverage includes:
  - Completely subsidize health insurance to adults earning up to 150% of federal poverty level
  - Substantial premium subsidy for adults between 150% and 300% of the federal poverty level
- ◆ Combined non-group and small group health insurance markets to lower the price and offer more choices



# Massachusetts Health Connector – 406,000 Newly Insured June 2006- March 31, 2009



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## Massachusetts Health Connector -- Structure & Governance

- ◆ **Set up Independent Public Authority**
  - = Governor appoints Executive Director who builds team
  - = 10 Member Board of Directors
    - Comprised of State A&F Secretary, Insurance Commissioner, Medicaid Director, and Business, Medical, and Academic representatives
- ◆ **Initial investment by state of \$25M**
  - = Startup funds to get off the ground, operations were soon self-funded
- ◆ **Snapshot of annual sources and uses**

Sources	
State Capitation	\$724M
Enrollees Contribution	41M
Administrative Fees	35M
<b>Total</b>	<b>\$800M</b>

Uses	
Vendors	26M
Employees	3M
Payments to MMCOs	771M
<b>Total</b>	<b>\$800M</b>



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# Massachusetts Health Connector -- Lessons Learned

- ◆ **Strategic Planning**
  - Define exchange strategy early in process
  - Open MMCO model or competitive bids for right to get market share
  - Define operations insource/outsource approach and model
- ◆ **Enrollment**
  - Highly mobile and variable population
  - Frequent eligibility and enrollment changes creates administrative burden
  - Membership outreach can reduce administrative burdens
- ◆ **System and Processes**
  - Leave sufficient time for requirements definition and vendor contracting
  - Business-process focused SLAs are critical
  - Dedicated call center operations team most effective
- ◆ **Working with MMCOs** – contract & benefit design shapes exchange
  - Requiring consistent benefit package allows real comparison shopping
  - Capitation model allows for population and experience weighting



## High-Risk Pools

- ◆ **Programs designed to cover individuals with pre-existing conditions who are unable to purchase coverage on their own**
- ◆ **According to the National Council of State Legislatures, thirty-five states have operated their own high-risk health insurance pools over the past three decades.**
- ◆ **Approximately 200,000 individuals are insured through those pools**
- ◆ **Federal health reform of 2010 establishes an interim high risk pool program to bridge gap between enactment of legislation and 2014**
- ◆ **As of July 6:**
  - 29 states and D.C. have selected to run the program themselves or designate a "HIPAA insurance carrier" to run the program.
  - 21 states have deferred to the federal government to run the new programs - federally funded programs have been renamed Pre-existing Condition Insurance Plan (PCIP).



## High-Risk Pools ( continued)

### ◆ Beginning July 1 the legislation:

- Provides immediate access to insurance for Americans who are uninsured because of a pre-existing condition
- Establishes a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions
- Provides \$5 billion among all 50 states, for expanded programs run by states or by a designated insurer if states choose those options; or states may defer to federal government
- Disallows states to reduce their current high risk pool efforts



## Health Insurance Premium Review Grants

- ◆ In June, \$51 million in Health Insurance Premium Review Grants was made available through the ACA.
- ◆ These funds are the first round of grants available to states through a new \$250 million grant program to create and strengthen insurance rate review processes.
- ◆ States must submit a plan for how it will use grant funds to develop or enhance its process of reviewing and approving, disapproving, or modifying health insurance premium requests.
- ◆ The Health Insurance Premium Review Grants that will be available during FY 2010 are only the first in a five-year grant program.
- ◆ HHS will take applications for a second round of state grants beginning in Fiscal Year 2011, after new regulations regarding rate review take effect.
- ◆ Second-round grants will allow states to further strengthen their rate review, and begin to provide the Secretary of HHS with the rate data required under the law.



# *Health Information Exchange*

## **Health Information Exchange (HIE)** *What Role Does HIE Play in Healthcare Reform?*

### ◆ **Immediate Drivers—\$\$:**

- HIE enables providers to meet key requirements related to meaningful use
- Enables providers to capture incentive payments and avoid penalties
- Through ARRA, states are offered partial funding to implement HIE

### ◆ **Long-term Drivers – serving the public:**

- Improved Outcomes:
  - Better, more timely clinical data
  - Patient interventions
  - Comparative research
- Improved Quality:
  - Reduced errors based on better data
- Lower Costs:
  - Increased efficiency in processes (accessing data, reduced errors, fewer duplicate procedures)
  - Comparative research (clinical analysis, provider analysis, payer analysis)

