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## INSIDE



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# Patient Access Financial Assistance Policies Face Intense Scrutiny: Two Lawsuits Already Underway

*Lawsuits allege charity care withheld from thousands of patients*

The way hospitals screen patients for financial assistance is facing intense scrutiny in light of two recent lawsuits. "The implications for patient access are significant," says **Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy at the Healthcare Finance Management Association.

Both lawsuits, filed by Washington state attorney general Bob Ferguson against St. Joseph Medical Center in Tacoma and Capital Medical Center in Olympia, allege that the hospitals withheld charity care from thousands of low-income patients.[1,2]

"More hospitals will be sued, unless they change. Advocates for consumers, as well as the government, expect legal compliance," warns **Ann M. LoGerfo**, an attorney with Seattle, WA-based Columbia Legal Services. Failure to screen patients for charity care and then pursue patients for bills they do not owe are violations of the Consumer Protection Act and legal obligations, says LoGerfo. "It is an unfair and deceptive practice, and is a breach of the financial contract with the patient."

"MORE HOSPITALS WILL BE SUED, UNLESS THEY CHANGE. ADVOCATES FOR CONSUMERS, AS WELL AS THE GOVERNMENT, EXPECT LEGAL COMPLIANCE." — ANN LOGERFO, COLUMBIA LEGAL SERVICES

## Roadblocks Not Uncommon

The practices alleged in the lawsuits may sound egregious to the general public, but they're surprisingly common. "Many hospitals set up roadblocks to their financial assistance programs," says **Holly Lang**, a New York City-based contractor specializing in healthcare financing, public policy analysis, and nonprofit hospital strategy.

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## EXECUTIVE SUMMARY

Two recent lawsuits allege that hospitals withheld charity care from thousands of patients. To comply with state and federal regulations, patient access departments should take several steps.

- Talk with patients about their financial responsibility.
- Determine patients' eligibility for financial assistance.
- Make financial assistance conversations an integral part of patient access processes.

In a 2017 study of nonprofit hospitals on the East Coast, Lang found that about one in seven provided no information at all about their policy online, although it is required by federal law. "That alone is a huge problem," says Lang, adding that she expects to see similar lawsuits filed at the state level. "I wouldn't be surprised if we started seeing more federal involvement in this as well."

Lang says that a well-designed, well-executed financial assistance program isn't just good for patients — it also benefits the hospital, because of the correlation between bad debt and insufficient charity programs. Additionally, most states have minimum requirements for charity care for hospitals to obtain Certificates of Need for capital construction and expenditures.

"It's far better to go ahead and qualify patients for charity care if they are eligible, as opposed to putting up roadblocks that place the patient in an even more precarious financial situation, just to have that account end up in bad debt," says Lang.

## High Level of Transparency

Washington state requires hospitals to streamline financial assistance application processes to make it easier for patients to apply. "Washington is one of many states that requires its hospitals to provide a high level of transparency about its financial assistance program," says Lang.

Based on court filings and the Attorney General's statements, the hospitals blatantly disregarded these laws, says Lang, and, instead, put in systematic barriers for financially vulnerable patients. "This means the problem started with management, who is alleged to have directed staff to put up these barriers," she notes.

Washington state law requires hospitals to do the following:

- Provide notice of charity care availability.
- Screen patients for eligibility.
- Require only one income-related document to prove charity care eligibility.

The lawsuits allege the hospitals violated all of these requirements and aggressively demanded payment from patients — without screening them for charity care eligibility.

**Cary Evans**, vice president of communications and government relations at CHI Franciscan Health, a Tacoma, WA-based health system with eight acute care hospitals, including St. Joseph Medical Center, disputes the allegations in the lawsuit. "As a nonprofit charitable organization, we are committed to providing the highest quality care to everyone who needs it," says Evans.

## Mission of Patient Access: Improve Access to Care

Many patients are transferred to Loma Linda (CA) University Medical Center (a Level 1 trauma center) from other facilities. Some have only minimal coverage or no coverage at all. "We want to see what we can do to help those patients financially," says admitting director **Denise Rotolo**.

Patient access does a great deal of education. Many people lack even a basic understanding of their benefits. "The complexity of coverage has increased tenfold," says Rotolo. "Trying to help patients understand that has been a big challenge."

All registration areas hand out a brochure titled *Understanding Your Health Care Insurance and Expenses*. Terms such as "deductible" and "coinsurance" are defined. "It also informs patients that the hospital has a department to help them with financial assistance, if needed," says Rotolo.

Insured patients with high out-of-pocket expenses sometimes qualify for some type of charity assistance. This is true even for people with income over 350% of the federal poverty level. "If your insurance pays very little and your responsibility is exorbitant, you're not going to have to pay anything more than what Medicare would pay us, plus 20%," says Rotolo.

If patients' incomes are between 201% and 350% of the federal poverty level, they pay the same amount as Medicare would pay. If their income falls below that level, they're responsible for only a percentage of what Medicare would pay.

"We have a really good program to help people who are underinsured and on a limited income," says Rotolo. "It's something we see every day."

Some uninsured patients even obtain Medicaid coverage. "Without our robust in-house Medi-Cal program, we would have a significantly higher self-pay population," says Rotolo. "This would likely end up in bad debt or charity write-offs." (*See the department's charity and discount payment policy in this issue*.)

San Diego-based Sharp HealthCare recently collaborated with regional hospitals to create a marketing campaign on financial assistance policies. The hospital's policy is posted in registration areas, the business office, and the emergency department.

"It is given to anyone who asks, and always immediately provided to any self-pay patient," says patient financial services manager **Perla Pace**. Patient access asks patients five simple questions to determine the following: their zip code, their citizenship, their household income, where they're employed, and whether they have any medical conditions or disabilities.

