



Gateway Gatherings

President's Message

Brian M. McCook, CPA
Chapter President



It is hard to believe that Fall is already here and the leaves are changing colors! Just as the seasons change, the health-care industry continues to evolve and change as well. Probably one of the biggest changes that has occurred relates to ICD-10 which went into effect on October 1, 2015. Up to this point it would appear that things have gone smoothly.... however, this may just be the calm before the storm. There was a session at Fall Conference presented by Rose Dunn regarding ICD-10 which cautioned that we may not be out of the woods just yet....stay tuned!

HFMA National will be sending a survey to all membership asking for membership satisfaction in a variety of areas. Please take the time to complete the survey as it provides valuable insight and information as Chapter leaders continue to strive to make HFMA a valuable and reliable resource for all of our members. Additionally, your comments help us develop new educational seminars that provide relevant content to you and your organizations.

Over the summer, our Chapter held a Mini Leadership Training Conference and continued the strategic planning initiatives from the previous year. The three major initiatives were partnering with other organizations, focus on early careerists/

student membership and improve communication. We made great strides over the past year and continue to make improvements in all areas. HFMA National has many of these same initiatives...many of which our Chapter has taken a leadership role and even been asked to serve on the National Committees to lead the charge for the entire country. This is just further validation of the strong leaders and talented membership our Chapter possesses.

I would like to personally thank all of our Officers, Directors and Volunteers for their hard work and dedication. This Chapter would not be the success it is without each and every one of you and your commitment to excellence. Also, a hearty thank you to our sponsors who allow us to continue to evolve and grow as a Chapter while offering quality educational programs to our members.

As we move through Fall to the Holiday season, I would like to personally wish all of you well. Make sure to take the time to enjoy family and friends while continuing to keep up in the fast paced healthcare industry. I appreciate our entire membership and look forward to seeing everyone soon at any of our networking or educational events!!

Brian McCook
President 2015-2016
Greater St. Louis Chapter of HFMA

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From the Editor...

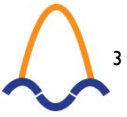
Thank you to everyone for submitting their articles to this Fall issue of the newsletter. You'll see on the upcoming events calendar we have several fun and educational events to attend. Be sure not to miss the Holiday Party on December 2. That is always a great opportunity to get to know your fellow HFMA members. As always, I welcome any feedback or suggestions for the newsletter. Please don't hesitate to contact me. Thank you again to those that contributed to this issue of Gateway Gatherings! lsuelmann@anderscpa.com.

Publication Dates and Deadlines:

Winter Issue

January 8
Deadline for Articles

January 29
Publication Date



Thank You to our 2015-2016 Chapter Sponsors

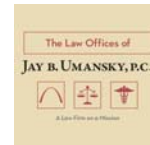
Diamond



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Sponsorship Updates

Jeff Morgan

BIG thanks to all our chapter sponsors. We have had another record breaking year. On behalf of the Chapter Officers, Board of Directors, the Committee Chairs, and the Members, THANKS FOR YOUR SUPPORT!

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Chapter Updates

HFMA Membership - Discount Extended Through October

Good News! Per the request of several of our chapter leaders we are **extending the NEW member discount** through the **end of October!** This will be your last opportunity to take advantage of this nearly 50% off discount if you are NEW to HFMA. Prices will go up on November 1st. **Anyone interested can take advantage of the discounted rate by contacting our Member Services Team at 800/252-3339 Ext 2, and provide them with discount code "16EXT".**

If you have any questions, please do not hesitate to contact:
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GO BEYOND

Fall Presidents Meeting
Chicago, IL



HFMA's New CHFP Certification Program is Now Available!

Theresa Kipper

With the new era in healthcare, Healthcare Financial Management Association (HFMA) has launched an improved Certified Healthcare Financial Professional (CHFP) program. This program is designed to provide the broad range of business and financial skills essential for succeeding in today's high-value healthcare environment.

