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Top 20 Risks Facing Today's Healthcare Industry: Are You Ready?

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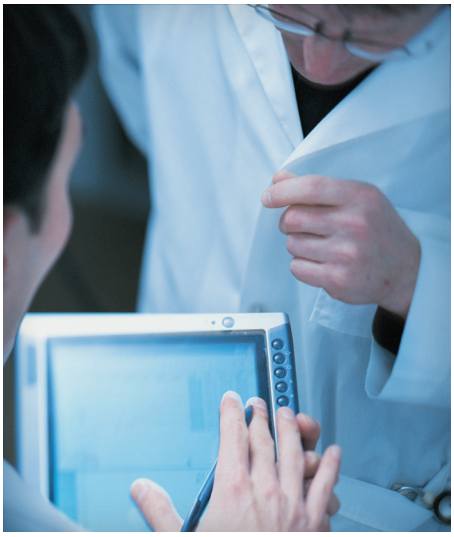

An evaluation of risk assessments conducted by CHAN Healthcare, a subsidiary of Crowe Horwath LLP, during the first six months of 2014 provides some valuable information for healthcare organizations. The evaluation analyzed more than 3,200 risks across 13 health systems and 270 entities and computed average risk scores based on two primary factors – strategic and business impact and business environment complexity. The top 20 risks, ranked highest to lowest, follow.

1. Physician Contracting

Organizations continue to pursue physician integration, and physician arrangements are increasingly complex, bringing with them greater risk. Hospitals often must move quickly on contracts with physicians who are crucial to the overall hospital strategy. It is critical for all appropriate parties to review contracts before they are finalized. A committee or attorney should review every contract for appropriate compensation based on location, specialty, and market comparability as well as for potential Stark law violations. The hospital also should have a robust system in place for tracking contracts and monitoring adherence to contract terms.

2. Joint Ventures

Joint ventures continue to grow in significance as healthcare organizations enter into a variety of creative arrangements across all aspects of the care continuum. In addition to managing cultural differences between not-for-profit and investor-owned businesses, the parties must address risks related to compliance with legal and ethical requirements and contractual obligations. A right-to-audit clause is an important contract term not only to demonstrate due care but also to be proactive in identifying noncompliance. The parties also should recognize that joint ventures typically come to an end, so items such as the proper distribution of reimbursements should be considered.

3. Meaningful Use

With the significance of meaningful use (MU) incentives for those who are eligible, it's no surprise that MU continues to pose a serious concern for both hospitals and physicians. The Centers for Medicare & Medicaid Services (CMS) avidly is pursuing audits of healthcare organizations, and some organizations are not prepared. To support their attestation, and thereby reduce the odds of being required to refund CMS payments, organizations must formally assign accountability and make sure thorough documentation is maintained.

4. Quality Process Improvement

Healthcare reform has brought an increased focus on the quality of patient care, with quality measures having a greater impact on reimbursement. To help improve outcomes and recover the highest reimbursement possible, hospitals need to implement evidence-based practices and reinforce the reliability of their clinical processes. Proper monitoring is essential to identifying and promptly addressing breakdowns.

5. ICD-10 Transition

International Classification of Diseases (ICD)-10 remains a top concern. Organizations are concerned that reimbursement will decline for a period of time after ICD-10 is implemented as a result of a lack of detailed physician documentation, inaccurate coding, loss of coding productivity, or information system issues. Extensive communication, education, testing, and contingency planning in advance of the Oct. 1, 2015, implementation date can help mitigate any potential negative impact. Post-transition monitoring also will be important to confirm that the processes are working as they should.

6. Accountable Care Organizations and Clinically Integrated Networks

A growing number of organizations are forming accountable care organizations (ACOs) or clinically integrated networks (CINs) in response to the Affordable Care Act. Common risks associated with these arrangements include securing patient data in compliance with Health Insurance Portability and Accountability Act (HIPAA) privacy laws; complying with waiver requirements to shield the ACO or CIN from potential federal or other regulatory violations (including Stark and antitrust); executing, tracking, and managing physician participation agreements and contracts; and establishing appropriate methods to distribute payments to all physician participants.

7. Denials Management

Denied or delayed claim payments are nothing new, but the risk associated with them has grown as healthcare organizations struggle with intensifying reimbursement pressures that threaten the bottom line. Hospitals should employ a dedicated denials staff populated by employees who understand payer contracts and their corresponding requirements. The staff should work every denial, responding in a timely manner with the specific information insurers require for reprocessing.

8. Two-Midnight Rule

The introduction of the two-midnight rule created significant operational challenges for many hospitals. Securing appropriate physician certifications prior to discharge became more challenging as new processes were designed. Although the physician certification requirement has been removed through the final 2015 Outpatient Prospective Payment System (OPPS) regulation that was issued on Oct. 31, 2014, many hospitals have chosen to keep their newly designed processes to support the medical necessity of a two-midnight stay.