"Based on this five-question survey, we provide a list of any funding programs the patient may be eligible for," says Pace. These include the hospital's financial assistance program, County Medical Services (a program that funds medical care for uninsured indigent adult county residents), food stamps, prescription cards, general relief, and Supplemental Security income (a government program that provides benefits to low-income people who are 65 years of age or older, blind, or disabled).

However, patient access does not stop after giving patients the name of a program for which they qualify. Staff help patients to apply, and stick with them through the entire process. "We have an internal Medi-Cal eligibility team who assists the patient through the process of navigating these programs," says Pace.

The patient is assisted from the initial application until a decision is made — and sometimes even after that. "We often appeal erroneous denials," explains Pace. "We are passionate about improving access to care for our most vulnerable populations."

Some patients still may be ineligible for any public program or financial assistance. Patient access offers to help in any way they can. "We assist them in arranging payments by negotiating discounts based on our established guidelines," says Pace. ■

**SOURCES**

- **Perla Pace**, Patient Financial Services, Sharp HealthCare, San Diego, CA. Phone: (858) 939-3740. Email: Perla.Pace@sharp.com.
- **Denise Rotolo**, Admitting Director, Loma Linda (CA) University Medical. Email: drotolo@llu.edu.

Evans adds that the hospital goes beyond what's required by state law by completely covering the cost of care for people with income below 300% of the federal poverty level: "We provided $20 million in charity care to 19,115 patients in the last year alone."

**Jeff Atwood**, senior vice president of marketing and communications at RCCH HealthCare Partners, which operates Capital Medical Center, says, "We are very disappointed to learn of the Office of the Attorney General's recent filing."

## Take a Hard Look at Patient Access Policies and Practices

***Put patient access staff in shoes of patients living below poverty level***

Recent lawsuits and media coverage scrutinizing hospitals' financial assistance practices send a strong message to patient access: Now is the time to review policies, procedures, and the way staff are trained.

"Ensure they are consistent with what state and federal law requires," advises Washington State Hospital Association spokeswoman **Mary Kay Clunies-Ross**. "The law is clear that charity care or financial assistance must be provided to low-income people for what the law considers 'appropriate hospital-based medical services.' It's not a staff judgment call. It's required by law."

In Washington state, for instance, all patients must receive notice of charity care availability. Signs with information about how to access charity care must be displayed prominently, and patients who request charity cannot be billed until screening is completed.

"Patient access departments and legal counsel should work together to ensure financial assistance is being offered and that the hospital can show that its policies and practices are aligned with the intent of the law," says Clunies-Ross.

Are you certain your patient access practices fully comply with state and federal requirements? "This is a chance to further strengthen your policies, by reviewing what you have in place and seeing where it could be better," says **Holly Lang**, a New York City-based contractor specializing in healthcare financing, public policy analysis, and non-profit hospital strategy. She says it is important to answer the following questions:

- Do you provide a copy or a plain language summary of your policy to all patients without their asking? Is it in the languages that your patients speak and read?
- Do you make it clear that payment is not required while a patient's application for assistance is being reviewed?
- Do you keep the application outside of the collections policy in the timeline dictated by state and federal laws, making sure patients who are eligible are not put through the collections process?
- Do you limit charges to eligible patients, making sure they never pay the full sticker price?

When clearing accounts financially, it is important for patient access staff to remember that each account represents an individual hospital patient. "Behind those numbers is someone going through what was likely a traumatic and exhausting experience," says Lang.

Role-playing exercises can put registrars in the shoes of a patient with an income at or below the hospital's eligibility threshold. "I think most would quickly learn that living at 300% of the federal poverty level or below for a family of four does not leave much room for discretionary spending, much less large, unexpected health bills," says Lang.

Checking in with registrars to be sure the job is still a good fit for them is important. "Working with patients and financial counseling can be tiring and lead to high burnout, among even the best employees," says Lang. ■

The hospital made changes to its financial assistance and charity care program after learning of the Attorney General's concerns in 2016, according to Atwood: "Even though Capital previously addressed the issues included in this lawsuit, and is providing financial assistance and charity care to more individuals than state law requires, the Attorney General filed this lawsuit." (*For more information on patient access processes for financial assistance and what patient access departments should do now, see related stories in this issue.*)

## Deficiencies Common

The Washington state lawsuits might be only the tip of the iceberg. "Patient access departments should understand that there are numerous lawsuits and investigations underway relating to the failure to screen for charity care eligibility," says LoGerfo.

Asking for deposits without first screening to see if a patient may be entitled to full charity care is unlawful, adds LoGerfo, and has cost hospitals millions in settlements. There is increasing evidence that many patient access departments are out of compliance with state and federal regulations.

Columbia Legal Services' recent analysis found charity care deficiencies among 12 of 20 Washington hospitals.[3] The report identified five primary areas in which hospitals were not meeting their obligations.

- Hospitals are not adequately addressing language barriers.
- Hospitals are not screening patients for charity care eligibility as legally required.

## Charity and Discount Payment: Income Qualification Levels

**Uninsured Patients**

1. If an uninsured patient's family income is 200% or less of the established poverty income level, based upon current FPL [federal poverty level] Guidelines, and the patient meets all other financial assistance qualification requirements, the patient qualifies for full charity care.