The new CHFP is geared toward financial professionals, clinical and nonclinical leaders, and payers – all those whose jobs require a deep understanding of the new financial realities of health care. The CHFP course modules include:

- **Module 1: HFMA's Business of Health Care** - Healthcare finance overview, risk mitigation, evolving payment models, healthcare accounting and cost analysis, strategic finance, and managing financial resources.
- **Module 2: Operational Excellence** - Exercises and case studies on the application of business acumen in health care.

"HFMA's goal is to build a broad understanding of healthcare finance together with leadership skills, business acumen, practical knowledge, and a collaborative spirit – skills essential for succeeding in today's environment," said HFMA President and CEO Joseph J. Fifer, FHFMA, CPA. "Healthcare leaders in all sectors will require a deep understanding of the new financial realities of healthcare that reflect an integrated delivery system with the complexities of the provider, payer, and physician perspectives intertwined."

CONGRATULATIONS to **Robert Royer**, our latest member to pass the CHFP exam!

Over 250 healthcare professionals have already pre-registered for this program. Find out what the excitement is all about. For more information, contact Theresa Kipper – Certification Chair at Theresa_kipper@ssmhc.com.

GO BEYOND

Region 8 Connection



Stephanie Hultman, CHFP

Greetings HFMA Region 8 Members!

It is hard to believe as I look out the window that Fall is really here. Fall brings with it change – change of colors, temperatures, school is back in session, the end of baseball and start of football and hockey my favorite time of year. The Officers and Leaders of our Region continued to “Go Beyond” in each of our chapters. It showed again at the 2015 MidAmerica Summer Institute as it was another phenomenal event this year in Minneapolis.

It takes a TEAM to make this event happen and we have an amazing group of dedicated individuals behind the scenes. The continued support of so many keeps our chapters and region successful. 2016 MidAmerica Summer Institute planning has already started and we are looking forward to the Minnesota Chapter hosting this event in Minneapolis, MN.

Towards the end of September the President and President Elects came together for our Fall President’s Meeting which was held in Chicago, IL. We discussed best practices and how we can achieve the goals and meet the needs of our memberships. I am confident by the interaction we had and ideas that were shared each chapter will have a WINNING season during 2015-2016. To quote my predecessor, Tracy Packingham, “Region 8 Rocks!!”

We also held the election of the 2017-2018 Region 8 Regional Executive. We had three talented leaders nominated for this position. Congratulations go out to Kyle Lee from the Show Me Chapter!

Now that the seasons are changing, why not put HFMA back on your calendar? Your chapter leaders have done a very nice job putting together high quality educational programs and great networking events. Just one sign that they “Go Beyond” to ensure you are provided with the information you need as a healthcare professional. If you haven’t done so already, please take the time to get to know your chapter leaders, thank them for their dedication to the chapter, and get involved in your chapter’s activities. Believe in yourself and the skills you could bring to a leadership role. You’ll find that by getting involved you’ll gain so much more from your membership!

I thank you again for the opportunity to serve Region 8. I welcome your questions and comments, anytime! My telephone number is 319-240-5306 and my email address is sjhultman@mediacombb.net.

Stephanie Hultman, CHFP
HFMA Region 8 Regional Executive 2015-2016



Join Us on LinkedIn!

Search St. Louis HFMA in the Groups search bar and join the conversation!



Educational Corner

Using Marketing's Playbook to Engage Patients Financially Kristen Jacobsen, Director of Marketing, Apex Revenue Technologies

Revenue cycle leaders at the HIMSS Revenue Cycle Solutions Summit in Chicago talked about key challenges facing the industry. They tackled tough topics, including ICD-10 and the growing complexity of collecting patient balances. They talked with consistency about the need for change, the goal of patient centricity and the importance of metrics to track payment performance.