# Health Information Exchange (HIE)

## What is an HIE? Enables Sharing Electronic Health Records



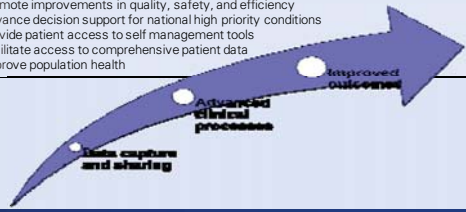
- Includes patient demographic and clinical health information such as medical history, prescriptions lists, and problem lists
- EHR has the capacity:
  - to provide clinical decision support;
  - support physical order entry;
  - to capture and query information relevant to health care quality; and
  - to exchange electronic health information with, and integrate such information from other sources



- EHR Technology** conveys an expectation that rather than adopt a complete, all-in-one solution, providers likely may adopt some number of technological components or EHR Modules
- Certified EHR Technology** Means a **Complete EHR** or a combination of **EHR Modules**, each of which:
  - Meets requirement included in definition of **Qualified EHR**; and
  - Has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary of HHS

- Health Information Exchanges enable the sharing of Electronic Health Records between providers and other entities.
- This exchange requires complex infrastructures and software.

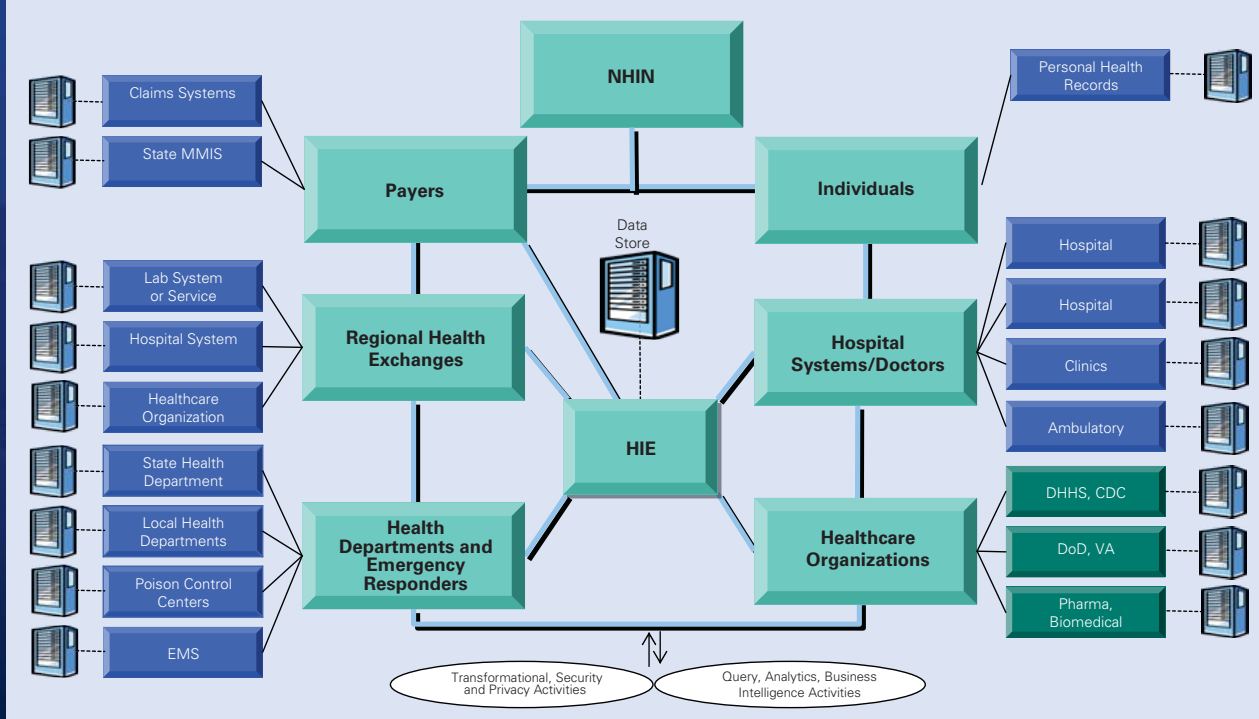
Stage	Focus
Stage 1 - Starting in 2011	<b>Capture Information</b> – capture electronic health information in a coded format, track key clinical conditions; communicate about care needs (including provider and patient communication); facilitate disease and medication management, implement clinical decision support tools, and report key quality and public health information.
Stage 2 - Starting in 2013	<b>Expands on Stage 1, Improve the Care of Individual Patients</b> Use of HIT Exchange of information in the most structured format possible (e.g., electronic transmission of orders entered using CPOE and diagnostic test results) <b>Apply more Broadly to both the inpatient and outpatient hospital settings.</b>
Stage 3 - Starting in 2015	<ul style="list-style-type: none"> <li>Promote improvements in quality, safety, and efficiency</li> <li>Advance decision support for national high priority conditions</li> <li>Provide patient access to self management tools</li> <li>Facilitate access to comprehensive patient data</li> <li>Improve population health</li> </ul>