2. If an uninsured patient's family income is between 201% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other financial assistance qualification requirements, the following will apply:

• If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be a percentage of the gross amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) the Medicare program would have paid for the service if the patient were a Medicare beneficiary. The actual percentage paid by any individual patient shall be based on the sliding scale shown below:

| ***Sliding Scale Discount Schedule*** | | |
|---|---|---|
| Family Percentage of FPL | Discount off M/ Care Allowable | Patient OOP Payment Percentage (of M/Care) |
| 201-260% | 75% | 25% |
| 261-320% | 50% | 50% |
| 321-350% | 25% | 75% |

3. If the patient's family income is greater than 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other financial assistance qualification requirements, the following will apply:

• If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full-billed charges, the total patient payment obligation will be an amount equal to 100% of the gross amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

**Insured Patients**

1. If an insured patient's family income is between 201% and 350% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance qualification requirements, the following will apply:

• For services received by patients covered by covered by a third party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount (fully loaded Medicare payment rate, i.e., wage index, IME, DME, etc., and patient payment obligation) that Medicare would have paid for the service if the patient were a Medicare beneficiary (i.e., if insurance has paid more than the Medicare allowable amount, the patient will owe nothing further, but if the patient's insurance has paid less than the Medicare allowable amount, the patient will pay the difference between the insurance amount paid and the Medicare allowable amount).

2. If the patient's family income is greater than 350% of the established poverty income level, based upon current FPL Guidelines, the following will apply:

• For services received by patients covered by a third party payer such that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service, plus twenty-percent (20%). For example, if insurance has paid more than the Medicare allowable amount plus 20%, the patient will owe nothing further; but if the patient's insurance has paid less than the Medicare allowable amount plus 20%, the patient will pay the difference between the insurance amount paid and an amount equal to the Medicare allowable amount plus 20%.

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• Hospitals do not adequately inform patients of their charity care rights.

• Many hospitals require an application process that is difficult and demanding for patients, or refuse charity care after the account is assigned to collection.

• Hospitals and debt collectors improperly collect on accounts when the patients actually were eligible for charity care.

The report's findings were disappointing, but not terribly surprising to the researchers. "We

had been hearing through clients and outreach that many hospitals were not fulfilling their social promises or legal obligations around charity care," says LoGerfo.

When Spanish-speaking callers asked for information about financial assistance, 80% of sites surveyed disconnected the calls at least once. "Treatment of Spanish speakers was worse than we had expected," says LoGerfo. "But on the plus side, some hospitals had much better policies than we anticipated."

Presumptive eligibility for patients who clearly are eligible, such as those already enrolled in very low-income-related programs, is one example. Also, some hospitals provide charity care to patients at higher income levels than the law requires.

LoGerfo suggests that initial screening for charity care can be done at the same time patients are registered. "When patients come to the hospital, as long as the patient is stable enough, hospitals ask numerous financial questions, including detailed insurance information, employer information, and other data, to ensure that they will be paid," notes LoGerfo.

At the same time, registrars also can ask the patient's family size and income, and notify patients that they can apply for charity care. "Even better, if patients are clearly eligible, the application process should be skipped, and patients should be granted charity care," says LoGerfo.

## Front-end Role

Financial assistance, charity care, and collections used to be "back-end" roles, handled only after the patient was discharged. This has changed dramatically. "Financial assistance is moving from a post-service, back-end process to a part of clearing the patient for services — which is a patient access function," says Wolfskill.

Earlier financial discussions can prepare patients for higher out of-pocket costs, but it's not enough to simply set up payment plans for everyone. Conversations need a much broader scope. "Federal IRS 501(r) regulations are very specific about what any 501(c)3 not-for-profit hospital must do in order to maintain their tax-exempt status," says Wolfskill.

To comply with federal requirements, hospitals must follow several steps.

- Establish written financial assistance and emergency medical care policies.
- Limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy.
- Make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in extraordinary collection actions against the individual.

"The IRS takes compliance with their regulations seriously and is now conducting audits to ensure provider compliance with the regulations," warns Wolfskill. ■

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- **Sandra J. Wolfskill**, FHFMA, Director, Healthcare Finance Policy, Healthcare Finance Management Association, Westchester, IL. Phone: (708) 531-9600. Email: swolfskill@hfma.org.


- The Healthcare Financial Management Association's Patient Financial Communications Best Practices recommend making financial assistance conversations an integral part of the patient access process. To download a PDF of best practices for the ED, at the time of service, in advance of service, and for all patient financial interactions, go to http://bit.ly/1s2u63E.
- The Baltimore, MD-based Hilltop Institute evaluates each state's charity care policies. For more information, go to: http://bit.ly/2znQzoi.

# Patient Access in a 'Fishbowl,' Some Assume Registrar Is Doing Nothing

*Accusations about patient access productivity often misinformed*

An emergency department patient with a painful condition got back to a room quickly at Ochsner Health System in New Orleans, but no one came to do his registration for more than an hour. The man made two assumptions, both incorrect: First, he assumed registration staff were in no rush to get to him, and second, he assumed his care was delayed as a result.

In fact, the exact opposite was true. "We explained to the patient that we are legally required to wait until he was assessed and stabilized, so that our process does *not* cause a delay in care," says patient access director **Mary Neal**, MBA, CHAM.

Patient access also took the opportunity to explain that the man already had been registered in the system, using only his date of birth. This allowed physicians to write orders and give medical treatment, with full registration done at a later point in time.

"We let the patient know that we did not delay his care. We delayed our *process*, so that his health could be top on the priority list," says Neal.

The unhappy patient's attitude changed after learning more about how things worked. "He was very thankful to have a different perspective and new understanding on the situation," says Neal.

Unlike other departments, patient access employees are visible to clinicians, administrators, patients, and other visitors. "We're in the 'fishbowl,' on display all the time. Everybody sees us, and perceptions are made," says **Marion Knott**, manager of clinic access at Tampa, FL-based Moffitt Cancer Center.

## EMR Can Shed Light

It's not only patients who wrongly believe registration staff are slacking off. Registrars often are quick to accuse their colleagues of taking long or frequent breaks or not using downtime productively. "These types of complaints are ones that we can investigate relatively easily," says Neal.