It struck me that many proven tactics marketers use to engage potential consumers can help financial leaders improve results in the patient-pay revenue cycle. Marketers consider demographics, personas, channels, messaging, conversion rates and more to tailor communications that drive results. That model can prove effective for patient financial engagement as well, leading to better experiences for patients and better financial results for the provider.

Consider the following:

Segment your audience

Marketers seek to understand common needs and behaviors of their audience because different segments are moved to action for different reasons. That's true, too, of patients. No two patients are the same. Each has distinct financial needs or preferences that have an impact on how, when and if they chose to pay their healthcare bill. Understanding common needs, motivators and payment patterns within your patient population—and building common profiles for those segments—is the first step in building a more effective financial communication framework.

Optimize your messaging

Segmentation allows you to vary messages to patients to achieve the best results. For example, you might emphasize the availability of online payments for a demographic segment that's inclined to pay in the moment. Or, you might tailor messages in printed bills, text communications and online payment portals based on the balance due, past payment tendencies or cycle. The right channel of communication can be as important as the right message. Therefore, you can establish messaging strategies that connect with patients where and when they choose to pay.

Measure conversions and results

Marketers measure success in conversions: a web view to an inquiry, then an inquiry to a sale. Through tracking, testing and analysis, marketers can pinpoint the various messages, communication channels and campaign processes that drive the highest conversion rates. Healthcare financial leaders can similarly focus on key "conversion" points—understanding what mix of messages, timing, billing and payment channels work best for each patient segment.

Putting it all together

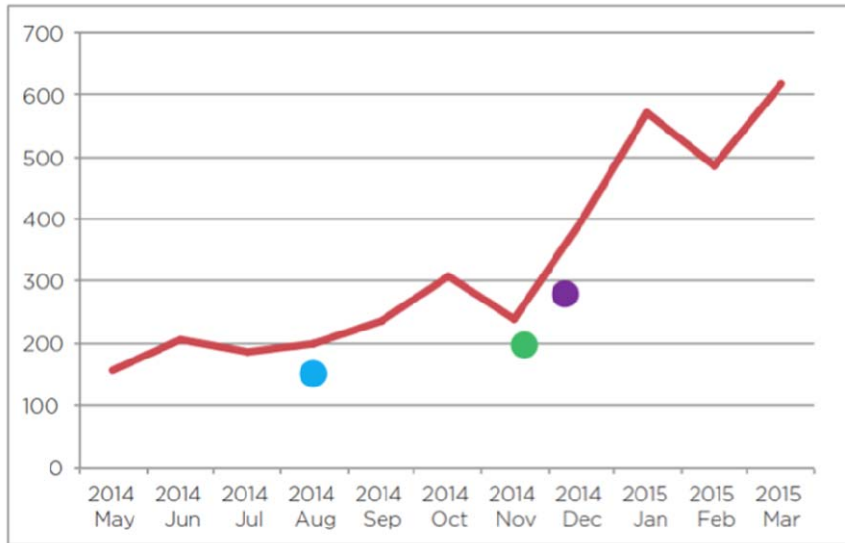
The following metrics show one provider's results applying this type of approach. The colored dots indicate messaging changes over time. By targeting messaging, testing the results and fine-tuning for improvements the provider realized a significant increase in dollars collected. This patient population was inclined to pay online, so with the right message to inspire online payment "conversions," the provider saw a significant increase in dollars collected—nearly quadrupling during the course of the analysis.

