Healthcare Reform Series – Provider Compliance Issues

Through a series of Congressional Bills in late 2009 and early 2010, we have healthcare reform. There is a significant amount of detail in the law, with the majority of regulations implementing the laws to be issued in the coming months and years. This paper will summarize many of the healthcare provider compliance issues identified in the law, which will give providers an idea of future compliance issues arising from regulations promulgated in response to healthcare reform – Public Laws 111-148 and 111-152.

What are the major healthcare provider compliance issues in healthcare reform?

Compliance Programs. Providers participating in the Medicare and Medicaid programs shall, as a condition of enrollment, establish a compliance program that contains core elements to be determined by the Secretary in conjunction with the Inspector General of the Department of Health and Human Services. The timeline for implementation will be determined by the Secretary based on the current extent of adoption of compliance programs in each industry segment. We speculate the compliance program "requirements" will not be significantly different than the current compliance program "guidance."

Community Health Needs Assessments. Not-for-profit hospitals will be required to obtain input from individuals who represent the broad interests of the community, including those with special knowledge or expertise in public health. Effective for fiscal years beginning subsequent to 3/23/2012, the assessments must be performed every three years, an implementation plan must be adopted and it must be widely available to the public. It will be interesting to see what requirements will be made on organizations with respect to the un-met needs of the community.

Financial Assistance Policies. Not-for-profit hospitals will be required to have a written financial assistance policy that outlines the eligibility criteria and method of applying for financial assistance, the basis for charging patients and if the organization does not have a separate billing and collections policy, the actions it may take with respect to collections and reporting to credit agencies. The organization must also have a written policy requiring the hospital to provide emergency medical care regardless of a patient's eligibility under the Financial Assistance policy. The policies must be widely publicized within the community. These provisions are effective for fiscal years beginning subsequent to 3/23/2010, but are not significantly different than many State regulations and EMTALA.

Limitation on Charges. Effective for fiscal years beginning subsequent to 3/23/2010, not-for-profit hospitals must limit the amounts charged to individuals who qualify for financial assistance to no more than the amounts generally billed to individuals who have insurance and prohibits the use of gross charges. It will be interesting to see how the Secretary addresses the "gross charges" provision in the regulations. We speculate that in effect, gross charges may be used, but that a discount from gross

charges based on income level will be required to get financial assistance patient balances due at or below amounts due from commercial insurance covered patient accounts.

Billing and Collections. Not-for-profit hospitals will be prevented from engaging in extraordinary collection efforts prior to making a reasonable effort to determine if a patient qualifies for financial assistance. This is effective for fiscal years beginning subsequent to 3/23/2010. We speculate this will essentially require that every account sent to collections have financial counseling notes and conclusions in the record to be compliant.

Billing Agents, Clearing Houses and Other Payees. Organizations that bill to or collect from the Medicaid program on behalf of providers must register with the State in a form and timing to be determined by the Secretary. This implies that all providers who use these organizations must ensure they are registered to ensure compliance and to avoid interrupted claims and cash flow.

Disclosure for In-Office Self Referrals. Referring physicians for in-office MRI, CT, PET and other designated health services must inform the patient at the time of referral, in writing, that the service may be received elsewhere and provide a list of providers who perform those services in the area in which the patient resides.

Skilled Nursing Facilities. There are a number of requirements for SNFs including; disclosure of ownership and other governing information, compliance and ethics programs, quality assurance and performance improvement programs, and other information from which the Secretary will use to public comparative information on a Department Health & Human Services web site.

Healthcare organizations should immediately start analyzing the Healthcare Reform compliance issues and developing implementation strategies for their organization. ***Exaltant can help you evaluate the compliance issues in healthcare reform and develop strategies to prepare.***

About Exaltant

Exaltant exists to help you succeed in improving the business performance of your healthcare organization. Our professionals have a wide range of experience across business operations of the healthcare continuum, which brings you targeted expertise to achieve your goals. We provide our experience to help *you* implement successful initiatives. Exaltant provides over twenty years of healthcare consulting experience to help analyze business issues, build strategies, design tactical plans and implement successful initiatives in the following areas:

- Strategy
- Business Operations
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- Project Management
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