The electronic medical record (EMR) is the go-to tool when complaints of this nature come in. "It tracks the times that every was patient seen, the user who checked in the appointment, and what time the appointment was checked in," explains Neal. Below are some common productivity-related complaints and how the EMR can help to determine their validity:

• ***Complaint:*** **A registrar is doing nothing.**

First, patient access managers review a week or so of data. The manager might notice a 30-minute gap of time where no patient was checked in by the registrar — yet others assisted many patients in that same 30 minutes. "That's a great starting point for a performance conversation with the person in question," says Neal.

• ***Complaint:*** **A registrar is around when it's busy, but disappears whenever things slow down.**

The case of the "disappearing registrar" can be solved by running a registration timing report. "This shows check-in totals over longer periods of time," says Neal.

• ***Complaint:*** **A registrar is not using downtime productively.**

The department expects registrars to use downtime to preregister the next day's accounts and verify insurance. If someone isn't doing so, there's an easy way to prove it. "We have a report that shows insurances verified by user," says Neal. "This determines if one person is doing the majority of the prep work for the next day." (*See related story on steps to address a patient access complaint.*)

## Just the Facts, Please

An irate patient at Moffitt Cancer Center recently complained that

### EXECUTIVE SUMMARY

Investigations of complaints claiming registrars are unproductive might reveal that staff were on the phone with payers, experiencing computer downtime, or conversing with patients. Patient access leaders can take the following steps to prevent complaints about delays.

- Inform emergency department patients that registration doesn't delay care.
- Use the electronic medical record to find out when events occurred.
- Ask for approximate dates and times registrars were observed.

## Complaint About Registrar? Take a Deep Breath and Follow These Steps

**Mary Neal**, MBA, CHAM, director of patient access services at Ochsner Health System in New Orleans, offers these practices when fielding a complaint about one of her employees:

**1. Know everyone on your team well enough to make an educated guess as to whether the reported behavior is out of character.**

"This is the best way to get an idea of what really happened in any given situation," says Neal.

Registrars typically react similarly in stressful situations, regardless of who they are speaking to. "If a report of a rude comment sounds eerily similar to something said 'off stage' when that team member didn't get his or her desired schedule, you can start to see those patterns emerge," says Neal.

**2. Listen to both sides, even if you suspect your team member was at fault.**

"Any coaching to follow is much better received when there is a foundation of trust," says Neal.

View the registrar as an impartial third party, and let him or her explain what happened. "You may think you know something and end up surprised at what you hear," says Neal.

Patient access leaders tend to want to defend their employees — especially those who usually deliver great service. "It's easy to think, 'She would never say that!'" says Neal. After learning more information, however, it might become apparent that an innocent joke turned into a major misunderstanding.

**3. Investigate what happened.**

"There are lots of places you can go to find clues about what may have happened in a given situation," says Neal. One easy source is the patient or family. By reaching out directly to whoever complained, it gives patient access a chance to apologize, and also to get the full story.

"There are also lots of clues present in your own EMR," adds Neal. These include time-stamping of registration activities, gaps in productivity reports, and notes left by other team members.

**4. Encourage your team to educate patients on their role.**

This is a great way to prevent misunderstandings — but only if the patient access employee has a solid understanding themselves. "If a patient's question is met with a short answer only because the team member does not know what else to say, things can escalate quickly," says Neal.

**5. Use role playing to practice difficult scenarios.**

Patient access employees may lack confidence when speaking to patients, family, and colleagues. "I have mediated many situations that have escalated because one or both parties were lacking in verbal communication skills," says Neal.

Hearing examples of positive, effective responses can help greatly in this regard. "We are often rushed during registration to keep the next patient from waiting in line," says Neal.

Giving patients enough time to listen, read, and understand the information can head off many complaints, however. "The more financial and regulatory requirements are added to the registration process, the more skeptical patients become of signing their names on the dotted line," notes Neal.

A simple statement such as, "I'm happy to give you a copy to review in detail. Please take as much time as you need and let me know what questions you have," is helpful — even if staff don't know the answer. Neal recommends stating, "That's a great question! If you will have a seat, I will contact a supervisor to make sure I am giving you the most accurate and up-to-date information." ■

a registrar was doing nothing but sitting and talking on the phone. "It turned out that her computer was down. She was on the phone with IT," says Knott.

It's wisest to stay neutral until you know the facts. Knott says to registrars, "This is the information that was brought to us. Help me understand what happened."

Often, registrars are able to shed light on things. This was the case when a clinician claimed to have walked by a registration area several times on a particular day; each time, the registrar was "sitting there doing nothing." The registrar's explanation was surprisingly simple: He was doing his job — on the computer. "Because all our orders are electronic, the clinical team will walk by and say, 'They are not doing anything,'" says Knott.

Knott always asks the person who's complaining for an approximate date and time he or she observed the registrar. This way, the registrar can report what they were doing at that point in time. "When they give me their answer, I'm usually going to take

the side of the employee, unless it's something we've already addressed," says Knott.

Knott then addresses two things with the person who complained:

• She tells them what she learned from the registrar.

• She encourages them to report problems immediately in the future. This way, patient access leadership can go observe what's going on directly. "We can't address it if we are not witnessing it," says Knott.

Passersby might frown at a registrar engaging in seemingly idle chitchat about the weather or a sports game. This might be the best possible use of the registrar's time, however, if a patient or family appears nervous or anxious. Knott encourages friendly conversation to put people at ease — as long as no one else is waiting. "It's all about being aware of what's around you," she says. If a patient is sitting in the corner in terrible pain, for instance, excited chatter about a late night television show can come off as very insensitive.

Small talk shouldn't interfere with the registrar's workload, of course. If a patient gets too chatty, Knott instructs registrars to get back to work by saying, "Nice talking to you today! Have a great day."

Some complaints are a case of mistaken identity. Recently, a physician complained that a newly hired patient access supervisor was wearing shorts and flip flops while eating a popsicle. Knott set out to investigate this strange complaint.