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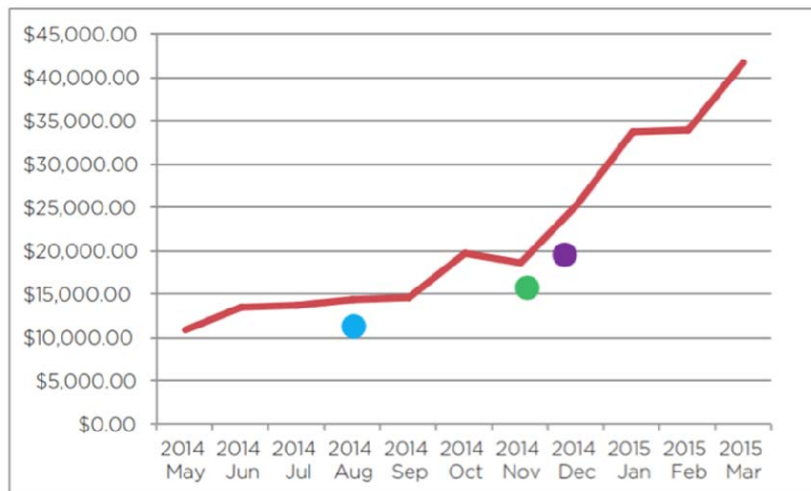
Educational Corner

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Online Payments Made



Dollars Collected



Marketers seek to grow revenue by striving to understand how and why their customers buy. Similarly, healthcare financial leaders can gain insight into how each patient population pays and what messaging strategies drive the best results. By taking a page from the marketer’s playbook, providers can build flexibility into how they connect with patients where and when they choose to pay and find new solutions to improve financial results and strengthen patient relationships.

Throughout her career, Kristen Jacobsen has held strategic marketing roles in organizations focused on strengthening customer relationships through analytics and communication technologies. Her experience spans a wide range of industries, including healthcare.



Healthcare Liability Insurance: Is Your Hospital Addressing Current and Emerging Challenges? Paul Sulaski, ProAssurance Vice President, Hospitals & Facilities

Healthcare is dynamic by its very nature, but rarely has U.S. healthcare experienced change on the scale of the past two years—with:

- over 10 million* people who have enrolled and paid for health insurance coverage through the Affordable Care Act (as of March 2015);
- an unprecedented number of hospital and medical group consolidations;
- urgent care centers, retail clinics, and other outpatient facilities proliferating;
- rapid adoption of electronic health records and an increasing number of healthcare data breaches; and
- a growing shortage of physicians.

How will these trends affect healthcare liability and what can hospitals do to prepare? You can help your organization meet the challenges of an evolving healthcare environment by clarifying what's most important. You also must understand coverage options and the balance of risk and control. This two-pronged approach of knowing what's most important and understanding risk/control options will help you ensure the right fit for your hospital's needs.

What is Most Important to Your Organization?

To be effective, your healthcare liability insurance program must align with your hospital's objectives, systems, and risk tolerance. This means your important control is respected—control over how the program is structured, how claims are handled, and strategies for containing costs.

You can help ensure program alignment with hospital objectives by considering:

- **Cost**—How can you utilize economies of scale, loss control strategies, and alternative options to reduce your hospital's healthcare liability insurance premium? Can your insurance provider bundle coverages to lower costs and deliver a single-source solution (such as umbrella, D&O, E&O, cyber liability, etc.)?
- **Risk tolerance**—What level of risk is your organization willing to assume? Can your insurance provider structure a risk sharing program that addresses both budgetary constraints and your organization's comfort level?
- **Control**—How can you help ensure your hospital retains important control over claims handling and key program parameters?
- **Mergers, acquisitions, growth**—What options are available to help make it easier to address coverage issues associated with consolidating new physicians and healthcare providers into your organization?
- **Loss control**—Does your hospital's current approach address emerging healthcare liability risks? Would your risk management team benefit from added assistance and resources?

