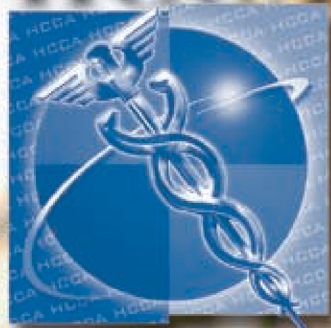

COMPLIANCE TODAY

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HEALTH CARE COMPLIANCE ASSOCIATION

Meet

Meet Rita A. Scichilone, MHSA, RHIA, CCS, CCS-P, CHC

Director, Practice Leadership, American Health Information Management Association

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SEE INSERT

Never say "never events"

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Effective compliance training

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The convergence of risk in the health care provider setting

By Cheryl Golden and Nadine Robinson

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Oftentimes when risks are being addressed, several departments may be working on parallel reviews; therefore, communicating among departments becomes more important than ever. The convergence of information from departments dealing with risk in the health care provider setting has taken on a new dimension, due to regulatory concerns and the Pay for Performance (P4P) requirements, as well as other quality-of-care initiatives embedded in hospital and physician settings.

Departments dealing very closely with risk concerns of the organization include: Compliance departments dealing with regulatory risk; Internal Audit departments dealing with finance and operational audits; Risk Management departments dealing with safety issues or adverse reactions; and, Quality Management departments dealing with quality standards and metrics related to patient care. With the increased focus on risk and risk assessments, it is becoming progressively more important for an organization to consider the convergence of its risk functions in a way to ensure that there is a focal point for addressing enterprise risks, as well as managing the corrective actions of areas where risk mitigation should be strengthened.

Ernst & Young recently spoke with five executives responsible for Compliance and/or Risk departments at organizations nationwide in an attempt to gauge their opinions on the convergence of risk. This article will address the numerous activities related to risks that may result in the requirements of risk convergence among hospital departments, leading practices currently used by health care facilities, and future projections.

What's new in the provider risk setting

The 900-pound elephants looming in the background are the new quality-of-care initiatives, including the P4P and Hospital Value-Based Purchasing initiatives. The P4P model focuses on providing monetary payment or non-monetary incentives for achieving specified outcome or process based goals.[1] The purpose of the Hospital Value-Based Purchasing program is to more directly link payment to the quality of care provided.[2] With these and other quality-of-care programs, it will become even more important for each department to assess risk and work collaboratively toward a common goal. Additionally, it will be critical to measure and confirm that the hospital is meeting its goals and implementing corrective action plans, when necessary, to improve upon or address risks as they are discovered.

Beyond the quality requirements facing hospitals are the growing compliance regulations, which include examining physician relationships and the large expansion of Recovery Audit Contractors (RAC) in the upcoming year. Federal agencies will be taking a closer look at selected hospitals and the investment and payment relationships they have with physicians, through a mandate of the Deficit Reduction Act of 2006 which requires that this information be provided. Additionally, RAC auditors were assigned to assist CMS in the review and recovery efforts of inappropriate Medicare payments. When the three-year RAC demonstration project initially began, three states were selected for review. Since then, the Tax Relief and Health Care Act of 2006 expanded it to include all 50 states by 2010. Such scope and depth of risk knowledge required to manage and update executives on these programs and other compliance regulations can be daunting. In order to monitor and respond to the associated risks, the various departments responsible for the areas must have a strong communication plan.

Some of the organizations we interviewed discussed having either a formal or informal risk officer who has oversight of the high risk areas within the various departments. These departments, mainly Internal

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Strategic

Governance

Board Performance

Tone at The Top
Control Environment
Corporate Social Responsibility

Business Practices
Anti-Competitive Market Activities
Conflict of Interest
Labor Force Shortage
Licensure

Regulatory Environment
Changing Reimbursement Methods

Culture
Tone From the Top
Motivation to Comply

Planning and Resource Allocation

Organizational Structure
3rd Party Relationships
Strategic Planning
Capital & Surplus Planning
Annual Budgeting
Forecasting
JV's /Alliances and Partnerships
Outsourcing Arrangements
Special Purpose Entities

Major Initiatives
Vision and Direction
Planning and Execution
Measurement & Monitoring
Technology Implementations
Technology Support
Business Acceptance
Identifying Opportunities

Mergers, Acquisition & Divestiture
Valuation and Pricing
Due Diligence
Planning, Execution and Integration

Market Dynamics:
Competition
Macro-Economic Factors
M Lifestyle Trends
Socio-Political Issues

Communication & Investor Relations
Media Relations
Crisis Communications
Rating Agencies
Regulators
Employee & Physician Communication