"I went to the supervisor and asked, 'Were you onsite at any point wearing flip flops?'" says Knott. The employee responded that he didn't even own a pair, and at that time, had been working elsewhere in dress clothes. When Knott went back to the physician who had complained, she asked an important question: Had the physician actually seen the employee doing this? "The physician admitted he'd never even met him, and had been told the information by someone else," says Knott. ■

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# If Patient Access Is Left Out of Big Decisions, Patient Experience Can Suffer

*Front-end feedback prevents poor satisfaction*

Recently, administrators at Kern Medical in Bakersfield, CA, decided to expand outpatient clinic hours of operation to accommodate evening and Saturday appointments. A target start date was announced.

However, the administrators forgot one important thing — telling patient access about the plan.

"Patient access was challenged to hire the additional human resources to accommodate the expanded services, without adequate lead time," reports patient access director **Edward Din**, CHAM.

This created a delay in getting the necessary six new employees hired, trained, and scheduled. "As a result, the overtime expense was high during the transition until the new staffing could be implemented," says Din.

More than 400 hours of overtime were needed. "New hires received two weeks of training before being assigned to their unit for specific orientation," says Din.

Had patient access been involved from the get-go, staffing would have been in place before the start date — without incurring overtime costs.

"This would have made the patient experience better and the patient access service delivery seamless," says Din.

## Hospital's 'Front Door'

Many hospital leaders fail to see the link between the patient experience and registration areas. "It

### EXECUTIVE SUMMARY

Patient access leadership is sometimes omitted from planning discussions involving staffing, technology, and new service lines. The following steps can help prevent problems with patient satisfaction.

- Attend meetings, even if patient access is not initially included.
- Give input on how planned changes will affect the front-end revenue cycle.
- Ask higher-ups to advocate for inclusion of patient access.

starts at your front door," says Din. "Patient access, historically, is that front door of your organization."

To improve the patient experience and service delivery, says Din, "including the patient access perspective is absolutely essential." He recommends patient access leaders use the following approaches.

**• Attend meetings about new services, even if patient access is not included initially.**

Patient access leaders are not always invited to important meetings that affect their day-to-day operations. "This is often due to the arbitrary exclusion of patient access leaders in the planning process," says Din.

Ideally, a project management template could be used whenever a new product or service line is being planned. The template would address the potential impact on all departments, including patient access, says Din.

If patient access is kept out of the loop, information is learned secondhand. This is less than ideal, since patient access has no opportunity for back-and-forth discussion with decision makers. Once problems occur, patient access then has to step in and do damage control.

"I have had to self-invite myself to attend meetings after-the-fact to offer support and suggestions regarding a new service line, once a system failure has occurred," notes Din.

**• Give input regarding how new or expanded services are going to affect the front-end revenue cycle.**

Are service providers going to be obtaining referrals and authorizations, determining eligibility and benefits, calculating patient copays, or obtaining e-signatures? If so, they'll need to access front-end revenue cycle applications. "Patient access leaders can provide invaluable insight and direction," says Din.

**• Involve hospital higher-ups.**

Asking frequently about planned changes helps to build relationships with hospital leaders. "Demonstrate your ability to collaborate. Be flexible and resourceful," says Din.

Once patient access has the support of key hospital leaders, such as the CFO or vice presidents, these individuals can become valuable allies. "Use the chain of command to escalate matters if necessary," says Din.

**• Involve registration staff in operational change planning.**

"How better to ensure improved employee engagement than making sure registration staff have a voice and feel valued?" asks Din.

Constant communication is needed to alert staff about coming changes that will affect their day-to-day jobs. "Be prepared to answer questions. Offer coaching through the changes," says Din.

## Patient Access Needs Identified

At Stanford (CA) Children's Health, an experienced patient access employee gets involved if a new site is being opened, a new program is rolled out, or new management is being onboarded.

"We assign one of our patient access leaders to lead the project, specific to the access needs," says **Andrew Ray**, director of professional revenue cycle at Stanford Children's Health.

This gives the employee a great deal of leadership experience. "It does so in a manageable way, in terms of defined scope and timing of the project," adds Ray. Since the project is of limited duration, it can be balanced with the employee's other responsibilities.

The hospital also created a registration leadership committee for admitting and ambulatory sites. Both hospital-based clinics and community-based practices are represented. "They review and approve any major process or system changes that impact patient access," says Ray.

The group reviews and approves any registration-related workflow changes and sets organizationwide registration policies. "The committee also acts as the governing body that addresses registration-related issues that are negatively affecting patient satisfaction or finances," says Ray. Below are some recent issues the committee addressed.

**• Gather additional necessary data from patients.**

"This is often driven by insurance, government, or hospital policy changes," says Ray.

**• Develop new processes to verify insurance eligibility or obtain authorizations.**

"We are attempting to do this as efficiently as possible through submissions from our source system, rather than requiring staff to call or go onto insurance company portals," Ray explains.

**• Identify ways to improve upfront collections initiatives.**

"Our front desk areas are tasked with point-of-service collections, attempting to collect prior balances, and helping patients understand the cost estimates for their care," says Ray.

**• Create strategies to ensure accurate registration and timely authorizations.**

These two items are crucial to the success of revenue cycle processes. "When not performed correctly, it can lead to significant lost revenue," says Ray.

**• Develop ways to avoid financial surprises for patients.**

"We are evaluating more efficient ways to provide accurate, useful cost estimates prior to, or at the time of, service," says Ray. Patient access currently does this only if requested, by performing manual calculations. "We would like to be able to do this more proactively, and across a broader patient population," says Ray. ■

### SOURCES


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# Keep PRN Employees in the Loop

*Constant updates needed: Hold 'as-needed' staff to high standards*

Constant changes in patient access necessitate constant updates for all employees. But what about those who only work in the department occasionally?

