Greater St. Louis HFMA Chapter

Volume 34, Issue 3

Winter 2015

Gateway Gatherings

President's Message

Amy Richter
Chapter President

Greetings Fellow HFMA Members!

I hope you all had a wonderful holiday season and enjoyed spending time with family and friends. We had a wonderful holiday party this year, which was held at the Ritz Carlton. It was nice to see many of you at the event.

Winter is upon us and our chapter committees are busy putting together the winter and spring educational programs, networking events and social gatherings.

I would like to thank each of our members who completed the membership satisfaction survey that was sent out in the fall by HFMA National. We truly welcome your thoughts and ideas. Everyone's participation is what makes our chapter successful. We want each member to get the most out of their HFMA membership. The results from the survey help us to make changes and plan for the upcoming HFMA year. We are listening to your comments, and at your request, have added new programs and networking events this year.

As I had previously mentioned in the fall, one of our chapter's strategic initiatives is to focus on partnering with other organizations (in addition to other HFMA chapters) in bringing programs to our members. We have several joint events scheduled in the upcoming months with MGMA, HBA and also MO ACHE. Our goal is to increase our overall membership's participation in our education programs. We will continue to offer the popular programs requested by our members, such as the insurance payer panel and legislative/compliance update. We realize that many of you have experienced budget cuts within your organizations and that every education dollar is important. We want to offer you the best choices in meeting your educational needs. We hope you were able to take advantage of the free HFMA National Virtual Conference offered to members in December. It is a great way to earn CPE hours without travel costs. Please check our Greater St. Louis chapter website for upcoming education programs and other events.

We are striving to reach our membership goal for the 2014-2015 year. Many organizations have cut expenses, including professional memberships/ educational dollars and many HFMA chapters across the nation are having difficulties maintaining their membership counts. Our chapter is also experiencing this challenge. We want to fulfill the needs of our members by offering what is important to them. So please do not hesitate to contact our Membership Chair and Board Director Karen Barker at Karen.Barker@53.com with any ideas you may have to enhance the value of your membership.

We are also going to be holding a series of webinars beginning in February and running through March which are study sessions for the CHFP (Certified Healthcare Finance Professional) exam. Our chapter goal this year is to increase the number of our certified members. In order to do that, we have secured the assistance of consultant, Christoph Stauder. Christoph has previously worked with other HFMA chapters nationwide in preparing their members for the CHFP exam. Christoph's curriculum will provide the tools needed in order to prepare for the exam. We have partnered with three other HFMA chapters to reduce the overall cost. If you would like more information on this series of webinars, please contact our Certification Chair and Vice-President, Theresa Kipper at Theresa_kipper@ssmhc.com.

Thank you for your continued support of our Officers, Directors and Volunteers. A special thank you to our chapter sponsors, who allow us to continue to offer quality educational programs to our members.

In closing, I would like to wish all of you a Happy and Healthy 2015. I look forward to seeing each of you at our upcoming programs and networking events. If you have any questions or concerns, please do not hesitate to contact me or any of our Officers and Board Directors.

Amy Richter
President 2014-2015
Greater St. Louis Chapter of HFMA

Inside this issue:

LEADING *the* CHANGE
hfma 2014 - 2015

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From the Editor…

In this issue, you'll find the Educational Corner has grown. We have many great local and national members lending their expertise to our readership, so please take a moment to read the articles, and I also challenge you to think about what you could contribute in this section. I would also like to point out a common theme from both Amy's and Tracy's letters from this issue. They talk about acting as a team and working together to accomplish more. Be sure to keep that in mind as you read the newsletter, and go into the New Year. 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:

Spring Issue

April 10
Deadline for Articles

April 30
Publication Date

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Chapter Updates

Programs Update

Jeff Morgan

Hello from the Programs Committee- Thanks to all members in their participation in both our live conference and webinars. Our chapter is on track to exceed our chapter education goals this year and we could not do it without the help and support from all of our members.