Compliance

General Risk Areas

Human Capital

Recruiting

Hiring / Termination
Training
Promoting

Code of Conduct
Business Practices
Ethics
HIPAA Privacy

Quality Data Reporting
Pay For Performance

Legal
Contract
Liability
Intellectual Property
Corruption
Fraud Waste, & Abuse

Regulatory
Labor
State/Local & Country Specific Compliance
Clinical
Backup Coverage for Essential Functions
DPH Compliance
Joint Commision Readiness

Data Protection and Privacy
Health and Safety
Environment of Care
- Clinical engineering
- Emergency management
- Employee injury
- Environment of care physical security
- Environmental services
- Flu epidemic
- Safety

Competitive Practices / Anti-trade
Discriminatory Practices
Tax Compliance and Audit Management
EMTALA

Financial

Corporate Finance

Financial Accounting and Reporting

Accounting Reporting and Disclsoure

Internal Control SOX 404/302
Governmental Reporting Standards (GAS)

Market
Interest Rate
Foreign Currency
Derivatives
Arbitrage Rebate
Private Activity Violation

Transactional Finance
Accounting for contributions
Accounts Payable
Assessing Assets for impairment
Cash Controls
Cash Intake
Cash Management and Handling
Cash Receipts Policies and Procedures
Cash Record-Keeping
Cash Safeguarding
Cash Transfer
Cash Disbursements
Credit balances—failure to refund
Debt Monitoring
Estimate third party settlements
Manual contractual adjustments
Estimating commitments and contingencies
Estimating the allowance of bad debt
Expense capture
Financial Statement Close
Fixed Assets/Depreciation
Investing Activities
Performance Based Compensation
Processing of Payroll
Purchases and Accounts Payable
Revenue recognition

Taxes
Tax Exempt Status
Tax Optimization
Transfer Pricing
Community Reporting

Capital
Equity
Pension Fund
Stock Options

Revenue Management

Patient Financial Services

Billing - Grant Management
Grant Requirements (Federal, State, Local)
Patient Services Billing Related to Grants/Contracts

Billing - Revenue Cycle
ABN (Medicare notice of non coverage)
Billing for discharge in lieu of transfer
Billing for items or services not actually rendered
Billing Medicare or Medicaidin excess of usual charges.
Charge capture
Charge Description Master
- CDM Access
- Data Verification
- Maintenance and Updating of Policies

Coding for Preventive Care Services
Discounts to Uninsured Patients
Charity Care

Free Care Pool
Identification of incorrect insurance plans and payment options
Outpatient services rendered in connection with inpatient stays
Pricing - Other
Professional Courtesy
Providing medically unnecessary services
Relationships with Federal health care beneficiaries
- Cost Sharing Waivers
- Free Transportation
- Gifts and Gratuities

Billing - Submission of accurate claims and information
Admissions and Discharges
Claims Edits
Outpatient Procedure Coding
Physician Coding
Physician Documentation
Supplemental Payment Considerations
Use of Information Technology
Unbundling
Upcoding
Duplicate billing

Business Office

Audit, Compliance, Risk Management and Quality, could then have a reporting responsibility to this individual when it came to addressing risks. The risk officer would serve as the chairman of the risk committee, which would include individuals from a diverse group of departments, as well as physicians. This individual serves as a liaison to senior management to help them understand the different types of risks and the integration of managing these risks within the organization.

Other organizations interviewed believe that assigning all that responsibility to a risk officer, whether formal or informal, was too much to expect of one person. Many risks are diverse. Some individuals lack the understanding or simply do not have the background to communicate with senior management, which might put the enterprise at risk. Furthermore, it is too much to expect one individual to understand the clinical, operations, finance, and legal intricacies of the organization.

Leading practices

From the information we obtained in conducting interviews with various compliance officers throughout the country, as well as our experiences within this industry, we have put together leading practices that may be useful in converging risks between departments to facilitate working together to address identified issues.

Conducting an annual risk assessment throughout the entire organization and working with the leaders from each area to discuss the findings will provide an opportunity for leadership within the organization to recognize potential problems that may occur. Currently, risk assessments generally cover all aspects of an organization and are very comprehensive. The illustrations on this and page 45 provide one example of a recent risk universe for a health care provider. More than 100 areas were covered and the assessment involved a number of potential areas of risk in the organization.

From the information obtained through the risk assessment, an action plan should be developed that outlines what each department will do throughout the year to address the identified risk. Further, updates on the progress of the corrective action plan should be discussed with the Board. Surveys have shown that approximately 40% of provider organizations have Internal Audit and Compliance functions together. With the intertwined operations of compliance issues, many organizations believe it makes sense to combine resources. By working together, better outcomes occur and everyone is aware of them versus individual departments implementing change, but not having the full support of the group. However, internal audit organizations have pointed out that Internal Audit and Compliance departments being combined (based on the assurance function that Internal Audit provides and the business function that the Compliance department provides) may not be the best solution. One alternative that may be more favorable is to have Internal Audit provide the support for compliance audits and have the Compliance function itself separate.