"One of the biggest challenges is communicating to employees who work only on the weekends," says **Anne McCabe-Staub**, director of training for patient financial services at Springfield, PA-based Crozer-Keystone Health System. About 10-15% of the department's patient access employees are PRN, meaning they work only as needed.

"PRNs need to be alerted about insurance plan code changes, changes to desk procedures, and new work flows, to name a few," says McCabe-Staub. "They are constantly getting information from us."

Below are some ways the department keeps PRNs updated.

**• All patient access employees, including PRNs, are required to check their email for updates at least once a shift.**

For important communications, managers ask that employees confirm that they reviewed the email.

**• Meetings are held during multiple shifts.**

PRNs simply are not physically present often enough to attend all monthly staff meetings. However, holding two meetings — one in the afternoon and one in the evening — makes it more likely. Allowing them to dial in and attend remotely is another option. "PRN staff may call in rather than physically come to the meeting," says McCabe-Staub.

**• PRNs work a minimum of every other weekend.**

"We don't have them work less frequently than that because they can't keep up their skills," says McCabe-Staub.

**• PRNs are encouraged to try for part-time or full-time positions.**

Turnover with PRNs is a continual challenge. "If we're lucky, they stay two to four years, but they usually don't stay longer than that — at least as a PRN status." Some PRNs move to part-time or full-time positions in the department, which is better than losing them altogether.

**• An experienced patient access employee always works alongside the PRN.**

"It's not a good idea to have a bunch of PRNs working together," notes McCabe-Staub.

**• Patient access leaders assess the quality of PRNs' work, just as they do with other employees.**

A consent form was recently revised, to include documentation that the registrar offered the Patient Bill of Rights and Notice of Privacy Practices. "Managers and trainers instructed employees on the proper way to complete the forms," says McCabe-Staub. Sign off sheets were used to document that employees attended onsite training.

"Audits were completed to ensure that employees were using the new consent forms and checking appropriate boxes on the new form," says McCabe-Staub. Any staff, including PRNs, who were having difficulty were sent for additional training. "It's challenging if somebody is attending school or has another job, but that's the condition for their

## EXECUTIVE SUMMARY

Keeping PRN employees updated is difficult because of constant changes in the field of patient access. The following are good approaches to keep employees informed.

- Give employees who are leaving the department the option of becoming PRNs.
- Schedule a time to review important changes with PRN employees.
- Assess PRN employees' ability to meet quality indicators.

employment," says McCabe-Staub. "They have to keep up with it."

## Same Quality Standard

Eight PRNs do ED registration at Knoxville-based University of Tennessee Medical Center. "I use email a lot for communication," says patient access manager **Michelle Reno**. All PRNs also have their own folders with information to view during their shift. "We print any communication that is sent out via email, and add it to the team members' folders," says Reno. "Any updated policies are also printed and put in folders."

At Albany (NY) Medical Center Hospital, PRNs are not used as much as they were in the past. "This is due to the concerns of ensuring competencies are maintained," says patient access director **Catherine M. Pallozzi**, CHAM, CCS.

The department offers part-time and full-time employees who completed school and are leaving for a position in their field of study the opportunity to remain as PRNs. "This is a huge benefit, as training and expectations are known!" says Pallozzi.

Since PRNs usually are absent from staff meetings, they are not up-to-date with changes in the department, the hospital, or the field in general. To address this, Pallozzi recommends several strategies.

**• Schedule a time when the PRN employee is at work to review changes to policies.**

Supervisors keep track of PRNs who are not at staff meeting or important training sessions. On the employee's next shift, they make sure to review the new information. "We have very few shifts not covered by a supervisor, manager, or staff lead, so reviewing with a per diem is not an issue," says Pallozzi.

All staff, regardless of status, are responsible to review emails for any updates. "This includes managers' weekly updates on changes to policies, areas needing improvement, or celebrating of successes," says Pallozzi.

**• Have a senior patient access employee or trainer determine if the PRN employee is meeting the required quality indicators.**

"Per diem staff are held to the same quality standard as full-time staff," says Pallozzi. ■

### SOURCES

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## COMING IN FUTURE MONTHS

- Registration practices to stop surprise ED medical bills
- Strategies if insurers will pay for observation, but not admission
- Prevent revenue cycle disasters if patient changes insurance
- Offer help if patients get billed for non-covered services

HOSPITAL ACCESS MANAGEMENT™

HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

# HHS May Be Taking Different Tack With HIPAA Enforcement

HHS and the Office for Civil Rights (OCR) may be adopting a different approach to HIPAA compliance under the Trump administration, as evidenced by a notable reduction in enforcement actions in the past year. But don't let down your guard just yet. HIPAA still has teeth.

The last year of the Obama administration saw a significant increase in HIPAA enforcement, with record-setting penalties and new compliance audits targeting both covered entities and business associates. There were 13 resolution agreements totaling almost $25 million in 2016.

That aggressive approach seemed to continue in the first half of 2017, with nine resolution agreements totaling $18 million in penalties. But then the enforcement actions dramatically slowed, explains **David P. Saunders**, JD, an attorney with the law firm of Jenner & Block in Chicago.

HHS went from commanding headlines with its HIPAA compliance resolutions to no one hearing from them at all for months, Saunders says. Does this signal a new attitude at OCR, one that would remove some heat from healthcare organizations' efforts to comply with HIPAA?

Not necessarily, Saunders says. "It's a little too soon to tell if this is the new normal or not, especially with a new secretary to be named," he says. "That new secretary will have his or her own priorities in terms of how to go about HIPAA enforcement. We don't know yet what HHS is going to look like under this administration."

Looking back at the past year does suggest that HHS has been much less active with HIPAA enforcement than in the prior year, and the continuation of aggressive enforcement in the first half of 2017 may have been only a continuation of Obama-era policies until the new administration had time to influence the department, Saunders says.