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# Health Information Exchange (HIE)

## What is an HIE? Sample Diagram



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# Health Information Exchange (HIE)

## What is an HIE? Stakeholders (PA Example)

Stakeholder Group	Numbers	Function
The Public	<ul style="list-style-type: none"> <li>• 12.5+ million residents</li> <li>• 2+ million Medicaid recipients</li> </ul>	<ul style="list-style-type: none"> <li>• Beneficiary of improved healthcare</li> <li>• Access and contribute to personal health records</li> </ul>
Providers	<ul style="list-style-type: none"> <li>• 50,000 doctors</li> <li>• 10,000 dentists</li> <li>• 4,000 chiropractors</li> <li>• 119,000 nurses</li> <li>• 20,000 pharmacists</li> <li>• 270 ambulatory surgery centers</li> <li>• 27 health systems</li> <li>• 255 hospitals</li> <li>• 700 nursing homes</li> <li>• 3,600 pharmacies</li> </ul>	<ul style="list-style-type: none"> <li>• Access a wide array of clinical data</li> <li>• Aid in decisions around health diagnoses</li> <li>• Assess health quality</li> <li>• Control costs</li> <li>• Meet meaningful use (MU) requirements</li> </ul>
Payers	Numerous	<ul style="list-style-type: none"> <li>• Support for claims adjudication</li> </ul>
The State	1+ ultimately, inter-state data will be shared	<ul style="list-style-type: none"> <li>• Public health</li> <li>• Medicaid management - Access to eligibility and claims data</li> </ul>
The Federal Government	1	<ul style="list-style-type: none"> <li>• Public health</li> <li>• Contain health costs</li> <li>• Clinical Intelligence dependent upon HIE</li> </ul>



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## Hot Topic: State Grant Opportunities

- ◆ **Multiple grants for states to establish and/or expand services**
  - = Health benefit exchanges by state
  - = Offices for health insurance consumer assistance
  - = Ombudsman programs
  - = Review of HHS data
  - = School-based health clinic/centers (SBHCs)
  - = Continuing educational support for health professionals serving in underserved communities
  - = Workforce development for health professions
  - = Health Homes for individuals with chronic conditions
  - = Programs for healthy lifestyles and early detection
  - = Early Childhood home visitation programs
  - = Pregnancy Assistance Fund



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# Hot Topic: State Grant Opportunities: Timing and Funding

- ◆ Most programs begin rolling out in 2010.
- ◆ Some programs continue through 2014 and 2019.
- ◆ Involve millions of federal dollars
  - In a few instances states are required to contribute an amount equal to the state Medicaid match for each fiscal year grant is awarded.
- ◆ All grants have requirements and reporting guidelines.



# Hot Topic: State Grant Opportunities: Timing and Funding

## State Grants Opportunities Analysis

	A	B	C	D
	Grant Program	Implementation Date	Funding	Summary
2	Health Insurance Consumer Information	FY 2010	\$30,000,000	Grant to fund the establishment, expansion, and or provision of support for: 1. Offices of health insurance consumer assistance 2. Health insurance ombudsman programs
3	Premium Review Grants	FY 2010	Each State grant will be between 1 and 5 Million dollars	Grants issues between 2010 through 2014 to assist states in carrying out the following: • reviewing and approving premium increases for health insurance coverage; • providing information and recommendations to HHS; and • establishing centers to analyze and organize information, and to make the information available to the issuers, health care providers, health researchers, health care policy makers, and the general public.
4	Assistance to States to Establish Health Benefit Exchanges	FY 2011	TBD each year	Funding for states to support planning activities relating to the establishment of an American Health Benefit Exchange. These exchanges must do the following: 1. Facilitate the purchase of health plans 2. Establish a Small Business Health Option Program
5	School-Based Health Clinic/Center Grants (SBHCs)	FY 2010	\$50,000,000 for FY 2010 through 2013	Establishment and operation of school-based health centers (SBHC)
6	Continuing Educational Support for Health Professionals Serving in Underserved Communities	FY 2010	\$5,000,000 for FY 2010 through 2014	Support activities to enhance education through distance learning, continuing educational activities, collaborative conferences, and electronic and tele-learning activities, with priority for primary care.
7	Demonstration Projects to Address Health Workforce Needs	FY 2011	\$85,000,000 for each FY 2010 through 2014	Demonstration project designed to provide low-income individuals with an opportunity to receive education and training for occupations in the health care field.
	State Option to Provide Health Homes			Planning grants for states choosing to participate in the new Medicaid state plan option promoting health homes for enrollees with chronic conditions. Term 'Health Homes' means a designated provider or a health team selected



