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Janice A. Anderson

Chicago, Illinois
312.832.4530
janderson@foley.com

Michael L. Blau

Boston, Massachusetts
617.342.4040
mblau@foley.com

Lawrence C. Conn

Century City, California
310.975.7725
lconn@foley.com

Maria Gonzalez Knavel

Milwaukee, Wisconsin
414.297.5649
mgonzalezknavel@foley.com

Charles B. Oppenheim

Century City
310.975.7790
coppenheim@foley.com

Lawrence W. Vernaglia

Boston, Massachusetts
617.342.4079
lvernaglia@foley.com

Judith A. Waltz

San Francisco, California
415.438.6412
jwaltz@foley.com

Top Ten Hospital Compliance Challenges for 2008

Foley's Health Care Industry Team is frequently asked to assist clients in identifying key compliance risks on an industry-wide basis. The following are our best estimates for the "Top 10" compliance risks for hospitals and health systems in 2008. Of course, every hospital has its own unique set of challenges, and this list is not meant to be exhaustive nor to exclude other issues from compliance review.

10. Medicaid — Deficit Reduction Act (DRA) and False Claims Act

For years, Medicaid compliance was the near exclusive domain of states' law enforcement agencies and Medicaid Fraud Control Units. The federal government would join Medicaid claims with similar existing Medicare cases, but would rarely bring a Medicaid claim absent a Medicare claim. Changes under the DRA of 2006 include rewards and penalties for states relative to their Medicaid enforcement programs, and promises increased attention to compliance and fraud issues under Medicaid programs.

9. Board of Directors (Boards) Involvement — Structural Issues

On September 13, 2007, the Department of Health & Human Services Office of the Inspector General (OIG) released its third in a series of compliance guides directed at Boards of health care entities. Increased scrutiny at the Board level will focus its attention on compliance issues as well as determine whether the Board has processes in place to effectively monitor compliance issues.

8. Centers for Medicare and Medicaid Services (CMS) Data Mining Implications

CMS's technological capabilities are increasing, assuring increased use of data mining and other automated compliance and recovery tools.

7. Recovery Audit Contractors (RACs) Audits and Other New Predators

Incented with contingency fees of 17–20 percent (or more) RACs are expanding, beyond their initial three-state pilot programs (New York, California, and Florida), nationwide over the next two

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years. With error rates approaching 100 percent, RACs will be increasing administrative expenses and significant overpayment recoveries.

6. Research, Clinical Trials Billing, Time and Effort Reporting

As research demands and related compliance obligations grow in prominence, so will the government's enforcement. Particular challenges relate to uncertain legal standards, inadequately trained employees, and overlapping public and private payment sources.

5. Medicare Severity Diagnosis Related Groups

Medicare is initiating a profound change in the grouping of diagnoses under the inpatient prospective payment system. New rules, and opportunities for significantly decreased reimbursement, require immediate vigilance in the hospital community.

4. Present on Admission and Hospital Acquired Conditions

These new rules will result in payment denials unless accurate coding is performed on patients' intake and admission. This requires education of physicians and nursing staff to capture needed data for reimbursement, but also to prevent erroneous documentation.

3. "Supplemental" and Certification/Status Payments

Front and center in the OIG's Supplemental Compliance Guidance for Hospitals released in 2005, and again in the 2008 Work Plan, includes a number of initiatives aimed at reviewing any payments in addition to the base inpatient prospective payment, such as payments under the disproportionate share hospital, medical education, and bad debt requirements.

2. Stark Phase III — Physician-Hospital Relations

CMS released both proposed and final Stark rules this year effective on December 4, 2007. The goal of these changes (both proposed and effective) is to dramatically limit physicians' financial relationships with other health care providers. Some of the changes have significant unintended consequences such as the new "stand in the shoes" provision, which may result in dismantling many beneficial relationships among health care systems and physicians.

1. Quality

Finally, we believe that the number one compliance challenge facing hospitals in 2008 will be quality. Both payment and compliance challenges face providers and payors struggling with how to address not just the "inputs" to the health care system, but the "results" as well.