With an increased awareness of quality, not only through the new federal programs and services, but also through accreditation organizations such as the Institute for Healthcare Improvement and National Quality Forum, the National Committee for Quality Assurance, and

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Operational

Patient Related Services

Patient Care
- DRA / False Claims Act
- Clinical Compliance
- Admissions/Registration
- Patient Satisfaction/Quality
- Discharge/Transfer
- Physician
- Relationships
- Physican Agreements
- Starke
- Credentialing
- Control Structure
- Monitoring
- Departmental

Patient Access
- Authorization/Precert
- Customer Service
- Pre-Registration
- Registration
- Upfront Collections

Patient Safety, Quality, and Infection Control
- Abbreviations (use and do not use)
- Accurate patient data
- Clinical Protocols
- Infection control
- Patient identification (verification, timing)
- Quality of Care monitoring
- Telephone orders (ead back, critical values)

Discharge and Transfer

Admissions
- Admissions/Registration
- Assinging of Correct Patient Status
  - One Day Stays
  - ED
  - Renal Dialysis
- Utilization Management Plan Compliance
- Over and Under utilization of days/services
- Proactive non-emergent conditions evaluation
- Clinical information for third party payors
- Monitoring continued stay medical necessity

Departmental

Medical Records
- Documentation

Pharmacy
- 340(B) Compliance
- Pharmaceutical purchasing
- Tracking of pharmaceuticals
- Public Health
- Innovation in novel public health programs
- Implementation of public health programs
- Fund-raising and budgeting for future projects
- Review of existing programs and campaigns
- Utilization and management of funds and grants

Research
- Human Subject Protection
- Time Studies
- Billing Restrictions
- Results Reporting

Organ Transplant

Renal Dialysis

Psych

Skilled Nursing (SNF)

Home Health (HHA)

Materials Managememt

Information Technology (IT)

Managed Care

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Utilization Review Accreditation Commission (URAC), organizations should consider establishing a compliance work group that includes individuals from the Compliance, Internal Audit, Risk Management and Quality departments, as well as other departments that may be involved in the risk management process. This work group should meet on a frequent basis, and everyone in the group should have an understanding of each other's roles in the organization. This work group could be responsible for suggesting corrective action plans for implementation in departments with identified risks, as well as conducting follow-up reviews on these corrective action plans to verify that they have been implemented. The work group would also monitor whether the plans resulted in improved processes.

Lastly, even if there is no one with the formal title of Risk Officer, there should be a process for communicating among the departments and upwards to the C-suite executives and the Audit and/or Compliance Committee of the board. Organizations should take an in-depth look at this function and ensure that the appropriate individuals have been assigned to the key roles of addressing compliance, risk, and quality. Further, individuals who are responsible for the compliance, risk, internal audit, and quality functions should have the prerequisite knowledge and experience that allows them to fully understand their job duties and how to best use their departments to meet the needs of the organization.

Future projections

Based on the current status of risk management and the leading practices that are currently used in the industry to address this issue, it may become common practice for organizations to either obtain a risk officer (or someone who may informally fill this role) and/or to implement a Risk Committee that meets on a regular basis. The Risk Committee is made up of a variety individuals, including those from Internal Audit, Compliance, Risk Management and Quality departments, as well as any other departments that play a role in addressing and managing risks within the organization. It will become imperative that these departments interact and communicate, especially when it pertains to conducting an organization-wide risk assessment, following an annual work plan, addressing risks, implementing corrective action plans, and verifying these corrective action plans.

Conclusion

The face of risk has expanded in most organizations. With the advent of new and broader risks in health care, organizations are looking for ways to better manage risk. It can be quite overwhelming when looking at a risk universe for health care, with over 100 regulatory bodies from which many providers are governed. Strategic and financial risks are also resident in everyday operations, and compliance risks continue to become more cumbersome to manage. Clearly, audit committees and boards recognize the fiduciary responsibility they have to the organization to provide oversight and guidance in the mitigation of risk.

Many organizations have performed risk assessments and update those assessments on an annual basis. However, there are still organizations that have yet to initiate a formal risk assessment process which can serve as the starting point of a risk work plan from which risks will be managed. Once an overall risk assessment has been completed, a more tactical plan should be administered to tackle the mitigation of those risks. ■

The views expressed herein are those of the authors and do not necessarily reflect the views of Ernst & Young LLP.

1 Physician Pay for Performance in Medicaid: A Guide for States, Center for Health Care Strategies, Inc., March 2007. Available at http://www.chcs.org/publications3960/publications_show.htm?doc_id=471272
2 US Department of Health and Human Services Medicare Hospital Value-Based Purchasing Plan Development, Issues Paper, January 2007. Available at http://www.cms.hhs.gov/AcuteInpatientPPS/Downloads/Hospital_VBP_Plan_Issues_Paper.pdf