# ***Monitoring, Compliance, Accountability***

## **Oversight and Accountability**

### **◆ Areas of expanded oversight requirements for states include:**

- Medicaid fraud, waste and abuse programs, which would include practices such as continuous auditing, using forensic and other payment analytic tools to prevent overpayments at the outset
- Expansion of Medicare Recovery Audit Contractor program to Medicaid
- Extension of time frame for State recovery of improper payments to one year
- New requirements for registration of organizations submitting Medicaid claims
- Requirement for States to screen Medicaid providers and suppliers based on fraud risk
- Reporting of additional Medicaid information to U.S. HHS for program integrity, oversight, and administration

## Oversight and Accountability (continued)

- ◆ **Additional expanded oversight requirements include:**
  - Requirement to terminate provider if terminated under Medicare or another state plan
  - Increased state/federal data sharing
  - Mandatory use of MMIS methodologies compatible with Medicare's national correct coding initiative
  - Prohibition of payments to financial institutions and entities outside of the United States
  - Timely reporting of "enrollee encounter data" to the state MMIS; failure to do so is grounds for withholding federal matching payments
  - Perform background checks on "direct patient access employees"
  - Monitoring and affirmation of "meaningful use" (under the HITECH Act)



## Oversight and Accountability (continued)

- ◆ **Begin planning now to meet increased oversight and reporting requirements**
- ◆ **Some key areas to focus planning include:**
  - How will the state obtain resources to meet increased responsibility for Bureau of Medicaid program integrity?
  - What will be the role of the recovery audit contractors and how will the state leverage this capability?
  - What will be the state's strategy for auditing HIT meaningful use?



# ***Wall Street Reform and Consumer Protection Act***

## **Wall Street Reform and Consumer Protection Act**

- ◆ **Two New Regulatory Bodies**
  - Financial Stability Oversight Council
    - Impact on Accounting Standards
  - Consumer Financial Protection Bureau
- ◆ **Municipal Securities**
  - MSRB
  - Credit Rating Agencies
- ◆ **GAO Studies**
  - Trading Practices
  - Disclosure Practices
- ◆ **Impact on GASB**
- ◆ **SOX 404(b) Exemption**
- ◆ **Executive Compensation**

# Wall Street Reform and Consumer Protection Act (continued)

## ◆ Also Known as the “Dodd-Frank Bill”

- Senator Christopher Dodd – D (CT), Senate Banking Committee Chairman
- Representative Barney Frank – D (Mass – 4th District), Chairman of the Financial Services Committee

## ◆ Legislative Process

- Cleared Congress upon Senate approval July 15
- Signed by President Obama July 21

## ◆ Considered by many the most important financial services legislation since 1933 and Glass–Steagall



# New Regulatory Body Financial Stability Oversight Council

## ◆ Financial Stability Oversight Council

### ◆ New systemic risk regulator

- Chaired by Treasury Secretary, members include heads of Federal Reserve, FDIC, SEC, and others
- Identify company, product, or activity that could threaten the financial system
  - Federal Reserve will supervise companies identified by the council
  - FDIC will manage liquidation of companies the council instructs it to close

### ◆ Duties

- Break up large firms
- Require increased reserve
- Veto rules from Consumer Financial Protection Bureau



# Council Impact on Accounting Standards

- ◆ **Council has the duty to monitor domestic and international financial regulatory proposals and developments**
  - Including Accounting Standards and Insurance
  - Make recommendations that will enhance the integrity, efficiency, competitiveness, and stability of U.S. Financial Markets
- ◆ **The Council may submit comments to the SEC or any standard-setting body regarding a proposed accounting principle, standard, or procedure**



# New Regulatory Body Consumer Financial Protection Bureau

- ◆ **Consumer Financial Protection Bureau**
- ◆ **Consolidates regulation of consumer financial services**
  - Replaces Office of Thrift Supervision seat of the FDIC Board
  - Credit providers with \$10 Billion in assets subject to new regulations