Many large healthcare organizations work with an insurance broker when deciding how to handle liability insurance. They then review how established insurance companies can offer expertise and resources to meet their needs, along with:

- **Financial strength and ratings**—Does the company have a history of proven financial stability?
- **Experience insuring hospitals and large healthcare entities**—Does the insurer have extensive experience, with a track record of successfully serving this complex market?
- **Ability to provide alternative and customized insurance programs**—Traditional healthcare professional liability coverage may not meet the needs of many of today's complex healthcare organizations. Large organizations may wish to retain risk and, potentially, share in good outcomes. Can the insurer provide alternatives tailored to your organization's unique needs?
- **Level of transparency**—Does the insurer provide straight facts, respect your expertise and knowledge, and work to help you fully understand how your insurance program could be structured and what services are included?
- **Ease of doing business**—Is the insurer vigilant in anticipating and helping you solve problems? Do they make it as easy as possible for you to secure coverage and services to fit your organization's criteria?
- **Claims defense**—Does the insurer commit to providing the level of claims handling you want for the level of risk you are willing to assume?

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Alternative Options

Hospitals and large healthcare organizations increasingly seek more sophisticated and customized alternatives for managing and financing losses associated with risk. Options within alternative risk include numerous methods of retaining, transferring, or financing risk. Advantages of these options include a high level of control and the opportunity for cost savings.

Another alternative for organizations large enough to support necessary start-up costs (generally those with premiums of \$1 million-plus) is a self-insurance program. These programs allow the hospital to directly assume the risk of claims. Various types of self-insurance are allowed under federal law, including:

- **Risk Retention Groups (RRGs)** are corporations or limited liability associations that are organized for, and whose primary activity consists of, assuming and spreading some or all of the liability exposure of its members. An RRG must be owned by its members or by an organization that is owned by members of the group. Members contribute capital, and membership is limited to individuals engaged in similar activities. RRGs are not subject to state regulatory requirements, and their members are not protected by their state's guaranty fund should the group become insolvent.
- **Risk Purchasing Groups (RPGs)** are formed by a group of individuals or entities with similar or related liability risks to purchase liability insurance coverage on a group basis. This is not an insurance company. The RPG does not underwrite its risks, but instead purchases coverage for its members, usually from an established insurance company licensed in at least one state.
- **Captive Insurance Company**—captive insurers are alternative risk vehicles that allow organizations to form an insurance company subsidiary to finance retained losses in a formal structure. Common types of captives include single parent, association, group, agency, and rent-a-captives. Healthcare organizations can use a "cell" of an existing captive facility for much easier captive-option access. Captives are not licensed by individual states and many are formed "offshore" at locations where regulation is not as stringent. This entity does not qualify for protection under state guaranty funds and retains responsibility for all dollar losses accruing from claims.

Unique solutions that address the needs of growing and merging healthcare organizations also are in demand. Innovative insurers are providing flexible protection, consultation, and service options to create the optimal program for a hospital's situation and preferences. For example:

- hospitals can purchase unique joint hospital/physician professional liability coverage; and
- hospitals can allow acquired physician practices to maintain their own insurance and seamlessly merge risk into the hospital's insurance program through risk transfer or retention layers.

Traditional Options

Healthcare organizations that do not meet premium levels necessary for self-insurance or that find such arrangements outside their comfort zone may benefit from traditional options. Insurance companies that are experienced with hospitals and healthcare entities can work with you to craft a policy with the coverage you desire. For example, you may save money through deductibles, retrospective rating, or staff participation in specific risk reduction activities or training. You also can take advantage of the insurance company's risk resources and expertise to augment your patient safety efforts.

Expertise is Key

Whether you take an alternative or traditional approach to mitigating risk, it's vitally important you are clear about your healthcare organization's needs and are comfortable with the company you choose. Working with insurance experts who have proven experience and success in healthcare liability insurance and risk options—along with selecting a stable and expert carrier—will net the best result.

*U.S. Department of Health & Human Services, press release June 2, 2015, <http://www.hhs.gov/news/press/2015pres/06/20150602a.html>

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This article is not intended to provide legal advice. *ProAssurance is a national provider of healthcare liability insurance and risk resource services. For more information, visit ProAssurance.com.*

MHA Update

2016 Medicare Payment and Policy Updates

Andrew B. Wheeler, MBA, FHFMA, Missouri Hospital Association

The Centers for Medicare & Medicaid Services have finalized many of the payment and policy updates for federal fiscal year 2016 and have issued proposed rules effecting calendar year 2016. Medicare payments for 2016 are estimated to be reduced by 0.5 percent, placing additional burden on organizations to ensure fiscal success. CMS has also issued a controversial Comprehensive Care for Joint Replacement proposed rule, which if finalized would affect certain hospitals beginning January 1, 2016.