We are planning a busy spring for additional 1-day conferences and look forward to seeing you there. Save the dates on upcoming conferences include:

March 3- We are excited to announce a joint conference with the St. Louis MGMA organization at the St. Charles Convention Center. This conference will bring together hospital and physician revenue cycle, finance, and operational educational sessions to cover the diverse environments of care our members work in.

March 24- We will host our annual payer panel in the Westport area and will offer free registration to members and guests and will include continental breakfast and lunch. As in past years, we will assemble representatives from 4-5 major payers in the St. Louis area. They will share news and updates from their organization and discuss trends and future programs.

April 23- We will host our annual legislation/regulation/compliance/risk/ethics update conference in the Chesterfield area. This will focus on 2015 updates and future trends around all aspects of legislation/regulation/compliance/risk/ethics.

May 13-15- We will host our annual Spring conference at a new location this year and new chapter joining us. We will be at the newest casino in town, the River City Hotel and Casino in Lemay, south of downtown and we are excited to announce that the Southern Illinois HFMA Chapter will join us and the Missouri Show-Me chapter for a great 3-chapter event.

Also, please help me welcome our newest members to the Programs Committee. These individuals have been added to the committee and have begun to get involved in helping to plan, coordinate, and schedule our exciting educational events. Our newest members are:

Chastity Werner
Anders CPAs + Advisors

Connie Stimpson
Salucro

Julie Greatting
SourceHOV

Leslie Strader
SourceHOV

RJ Crotser, MBA, CPHIMS
Medecision

Chapter Updates

Sponsorship Updates

Jeff Morgan

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

Please contact our Sponsors:

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The Greater St. Louis HFMA Chapter would like to offer you the opportunity to participate in our 2015-2016 Corporate Sponsorship Program, starting on June 1. Current program details can be found on our website.

We host multiple conferences per year to include: the Joint Spring Conference in May, the Fall Conference in October, the Region 8 Mid-America Summer Institute in August, and several other local one-day conferences throughout the year with other leading healthcare trade organizations. These include MGMA, ACHE, and LeadingAge.

We continuously strive to provide quality educational events and networking opportunities at a reasonable cost to our members. In order to do this, we need the support of our sponsors. We have developed our sponsorship program to maximize the effectiveness of your sponsorship dollars.

Please let me know if you have suggestions on how to improve our programs! Please consider sponsorship for our upcoming chapter year June 1, 2015-May 31, 2016.

Also, please help me welcome our newest member to the Sponsorship Committee. I am excited to have **Maureen Kelly** from McKesson join the Sponsorship Committee and work to bring value to all of our sponsoring organizations.

Region 8 Connection

Tracy Packingham

Happy New Year!!! As I write this, the football season is winding down and the Super Bowl is right around the corner. It reminds me of what a great team we have within HFMA. ***"TEAM"*** **T**ogether **E**veryone **A**chieves **M**ore.

I believe that TOGETHER we can truly achieve anything. Being part of the HFMA Line Up has been a phenomenal journey that I have had the opportunity to be a part of. As I talk with other members, officers and colleagues, I realize that I am not alone in this reflection. The chapter leaders and members of Region 8 make a fabulous team.

Please reach out and become part of your chapter. Regardless of whether you are a sports fan, be a fan and love the Association of which we are a member. Become a part of a "team" of dedicated healthcare Professionals. "Lead the Change", with the constant change we all have talents and contributions. Not one of us can do it ALL. Get involved and make the most out of your membership.

Thank you for the continued support of all of our officers, directors, volunteers and members. Our chapters are truly exceptional. Region 8 ROCKS!!!

Tracy Packingham
Regional Executive
HFMA Region 8

LEADING *the* CHANGE
hfma 2014 - 2015

Join Us on LinkedIn!
Search St. Louis HFMA in the Groups search bar and join the conversation!