# SEC Office of Municipal Securities

## ◆ The Act requires the SEC to create the Office of Municipal Securities

- The Office reports directly to the chairman of the SEC.
- Tasks include:
  - Administering the rules of the SEC with respect to the practices of municipal securities brokers and dealers, municipal securities advisors, municipal securities investors, and municipal securities issuers
  - Coordinating with the Municipal Securities Rulemaking Board for rulemaking and enforcement actions as required by law



# Municipal Securities Rulemaking Board (MSRB)

- ◆ Providing for new regulatory authority over municipal financial advisors
- ◆ Financial advisors are required to register with the MSRB and be subject to MSRB regulatory jurisdiction
  - Swap advisors
  - GIC brokers
  - Pension placement agents
- ◆ Directs the MSRB to prescribe rules relating to a municipal advisor's fiduciary duty



# Municipal Securities Rulemaking Board Members

- ◆ **Eight of the members must be independent of any municipal securities broker, dealer, or advisor and at least one of those eight must be a representative of institutional or retail investors in municipal securities (majority public members)**
  - At least one of the eight should represent municipal entities
  - At least one of the eight should be a member of the public knowledgeable in the municipal arena
- ◆ **Seven members may be associated with a broker, dealer, municipal securities dealer, or municipal advisor**



# Credit Rating Agencies

- ◆ **Requires universal credit rating symbols for all securities**
  - Different scales for corporate and municipal securities led to past confusion and have been an issue for municipal issuers in obtaining credit. (A rating of AA for a corporate security is the same as AA for municipal security.)
  - The Act creates an Office of Credit Rating within the SEC
    - Authority to fine credit rating agencies
    - Administer the rules of the SEC regarding the practices of Nationally Recognized Statistical Rating Organizations.
- ◆ **Credit rating agencies must disclose their methodologies and their use of third parties for due diligence.**
- ◆ **Investors can bring private rights of action for agencies that knowingly or recklessly fail to conduct a reasonable investigation of the facts or obtain a reasonable verification of facts by a competent independent party.**



# GAO Municipal Market Study Trading Practices

- ◆ **GAO will conduct studies.**
  - Trading practices in the municipal market
    - Mechanisms for trading    Quality of trade executions
    - Market transparency    Trade reporting
    - Price discovery    Settlement clearing
    - Credit enhancements    Potential uses of derivatives
  - The GAO will make recommendations to improve the trading markets for municipal securities.
  - The SEC will provide a response to Congress stating actions taken in regards to the GAO recommendations.



# GAO Municipal Market Study Disclosure Practices

- ◆ **Compare disclosure practices in the municipal market to the corporate sector**
- ◆ **Provide a cost analysis of issuers providing additional financial disclosures**
- ◆ **GAO will make recommendations concerning municipal disclosure and the ongoing feasibility of the Tower Amendment.**



## Impact on GASB

- ◆ Provides a stable federal funding source for GASB based on new bond issuances
- ◆ SEC or Financial Industry Regulatory Authority (FINRA) to collect fee
  - Fee cannot exceed GASB annual budget
  - SEC cannot “directly or indirectly” involve itself in GASB’s budget, technical agenda, or setting GAAP
- ◆ GAO study
  - Role and importance of GASB and funding
  - GAO must consult with SLG representatives, including finance officers
  - Report to be complete within six months



## SOX 404(b) exemption

- ◆ Permanent exemption from 404(b) for nonaccelerated filers (Market Cap <\$75 Million)
- ◆ Requires SEC study
  - How to reduce the burden of 404(b) compliance for companies between \$75 and \$250 Million in Market Cap
  - Recommend how to reduce burden or increase exemption
  - Completed within nine months of the Act



# Executive Compensation

- ◆ Requires nonbinding shareholder vote on executive pay
- ◆ Compensation based on financial statements that are restated must be returned for the three years preceding the restatement
- ◆ Listing Exchanges are to provide enforcement



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## Q & A

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# Upcoming KPMG Government Institute Webcast

## ***GASB Statement No. 53: Accounting and Financial Reporting for Derivative Instruments***

- ◆ **Date:** August 26, 2010; 2:00–4:00 p.m.
- ◆ **Speakers:**
  - **Shawn Warren, Partner and KPMG State and Local Government Audit Practice Leader**
  - **Greg Driscoll, Partner, KPMG State and Local Government Audit Practice and Department of Professional Practice**
  - **Jeff Markert, Partner, KPMG State and Local Government Audit Practice and Department of Professional Practice**
- ◆ **Description:** This Webcast will provide an overview of GASB Statement No. 53 and a discussion of the various provisions, including the recognition, measurement, and disclosure information for state and local governments.
- ◆ **To register, please go to the KPMG Government Institute:**  
<http://www.kpmginstitutes.com/government-institute/>



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