The CCJR proposal continues to align with the CMS "[Better Care, Smarter Spending, Healthier People](#)" strategic direction announced earlier this year. The proposed rule would penalize or pay bonuses to certain hospitals based on their episodic cost for treating Medicare major joint replacement patients (DRG 469 and 470). Hospitals in Missouri that would be subject to the rule are those inpatient prospective payment system facilities physically located in metropolitan statistical areas of Cape Girardeau, Columbia, Kansas City, and St. Louis.

The CCJR episode will consist of the major joint replacement treatment plus services delivered 90 days post discharge. Services provided by most providers will be included, such as inpatient readmissions, long term care hospitals, inpatient rehabilitation facilities, home health, durable medical equipment, physician services and others. Services performed post discharge not related to the joint replacement service will not be included.

CMS will then aggregate how much was paid to providers for the episode. The episodic cost will then be compared to a benchmark to determine whether the facility will incur a penalty or bonus. The benchmark will be weighted for the first two years as 2/3 based on their hospital historic cost and 1/3 based on a regional benchmark. This weighting transitions to be solely based on the regional benchmark for years four and five. The region that Missouri will be included with is the west north central region.



Legal Lines

Provision of Complimentary Transportation Services: OIG Weighs In and Provides Additional Guidance Stuart J. Vogelsmeier, J.D., Lashly & Baer, P.C.

On October 14, 2015, the Office of Inspector General (“OIG”) issued Advisory Opinion 15-13, under which a hospital proposed offering free van shuttle service to patients to certain medical facilities within an integrated health system. In this Advisory Opinion, the OIG concluded that it would not impose administrative sanctions on the health system that proposed the arrangement. Given this result, many hospitals will certainly want to take note of the guidance that can be gleaned from this Advisory Opinion.

As hospitals are aware, HIPAA added a fraud and abuse provision which provides that a person who offers or transfers to a Medicare or Medicaid patient something of value that the person knows or should know is likely to influence the patient’s selection or a particular provider may be liable for civil monetary penalties of up to \$10,000 for each act (referred to as the “CMP”). One issue that hospitals have struggled to answer is whether providing complimentary transportation is likely to be subject to the CMP.

The OIG has not developed a regulatory safe harbor or exception to the CMP for complimentary transportation by hospitals. The OIG stated the following in 2002: “Offering valuable gifts to beneficiaries to influence their choice of a Medicare or Medicaid provider raises quality and cost concerns. Providers may have an economic incentive to offset the additional costs attributable to the giveaways by providing unnecessary services or by substituting cheaper or lower quality services”.

In 2005, the OIG stated, “The plain language of the CMP prohibits offering free transportation to Medicare or Medicaid beneficiaries to influence other selection of a particular provider, practitioner or hospital.” However, at the same time, the OIG stated that hospitals can offer free local transportation of nominal value, which they have interpreted as no more than \$10 per trip, or \$50 in the aggregate on an annual basis.

In December of 2002, the OIG announced that it is considering developing some type of regulatory safe harbor or exception. This safe harbor, however, has never been published. While it evaluates the possible regulatory solutions, the OIG has said that it will not impose sanctions on hospital based transportation programs that:

- Were in existence on August 30, 2002.
- Provide transportation on a uniform basis without charge or at reduced charges to all patients and families.
- Provide transportation only to and from the hospital.
- Provide transportation only within the hospital’s primary service area.
- Do not claim the costs of the transportation on cost reports or shift the costs to Medicare.
- Do not provide ambulance transportation.