Educational Corner

ED Patient Flow is a Hospital-Wide Issue

Judy Chamberlain, RN, ARM, CPHRM, AHA Fellow, ProAssurance

Boarding patients and overcrowding may contribute to medical mistakes and poor patient outcomes. Not only does overcrowding affect critically ill patients needing a hospital bed, it also delays care for emergency department (ED) patients in the waiting room. The primary cause of overcrowding in the ED is boarding.

The American College of Emergency Physicians (ACEP) defines a "boarded patient" as a "patient who remains in the emergency department after the patient has been admitted to the facility, but has not been transferred to an inpatient unit." The Joint Commission recommends boarding times be less than four hours. However, facilities are not graded on whether they meet this recommendation. They are graded on their individual plans for patient flow management and how actual boarding times measure up to internal plan goals.

Problems associated with patient flow (like boarding and overcrowding) are best addressed across the organization. This involves leadership from all facility areas, both clinical and non-clinical, working together to eliminate patient boarding in the ED.

Scenarios causing increased ED boarding are many and complex. Consider the patient who needs to be admitted to the ICU and cannot be transferred immediately. Are all rooms full or is there an empty room that has not yet been cleaned? Consider patients needing lab or other diagnostic testing before an admission decision is made. Are there performance or interpretation delays? Hospitals must delve into identifying flow breakdowns, recommending changes, continually evaluating patient flow based upon changes, and determining whether patient boarding times have been affected.

If boarding times do not decrease after changes are made, analysis should begin anew. It is imperative that situations where patients are boarded beyond four hours (or less, if that's the facility's goal) be analyzed in detail. ED staff analysis of the basic issues causing delays in admission, transfer, or discharge, is critical.

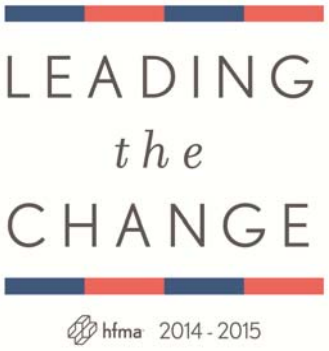
Strategies for improving patient flow include, but are not limited to:

- establishing multidisciplinary teams to identify problems, implement solutions, and facilitate change;
- allocating sufficient resources to provide safe and effective patient care for current and arriving patients;
- providing appropriate training to emergency nurses on managing ill patients held in the ED;
- creating an admissions unit adjacent to the ED for patients awaiting an inpatient bed;
- developing a bed control officer or committee to monitor hospital bed status; and
- holding patients in inpatient units rather than the ED.

By addressing ED patient flow as a hospital-wide issue, your hospital may find it can lessen medical mistakes and improve patient outcomes.

http://www.acep.org/Clinical---Practice-Management/Definition-of-Boarded-Patient/, January 2011. Accessed January 15, 2015.

This article is not intended to provide legal advice, and no attempt is made to suggest more or less appropriate medical conduct.



Educational Corner

Focus on Three Areas to Reduce Financial Loss

John Weiss, CEO, The Audit Group, Inc. (TAG)

In complex, procurement-to-payment processes, a multitude of details help hospitals and healthcare systems lose funds through error or oversight. However, finance professionals focusing on three areas can improve processes, reduce future financial losses, and recover previously lost funds.

In conducting hospital and healthcare system AP/Purchasing recovery audits, The Audit Group (TAG) finds more than two-thirds of fund recoveries are related to duplicate payments, overcharges, and returned goods and rebate credits.

Duplicate Payments
Recovery audits reveal duplicate payments occur because of keying data from poor invoice copies, inconsistent data entry, and multiple accounts internally created for the same vendor.

It's easy to mistake a zero for an 'O' or a '5' for an 'S' when keying invoice numbers from "fuzzy" faxes or photocopies. An erroneous invoice number gets paid, as well as the correct number. It's *clearly* (pun intended) important to have clerks process from original invoices, or high quality photocopies or fax copies when keying invoice data; lacking this capability it is important to contact vendors for clarification.