"It could be because everyone's attention was taken up with Obamacare reform, or it could be a purposeful new direction, but the objectively true fact is that they are concluding a lot fewer enforcement actions," he says. "They seem to be more reactionary to breaches than proactive, aggressively so, in the prior year."

> IT IS POSSIBLE THAT THIS IS ONLY A LULL UNTIL THE NEW ADMINISTRATION EXPRESSES A CLEAR INTENT TO CONTINUE ACTIVE ENFORCEMENT, PARTICULARLY SINCE THE AGENCY IS WAITING FOR A NEW DIRECTOR.

But Saunders cautions that this is not necessarily what the healthcare industry will see from OCR in the next three years. It is possible that this is only a lull until the new administration expresses a clear intent to continue aggressive enforcement, particularly since the agency is waiting for a new director. OCR leaders may be waiting to get the go ahead for continuing enforcement actions at the same level as 2016, he suggests, because the Trump administration has a pro-business stance and has criticized what it calls excessive regulations.

The amount of money at stake may be a factor in deciding to continue the previous level of enforcement, Saunders says.

"Until May of this year HIPAA had been an area of tremendous growth for enforcement actions, going from low-level, million-dollar fines to double-digit, million-dollar fines, and billions in the aggregate," he says. "They were doing it against not just ordinary run-of-the-mill hospitals, but they were also coming after business associates and not-for-profit hospitals. If you were violating HIPAA, you stood at some risk."

Those large settlements are major achievements and career boosts for OCR leaders, so it will be hard for them to stop pursuing such trophies, Saunders says. The enforcement strategy could change, but OCR is unlikely to become a pushover in the next three years.

OCR has begun Phase 2 of the HIPAA Audit Program, reviewing the policies and procedures of covered entities and their business associates, and that is likely to yield some significant violations, Saunders says.

The enforcement actions that come out of the Phase 2 audit could bring more clarity to how the Trump administration's OCR will pursue HIPAA compliance, he says.

Aggressive enforcement and huge settlements could mean a continuation of 2016's OCR strategy, or smaller settlements could signal a more relaxed approach.

At whatever level, OCR will continue to focus on business associate agreements, Saunders says. OCR has demonstrated that the agreements are a primary concern in audits and enforcement actions, with regulators wanting to see that covered entities have agreements with associates and also that they are monitoring the compliance of contractors and subcontractors.

"It's great to have the piece of paper, but if you're not doing anything to confirm that the subcontractor is complying, that exposes you to some risk. HHS has made it clear that you can't just point to a piece of paper and they'll assume everything is fine," Saunders says. "One organization got fined last year because they had the paperwork but weren't doing anything with it."

Saunders cautions that the current drop-off in HIPAA enforcement actions is no reason to let up on compliance. Even if OCR does pursue enforcement as much as it did in 2016, covered entities and business associates still have plenty of reasons to comply, he says.

"Don't be led astray because of the small sample size of what's going on late in 2017," he says. "This is still a significant risk factor for any company that handles protected health information. The risk of HIPAA enforcement action is great, and you don't want to be the next Equifax with not only the financial penalties and losses but also the damage to your reputation." ■

### SOURCE


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# HIPAA Hampering Patient Engagement, But Solutions Exist

Risk managers and compliance officers have heard the same complaint from so many clinicians: Complying with HIPAA gets in the way of interacting well with patients. And they're right.

There is evidence to back up their complaints, but it doesn't have to be that way, says **Ameet Sarpatwari**, JD, PhD, instructor in medicine at Harvard Medical School and assistant director of the Program on Regulation, Therapeutics, and Law in the Division of Pharmacoepidemiology and Pharmacoeconomics at Brigham and Women's Hospital in Boston. Misinterpreting HIPAA as inflexible is a key problem, he says.

HIPAA often prevents providers from properly engaging patients, according to a recent report in *The New England Journal of Medicine* by Sarpatwari et al. (*An abstract of the study is available online at http://bit.ly/2m0ZF4B.*)

Covered entities and business associates are so afraid of HIPAA noncompliance penalties that they have "understandably interpreted HIPAA conservatively," the report says.

Conservative interpretations often mean saying no when someone requests information, which can stifle communication and hamper patient engagement, Sarpatwari says.

"It is easy to establish blanket policies from an administrative perspective because it requires fewer resources to comply and monitor compliance," Sarpatwari says. "But that fails to capitalize on approaches that could foster patient engagement but also be HIPAA-compliant."

The use of encryption, while highly touted for improved security, can be detrimental to patient engagement. When a patient receives an encrypted message on a patient portal, the content of the message may be mundane but may require more effort and time than the patient is willing to take, he says.

"It might just be a notification that a prescription is ready, or it could be something more significant, but the steps necessary to read that message are often a bit of a hassle," he explains. "That can discourage engagement in the health system, but that encryption is an addressable issue. There is discretion as to whether it is necessary, but there is a misnomer that HIPAA is inflexible. It's actually quite flexible."

Healthcare providers are not capitalizing on that flexibility, he says.

There are ways to improve patient engagement without violating HIPAA, he notes, including the more strategic use of patient portals, Bluetooth-enabled biometric devices, smartphone applications, and text messages, which all can help improve patient engagement.

In addition, clinicians should be given some leeway to use common sense with individual patients, Sarpatwari says. The clinician can ask the patient if anyone else has access to the email address on file, and if the answer is no, there may be no need for encryption, he says.

"You can craft a more tailored policy that is still HIPAA-compliant but encourages more patient engagement," he says. "The trouble comes when you try to impose one blanket policy that takes the most conservative approach so that you can be assured every single encounter is HIPAA-compliant even if it means you're inconveniencing people and discouraging the patient engagement that is so important to providing good care."