Advisory Opinion 15-13 shed more light on this issue. (Advisory Opinions are binding only on the parties who requested the opinions, and they cannot be relied upon by third parties. These opinions are, however, instructive on the OIG enforcement policy). In Advisory Opinion 15-13, the health system proposed offering free van shuttle service between medical facilities run by the health system, as well as a central “pick-up/drop-off” location in the center of the community. Two shuttle circuits would exist: one with an 18 mile round-trip, and one with a 10 mile round-trip. Individuals would be transported without regard to their health insurance or their ability to pay for medical services. The vans would not be equipped or operated as ambulances, and there would be no medical care on board. No marketing of the system’s services would occur during the transport. The shuttle would not be advertised to the general public. The availability of the shuttle service would be communicated only to persons who are already patients of the health system physicians. The health system also certified that the costs of the shuttle system would not be shifted to Medicare or Medicaid.

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Legal Lines

Provision of Complimentary Transportation Services: OIG Weighs In and Provides Additional Guidance Stuart J. Vogelsmeier, J.D., Lashly & Baer, P.C.

Even though the value of the transport could exceed \$10 per transport or \$50 on an annual basis, the OIG concluded that the proposed arrangement presented a minimal risk of fraud and abuse under the Anti-Kickback statute or the Civil Monetary Penalty Statute for the following reasons:

- The availability of the shuttle service would not be related to the anticipated volume of Medicare/Medicaid business generated by the health services rendered to the riders.
- The transportation would not include air, luxury or ambulance-level transportation.
- Van drivers would not be paid on a per-person or per-patient basis.
- All transportation would be local, and within the health system's primary service area.
- The transportation service would not be advertised or marketed.
- The health system would bear the cost of the shuttle service, and would not shift those costs to Medicare/Medicaid.
- There was no evidence that the purpose of the arrangement was to induce referrals to the system by private physicians, or to steer patients to any particular provider.
- The availability of local public transportation in the health system's service area was very limited.

Health systems that are considering offering complimentary transportation to patients should study the Advisory Opinion, and consider other guidance issued by the OIG to ensure that no improper inducement exists.

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Stuart Vogelsmeier is a partner with the St. Louis law firm of Lashly & Baer, P.C. Mr. Vogelsmeier regularly counsels health care providers on issues such as Stark Law and Anti-Kickback Law compliance, corporate structure, employment agreements, joint ventures, adding ancillary services to practices, and asset protection. He can be contacted at (314) 436-8349 or at sjvogels@lashlybaer.com. The firm's website is www.lashlybaer.com.

This article is for informational and educational purposes only. Hospitals, individual physicians and other providers should contact their advisors for assistance.



Greater St. Louis HFMA Events



November 17	Region 8 Webinar - 8:00 - 9:00 a.m.
December 2	Annual Greater St. Louis Holiday Party Ritz Carlton, 4:30 - 7:00 p.m.
December 3	HFMA Virtual Conference
December 4	ICD-10 - Bring us Your Difficulties 8:00 a.m. - 12:00 p.m.
December 15	Region 8 Webinar - 8:00 - 9:00 a.m.
January 19	Region 8 Webinar - 8:00 - 9:00 a.m.
January 29	Half Day Compliance and Risk Ethics Class 8:00 - 9:00 a.m.
February 11	HFMA Certification Candidate Practicum 8:00 - 9:00 a.m.
February 18	Annual Legislative Update 8:00 - 9:00 a.m.
February 18	HFMA Certification Candidate Practicum 8:00 - 9:00 a.m.
February 25	HFMA Certification Candidate Practicum 8:00 - 9:00 a.m.

Visit the [HFMA Calendar](#) for more information!

GO BEYOND

Board Meeting Date

Thursday, November 12, 2015
SSM Healthcare
Address
Location

All members are welcome to attend, but RSVP is required.
Please RSVP to Theresa Kipper, Theresa_Kipper@ssmhc.com