Duplicate payments also occur from inconsistent data entry. To minimize these occurrences, establish policies for data keying special characters like dashes, slashes, hyphens, ampersands, spaces, and leading zeroes (in invoice numbers).

Given the recent increasing levels of vendor mergers and acquisitions, duplicate database information results when both the acquired supplier's account and the acquiring company's account remain independent. An annual Vendor Master Database review, similar in concept to an annual end of year product inventory, should reveal duplications that can be merged or deactivated.

Restricting the ability to enter or edit information within your vendor database to a few personnel should also reduce duplicate entries and other erroneous information.

Overcharges
TAG finds overcharges often occur due to lapsed contracts, POs incorrectly changed to match invoice pricing, and item price differences within individual entities of the healthcare organization.

When contracts lapse before new ones are officially approved, pricing can revert to vendors' higher list prices. To prevent this, work with the Contracts department to create alerts to upcoming contract expirations far enough in advance so a new contract can be put into place prior to item pricing going to list price. Upon agreement of new terms, they should be immediately loaded into your ERP system.

When PO and invoice pricing disagree, don't pay the invoice until resolving the discrepancy. The discrepant amount may be small but can accrue significantly if allowed to continue without correcting why overcharges occur. Discrepant information can also be used to review previously paid invoices for overcharges.

Item pricing variations can happen between a healthcare organization's entities, due to system acquisitions and/or by locations approving their own contracts. System-wide item pricing reviews reveal the best pricing, which can be used to leverage lower prices for the organization and recover funds at particular locations.

Unapplied Returned Goods and Rebate Credits
Often, lost returned goods or rebate credits are due to incomplete processes preventing credits from being applied to accounts. Because AP is responsible for applying credits to accounts, it can drive improvements to reduce lost credits.

Working with other departments to create tracking tools for credits due helps AP to both anticipate and follow-up on them, ensuring better collection *and* application. Without AP follow-up, "old" credits (the definition of which is determined by your vendors) may be applied by suppliers to outstanding invoices (which later get paid, creating "unapplied cash" on account), vendors may add unapproved and unacceptable charges (for example: bogus "late fees"), or vendors even allow them to "expire" (and reabsorb them).

Do not allow vendors to apply credits to outstanding invoices. The practice perpetuates errors and creates extra AP work when new invoices are internally "paid" by the vendor.

Click here for an example of a recommended returned goods process for hospitals and healthcare systems.

By focusing just on duplicate payments, overcharges, and credits, hospital and healthcare systems can attack three important areas of financial loss.

John Weiss is Founder and CEO of The Audit Group, a healthcare consulting firm helping hospitals and complex healthcare systems identify financial waste in procurement to payment cycles, reclaim funds through AP/Purchasing recovery audits, and improve processes to avoid future fund loss. He may be contacted at johnw@theauditgroup.com.

Educational Corner

You and Your 340B Program: Are You Compliant or Confused?

Venson Wallin and Bill Bithoney, MD, The BDO Center for Healthcare Excellence and Innovation

What is the 340B program?

The 340B program is a means through which providers, known as "covered entities," can offer pharmaceuticals to a greater amount of eligible patients than they could at traditional manufacturer pricing. This is because the program requires that manufacturers sell the drugs to the eligible providers at a discount, thereby enabling a larger number of those in need to get the assistance they need with purchasing their prescriptions. The 340B program is very popular for this very reason; covered entities are able to purchase drug supplies at the 340B discounted price, and then bill the patient's insurance company the traditional rate. This "margin" generates much needed profit for some of the more income-challenged providers, while having minimal impact on the Medicare and Medicaid program costs. The patient wins, the provider wins, and the government programs win. Providers understand the upside, and annual 340B drug spending by covered entities exceeds six billion dollars and approximately one-third of U.S. hospitals participate in the program. The spending and number of participating providers is forecast to increase significantly during the coming years.