Another possible solution is for providers to let patients opt into a system that allows sharing of protected health information, Sarpatwari says. That could require amending current HIPAA laws, but would it improve patient engagement for many people, he asks.

"There can be a greater discussion in the industry about steps that could be taken to make sure patients are aware of the risks and can give informed consent to have their information shared without encryption and without some of the other impediments to patient engagement," he says. "Those are the areas where you can craft more tailored policies that don't come in a one-size-fits-all approach." ■

### SOURCE


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# HHS Clarifies HIPAA as It Applies to Opioid Crisis

The HHS Office for Civil Rights (OCR) has clarified how it expects healthcare providers to comply with HIPAA when they need to share patient information on opioid overdoses: Providers can share protected health information (PHI) in limited ways during overdoses.

There has been some confusion about how to comply with HIPAA during emergencies, such as drug overdoses and natural disasters, OCR notes. Healthcare providers have been confused about whether the law allows them to disclose necessary information to family members or caregivers when the patient is experiencing an opioid emergency.

OCR makes clear in recent guidance that providers can use common sense in these situations because HIPAA was never intended to interfere with proper medical care. In some situations PHI can be shared without the patient's permission if that is in the patient's best interest, the guidance explains. (*The OCR guidance is available online at http://bit.ly/2ieZopg.*)

OCR includes the caveat that the sharing must be limited to what is necessary related to the immediate emergency. It is not OK to open the door completely and share other PHI.

OCR cites two examples in which healthcare providers can share limited PHI without the patient's permission during a drug overdose.

PHI may be shared with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient and the information shared is directly related to the family or friend's involvement in the patient's healthcare or payment of care. "For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission."

The healthcare provider may inform persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety. "For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge."

However, the OCR guidance notes that patients with decision-making capacity must be given the opportunity to agree or object to sharing health information with family, friends, and others involved in the individual's care or payment for care. The provider must respect a patient's decision not to share PHI unless there is a serious and imminent threat to safety.

OCR also points out that a patient's decision-making capacity may change during the course of treatment, and the provider must adjust accordingly. ■

# Most Clinicians Admit to Sharing EMR Passwords

A majority of medical staff surveyed recently said they have accessed an electronic medical record (EMR) system using a password improperly supplied by a fellow medical staffer, and explained that strict confidentiality rules can make it difficult to get the data needed to do their jobs properly.

The survey results are part of the first study to examine EMR access among medical providers. In the study, researchers gathered survey responses from 299 medical professionals, including residents, medical students, interns, and nurses. The research team included researchers from Ben-Gurion University of the Negev, Harvard Medical School, Duke University, Hadassah-Hebrew University Medical Center, and the Interdisciplinary Center in Herzliya, Israel. (*The survey results are available online at http://bit.ly/2x2tdiw.*)

Nearly three-quarters (73%) of the 299 participants claimed to have used another medical staff member's password to access an EMR at work, and more than 57% of participants (171 out of 299) estimated they have used someone else's password an average of 4.75 times.

All medical residents said they had obtained another medical staff member's password with consent. Within the student and intern groups, 77% and 83%, respectively, used someone else's access credentials because they said they "were not given a user account."

In addition, 56% of students and almost 70% of interns cited that their user access had inadequate permissions "to fulfill my duties," forcing them to ask for someone else's access credentials. Only half of the nurses surveyed (57.5%) reported using someone else's password. The researchers offer these recommendations:

• Attaining access credentials needs to be less difficult and time-consuming.

• "Understaffed hospitals, especially during on-call hours, may need to delegate administrative tasks and extend EMR system access to paramedical, junior staff, interns, and students," they say. "Nurses, who generally carry out more precisely defined duties, are more likely to have the EMR privileges they need."

• "Healthcare organizations should add an option for each EMR role that grants maximum privileges for one-time use only. When this option is invoked, the senior physician and a protected health information security officer would be informed," the researchers say. "This would allow junior staff to make urgent, lifesaving decisions under formal retrospective supervision without having to sneak onto the EMR." ■

# IT Workers Can Fall for Online Scams

Healthcare IT staff often assume they know what they're doing when it comes to data security, and all the other employees are likely to create a data breach by falling for an online phishing scam or other hacking attempt. But a recent report suggests IT staff can make big mistakes, too.

One-quarter of IT workers admitted to falling for a phishing scam, compared to 21% of office workers and 34% of business owners and high-execs, according to a recent survey by Intermedia, a company providing data protection. Intermedia surveyed more than 1,000 full-time workers and asked questions about data security and the behaviors that can lead to data breaches, malware, and ransomware attacks. (*The report is available online at http://bit.ly/2zlyGWS.*)

Another disconcerting finding was that 14% of office workers either lacked confidence in their ability to detect phishing attacks or were not aware what phishing is.

Confidence in the ability to detect phishing scams generally was high among office workers, with 86% believing they could identify phishing emails, although knowledge of ransomware was found to be lacking, especially among female workers. Forty percent of female workers did not know what ransomware was, compared to 28% of male workers. Thirty-one percent of respondents said they did not know what ransomware was prior to taking part in staff training sessions. The report includes these other findings:

• Thirty percent of office workers said they did not receive regular training on how to deal with cyber threats. Only 70% of companies provide regular training and threat information to employees, and 11% of companies offered no security training whatsoever.

• Many employees are so embarrassed and concerned about installing ransomware that they pay the ransom demand out of their own pocket. Out of the office workers who had experienced a ransomware attack, 59% personally paid the ransom and the average ransom payment was $1,400. The ransom typically was paid quickly in the hope that data could be restored before anyone else found out about the attack. Only 37% said the ransom was paid by their employer.

• Even when the ransom is paid, businesses still experience considerable downtime. One in five ransom payments will not see viable decryption keys provided by the attackers. ■