9. IT Application Post-Implementation

Recent years have seen a surge in hospitals' reliance on IT applications, including electronic health records (EHRs) and various financial and business systems. These applications are intended to improve efficiency and effectiveness, but they can carry risks related to both clinical care and reimbursement. Controls must be put in place to confirm that applications capture all of the patient information needed to provide proper care and satisfy reimbursement requirements.

10. 340B Drug Pricing Program

Requirements under the 340B drug pricing program are complex, and guidance is not always clear. A mega-regulation was expected during the summer of 2014, but it was canceled, leaving healthcare organizations without much-needed clarity. Healthcare organizations should develop system and data analysis processes to identify and remove patients and drugs that aren't actually eligible for the program.

11. Physician Practice Revenue Cycle

Healthcare organizations continue to acquire physician practices, which leads to revenue cycle risks as a result of a lack of formal process documentation, inadequate staff training, and issues with accountability. In addition, many practices recently have implemented new systems, and these process changes also boost risk. Organizations should review the entire revenue cycle – from pre-appointment insurance verification and payment arrangements to billing and claims submissions – for weaknesses and potential problem areas.

12. HIPAA

Data breaches are in the headlines regularly, and numerous healthcare organizations have been among the victims. Enforcement activities by the Office of Civil Rights have been on the rise, with the number of resolved complaints jumping from about 9,400 in 2012 to 14,300 in 2013. To avoid fines and penalties, hospitals routinely should audit their administrative, physical, and technical safeguards for vulnerabilities in their security policies, processes, and systems. And, of course, security risk assessments are a requirement of the HIPAA Security Rule and for reimbursement through the MU program.

13. Financial Statement Close Process

The close process consistently has ranked among the top risks facing the healthcare industry. Accurate and timely financial reporting is required of healthcare organizations, and the associated risks of not meeting reporting requirements and standards include misstated financial position, fraud and misappropriation, and lost balances. An organization needs to have in place policies and procedures to guide the staff and management on how to properly close financial statements, addressing, among other things, account reviews, balance sheet and income statement balances, and reconciliations.

14. Billing and Collection

Producing a timely, error-free claim that can be adjudicated and paid quickly remains a burdensome process. An ineffective or inefficient process translates to lost revenue. Many organizations recently have implemented significant changes to their billing and collection functions, including centralization or outsourcing. These shifts can mean greater efficiency but only if they are managed properly. Hospitals should run daily accounts reports to monitor unbilled services and past-due balances and should respond accordingly.

15. Third-Party Vendor Oversight

Vendors that are subject to inadequate oversight can easily inflate charges, bill for services not provided or contracted for, or engage in other fraudulent schemes, sometimes even with an organization's own employees. Management oversight of contracts is crucial. Management should be involved in negotiations and then reconcile services received against contracts (to confirm the organization is receiving the services contracted for) and invoices (to confirm the organization isn't being charged for services not received).

16. Charge Capture

Leaking revenue from inadequate charge capture remains an area of concern for a variety of hospital departments, particularly as EHR systems are implemented and other systems are updated. Hospitals must reconcile patient schedules and records against the respective billing to verify that charges are passing accurately between systems.

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17. Health Insurance Plans

This area is new to the list of top risk areas for healthcare providers, as many health systems are venturing into the health insurance market. The unique risks of insurers are a different consideration for most providers. For example, insurers must maintain adequate risk-based capital reserves. They also must comply with a far-reaching web of federal and state regulations and monitor medical loss ratio limits.

18. IT System Access

Unauthorized access to data or applications is a significant organizational risk. Healthcare organizations often struggle to maintain consistent core controls (for example, passwords, timeouts, and lockouts) around system access, especially given the speed with which they are implementing new systems. Provisioning – or granting the right type of access to the right user – also has come up regularly in healthcare organizations' risk assessments. Tight deadlines can't be allowed to usurp proper controls.

19. Payroll

Payroll is the single largest expense for most healthcare organizations. Related payroll risks include timekeeping, pay practices, and the potential for payroll fraud. One of the most powerful controls for payroll risks is segregating payroll duties, so that different employees are responsible for payroll preparation, authorization, check generation, and distribution. Also, access to payroll records should be restricted to those who legitimately require it.

20. Purchasing

As organizations seek to control rising costs, purchasing continues to be a focus. Risks include the accuracy of pricing compared with contracts as well as processes related to vendor selection. A problem arises when multiple suppliers provide different types of the same products (for example, different types of gloves based on individual physician preferences). Healthcare organizations can improve cost efficiency by consolidating suppliers. This also is an area where invoices should be reconciled with contracts to catch price changes and other disparities.

Looking Ahead

The risks facing the healthcare industry are complex and constantly changing. Organizations need to monitor their risks and have processes in place to test controls in high-risk areas, uncover gaps, and take the appropriate actions to mitigate risks.

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