In 1992, Congress created the 340B program via Public Law 102-585, the Veterans Health Care Act of 1992, which is otherwise known as Section 340B of the Public Health Service Act. The law requires drug manufacturers that participate in the Medicaid program to agree to provide discounts on covered outpatient drugs purchased by government-supported facilities, or "covered entities." Examples of "covered entities" include disproportionate share hospitals, sole community hospitals, rural referral centers, critical access hospitals, and children's hospitals and cancer hospitals exempt from the Medicare prospective payment system. Enrollment periods for those providers seeking to participate in the program are open on a quarterly basis. Administration of the 340B program is performed by the Office of Pharmacy Affairs (OPA) of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

Achieving Compliance with 340B Program Guidelines

Compliance pertaining to a 340B program is relative. A provider may consider themselves in compliance with the guidelines of the program based on their understanding of these guidelines, whereas HRSA and the OPA may consider the provider to be noncompliant based on their interpretation of these same guidelines. These divergent opinions are a result of a set of rules that are written in a somewhat general manner, excluding the detailed implementation regulations that are common to other HHS programs. HRSA recognizes the need for more clarity on the part of the covered entities and is actively working to close the interpretation "gap" and to achieve more compliance within the program.

HRSA has heard the rumblings from the industry and Congress over the past several years regarding the 340B program and the need for more detailed directions to minimize both unintentional violations of the program as well as intentional efforts to take advantage of the interpretation "gap" to prosper to an extent not anticipated by the authors of the program. Audits in recent years by HRSA and the Office of the Inspector General (OIG) of HHS have confirmed the fact that covered entities are having challenges meeting full compliance with guidelines, particularly in the areas of diversion and duplicate discounts. Another key factor in meeting compliance requirements identified through the audits is the degree to which providers utilize contract pharmacies and their oversight of such. The use of contract pharmacies, while occurring in the minority of covered entities at this point, is growing and there is a wide disparity in their treatment and oversight. HRSA has strongly recommended the use of independent audits of contract pharmacies to address compliance.

Increased Focus on Integrity and Compliance

So where does one go from here? Good question and one that the HHS OIG and HRSA intend to address in the immediate future. They are both being very active in publishing clarifying documents and preparing to conduct more extensive audits of 340B programs. The HHS OIG 2014 Work Plan contains initiatives pertaining to the 340B program, including a focus on contract pharmacy compliance by covered entities. In February, 2014, the OPA issued a program update that addressed contract pharmacy compliance and the continued focus on the program's integrity. In its June, 2014 program update, HRSA discussed an additional six million dollars that Congress had set aside for the 340B program. The additional funding is being used to establish a new branch of HRSA – Program Performance and Quality – which is tasked with overseeing program integrity. HRSA stressed that program integrity has always been a focal point of their staff, but that the new branch will now enable them to devote even more emphasis on this topic. And in its July, 2014 program update, HRSA further clarified its audit process, reaffirming its focus on increased audits and the intent to no longer issue preliminary audit reports but to only issue final reports. The commitment to a renewed attention to compliance through increased audits is evident through these updates and publications and covered entities would be advised to prepare for the inevitability of an increase in 340B program audits and that they may soon fall within HRSA's radar.

Continue on next page

Educational Corner

Continued...

"Mega-Reg" to provide clarification
Many facilities may be feeling somewhat alarmed by this enhanced focus on program integrity in that they believe they may need more guidance to ensure that their program is truly compliant. As discussed before, heretofore, detailed implementation guidance on the 340B program has been found to be somewhat lacking, and compliance became an "interpretation of the rules" exercise. Now, with more expected of them, the covered entities are in need of specific clarification of the rules and HRSA is preparing to provide such guidance. The much discussed "mega-reg" that HRSA is expecting to issue will provide specific guidance on issues such as the definition of an eligible patient, compliance requirements for contract pharmacy arrangements, hospital eligibility criteria, and the eligibility of off-site hospital facilities.

Throwing a potential curve into HRSA's plans is the recent (May, 2014) decision by the United States District Court for the District of Columbia (USDCDC), which held that HRSA lacked the ability to issue the regulation regarding orphan drugs. HRSA had attempted to promulgate limitations on the use of orphan drugs by certain covered entities; however, the USDCDC found that the 340B regulation itself limited HRSA's ability to promulgate regulations to only those areas dealing with the administrative dispute resolution process, calculation of ceiling prices, and civil monetary penalties. Furthermore, orphan drugs were not deemed to be included in the definition of any of these three areas, therefore, HRSA was found to not have the authority to issue any regulations pertaining to them.

Covered entities may wonder why this is important if orphan drugs are not a large part of their 340B program. The importance lies in the ability of HRSA to issue and enforce the "mega-reg." HRSA has so far chosen not to appeal the USDCDC finding, and it must decide, before proceeding, whether the issues covered by the "mega-reg" would survive a likely court challenge in light of the USDCDC decision, and whether a further "tweaking" of the regulation should occur prior to its actual issuance. At this point, HRSA has indicated that they continue to look to move forward with the "mega-reg."

Conclusion
It is very clear that the history of the 340B program being loosely regulated and enforced is just that – history. HRSA, the OPA and the HHS OIG all have the 340B program high on their list of priorities and they are committed to ensuring a more consistent implementation of the program and to strengthening its integrity. Through audits and publication of clarifying guidance, they are working with covered entities to achieve those goals. Covered entities should be proactive in assessing the compliance of their 340B programs and taking steps to document compliance and/or perform corrective efforts to become compliant. Steps may include performing internal assessments of policies and procedures or partnering with external agents to assist with these assessments, performing audits of the program components, obtaining independent audits of contract pharmacy arrangements, and developing a routine process of monitoring new HRSA program updates and their impacts, including the new "mega-reg." By taking these steps, covered entities can begin to move the gauge from "confusion" to "compliance."

Click here for additional information and links for The BDO Center for Healthcare Excellence & Innovation

2015 Federal and State Legislative and Regulatory Outlook

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

As the 113th United States Congress ends and the 114th begins, "shots across the bow" are already taking place to reform and protect the integrity of the Medicare program. The U.S. House of Representatives Committee on Ways and Means recently released discussion drafts, which have the potential to influence the Medicare program. These documents can be used to gain an understanding about what hospitals might be facing in 2015.

The Hospital Improvements for Payment Act of 2014, released in November 2014, contains several sections aimed to reform the Medicare program. The draft is intended to address nine specific issues, including a new hospital prospective payment system, a new per diem rate for short lengths of stay, repeal of the two-midnight payment reduction policy, make improvements to the recovery audit program and expand access to Medicare data. Other proposed sections include retrospective and prospective hospital solutions to address problems in the Medicare appeals process, repeal the "ObamaCare Bay-State Boondoggle," and changes to the critical access hospital 96 hour condition of payment provision.

The Protecting the Integrity of Medicare Act of 2014, also released by Ways and Means as a discussion draft, would combat fraud, waste and abuse in the Medicare program. Sections of PIMA include preventing wrongful Medicare payments, use of Smart Card technology, modifications to face-to-face encounter documentation requirements, reducing improper payments through Medicare administrative contractor outreach and education programs, and the renewal of MAC contracts.

On the federal regulatory front, the Internal Revenue Service now has finalized the rule on standards for tax-exempt hospitals regarding financial assistance, collection practices and community health needs assessments. While the rule finalizes a 2012 proposed rule on financial assistance and a 2013 proposed rule on community health needs assessments, several nuances to the rule have changed. The changes include:

- The final rule changes the threshold for translating financial assistance documents into primary language of those with limited English proficiency. A tax-exempt hospital's financial assistance policy and related documents must be translated for each population that exceeds 1,000 individuals or 5 percent of those likely to be affected by, or have an encounter with the hospital, whichever is less. The proposed rule included a threshold of 10 percent of the residents of the community served by the hospital.
- A "hospital organization" is one that operates one or more hospital facilities, which is defined as a facility that is required by a state to be licensed, registered or similarly recognized as a hospital. Multiple buildings operated under a single state license are considered a single facility.
- Following the language of the federal law, no exemptions or exclusions are provided for tax-exempt governmental hospitals.
- A tax-exempt hospital's omission or error regarding its community health needs assessment will not be viewed as noncompliant if it is minor and either inadvertent or due to reasonable cause and is corrected by the hospital.
- A tax-exempt hospital's financial assistance policy must list the providers, other than the hospital itself, delivering emergency or other medically necessary care in the hospital, and specify which providers are covered and not covered by the hospital policy.
- The final regulations allow a tax-exempt hospital to change the method it uses to determine "amounts generally billed" at any time, so long as the change is reflected in the hospital's financial assistance policy documents.
- The billing periods specified in the regulation will begin with the first "post-discharge" billing statement, rather than the first billing statement.
- A plain language summary of the hospital's billing policy must be included with one post-discharge written communication. Also, billing statements must include a notice about the availability of financial assistance and how to get information about the hospital's financial assistance plan. The IRS had previously proposed that a financial assistance policy summary be included with all billing statements and other written communications during the first 120-day billing period.
- Notice requirements for "extraordinary collection actions" are narrowed in the final rule.

Within the state of Missouri, the Missouri Hospital Association will continue to work diligently with community leaders and state officials to decrease Missouri's uninsured rate. Medicaid transformation will be the cornerstone of MHA's advocacy efforts during the 2015 state legislative sessions. A key component will be explaining the positive experiences of bordering states that have expanded Medicaid eligibility. Results of expansion are starting to surface, contributing to marked improvements in payer mix, utilization trends and reduction in uncompensated care expenses. Recently, Arkansas Hospital Association, in conjunction with the Arkansas Chapter of the Healthcare Financial Management Association, released a document illustrating the major effects of Medicaid expansion on their hospitals. According to the report, uninsured admissions have decreased more than 46 percent, uninsured emergency room visits are down more than 35 percent and uninsured outpatient visits have decreased 36 percent. In addition, the losses incurred to treat the uninsured in Arkansas have declined by $69 million through June 2014. To date, Missouri's border states that have expanded coverage include Iowa, Illinois, Kentucky and Arkansas. As a nation, 27 states and the District of Columbia have all expanded Medicaid coverage, with four other states currently considering expansion, including Tennessee. This now places Missouri in the minority among states.

Once again, MHA will be coordinating its advocacy efforts with a broad coalition of organizations that support Medicaid transformation.

Legal Lines

2015 OIG Work Plan Provides Insight for Providers

Stuart J. Vogelsmeier, J.D., Lashly & Baer, P.C.

The Office of Inspector General of the United States Department of Health & Human Services (the "OIG") recently released its Fiscal Year 2015 Work Plan. The Work Plan identifies new and ongoing reviews and activities that the OIG plans to pursue in the next 12 months. Providers who read the HFMA Newsletter are aware that the majority of the OIG's resources are directed toward safeguarding the integrity of the Medicare and Medicaid program. The OIG is charged with detecting and preventing fraud, waste, and abuse, and identifying opportunities to improve program economy and efficiency, as well as holding accountable those providers and suppliers who do not meet program requirements or violate Federal law. The 2015 Work Plan provides a small glimpse into the OIG priorities for 2015. The 2015 Work Plan is actually more concise than previous years' Work Plans, and it is well-organized and easy to review. Here are some key areas of emphasis:

Home Health Services:

- Review of employment by home health agencies of individuals with criminal convictions.
- Review of compliance with various aspects of the home health prospective payment system.

Hospitals:

- Review the extent to which provider-based facilities meet the CMS criteria.
- Review of Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments.
- Review of outpatient evaluation and management services billed at the new-patient rate.
- Oversight of pharmaceutical compounding by hospitals.

Nursing Homes:

- Review of procedures implemented by facilities for background checks.
- Review the extent to which Medicare beneficiaries residing in nurse homes are hospitalized as a result of conditions thought to be manageable or preventable in the nursing home setting.

Hospices:

- General review of hospice inpatient care.
- Review of the extent to which hospices serve Medicare beneficiaries who reside in assisted living facilities.

Medical Equipment and Supplies:

- Review of potential savings by Medicare if power mobility devices are rented or purchased.
- Frequency of replacement of supplies for durable medical equipment.
- Review of payments for home blood glucose testing supplies, diabetic testing strips and lancets, to identify questionable billing.

Physicians:

- Review of physician-owned distributors of spinal implants, especially those distributors that provide spinal implants to hospitals.
- Review of place of service coding errors.

Other Providers and Suppliers:

- Review of questionable billing for chiropractic services.
- Review of medical necessity for high-cost diagnostic radiology tests.
- Review of independent clinical laboratory billing requirements.
- Review the high volume of sleep-testing procedures.

This article just scratches the surface on the multitude of issues that the OIG intends to address in the upcoming year. Providers are urged to review the actual Work Plan at http://oig.hhs.gov/reports-and-publications/workplan/index.asp.

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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 reimbursement-related issues. He can be contacted at (314) 436-8349 or at sjvogels@lashlybaer.com. The firm's website is www.lashlybaer.com.

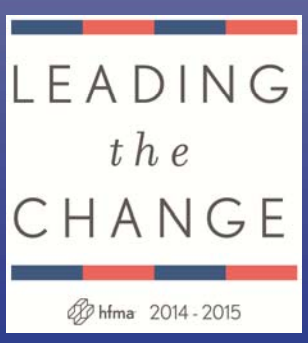
This article is for informational and educational purposes only. Hospitals, individual physicians, and other providers should contact their advisors for assistance.

Greater St. Louis HFMA Events

hfma greater st louis chapter
healthcare financial management association

February 5	**HFMA Virtual Conference**
February 12	**HFMA Certification Practicum Webinar Series** **12:00 - 2:00 p.m.**
February 17	**Region 8 Webinar: The Importance of Properly Reporting Charity Care and Bad Debt** **12:00 - 1:30 p.m.**
February 18	**Happy Hour at Gamlin Whiskey House** **4:30 - 7:00 p.m.**
February 19	**HFMA Certification Practicum Webinar Series** **12:00 - 2:00 p.m.**
February 26	**HFMA Certification Practicum Webinar Series** **12:00 - 2:00 p.m.**
March 3	**Joint MGMA of St. Louis and Greater St. Louis HFMA 1-Day Conference at St. Charles Convention Center** **9:00 a.m.**
March 5	**HFMA Certification Practicum Webinar Series** **12:00 - 2:00 p.m.**
March 12	**HFMA Certification Practicum Webinar Series** **12:00 - 2:00 p.m.**
March 17	**Region 8 Webinar**
March 24	**Annual Payer Panel at Syberg's** **9:00 a.m. - 4:00 p.m.**
April 16	**HFMA Virtual Conference**
April 23	**Legislation, Regulation, Compliance, Risk, and Ethics Update** **9:00 a.m. - 4:00 p.m.**
April 23	**HFMA Awards Night at the St. Louis Zoo**

Visit the HFMA Calendar for more information!



Board Meeting Date

February 19, 2015
4:00 - 6:00 pm
BJC - The Commons
4249 Clayton Ave., St. Louis, MO

All members are welcome to attend, but RSVP is required.
Please RSVP to Amy Richter, arichter@hospice.org