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INSIDE

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Patient Access to See More Affordable Health Plans, Possible Higher Liability

Insurers and states will soon have flexibility to offer more affordable health plans — but there are significant implications for patient access.

"Lower premiums typically lead to reduced benefits, more non-covered services, and more restricted site-of-service limitations," says **Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy at the Healthcare Finance Management Association.

The HHS Notice of Benefit and Payment Parameters for 2019, recently issued by the Centers for Medicare & Medicaid Services (CMS):

- returns important oversight authority to states regarding review of network adequacy;
- eliminates the meaningful difference requirement for Qualified Health Plans, giving insurers more flexibility in designing plans;
- provides states with more flexibility as to what benefits are included in plans.

"Under the final rule, insurers will be able to offer plans that are not subject to the ACA mandates requiring them to provide coverage for certain services," notes **Jolene Calla**, Esq., vice president, healthcare finance and insurance for The Hospital and Healthsystem Association of Pennsylvania. For example, insurers won't have to cover preventive care. Insurers can exclude coverage for pre-existing conditions, and charge more to cover older people or those with chronic and complex conditions such as cancer, heart disease, and diabetes.

Under the ACA, 10 essential health benefits are required. These include prescription drugs as well as maternity and newborn care. Now, states will be given more options as to what they can offer as essential health benefits.

"While these plans are likely to have lower monthly premiums, cutting consumer benefits under the language of affordability is not a sustainable model," says Calla. This is because plans with limited coverage and high deductibles will attract younger and healthier populations. "The limited and catastrophic-coverage plans only work as long as consumers remain healthy," Calla continues. However, these consumers may be one healthcare crisis away from financial hardship.

"Older and sicker populations will be left at the mercy of the marketplace, further driving up those costs," Calla says. "This model could drive up the cost of care in the long term, and contribute to increases

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in hospital uncompensated care." The ACA has priced many consumers out of the insurance market, according to CMS. However, cheaper plans likely mean higher out-of-pocket costs for patients — and possible lost revenue for hospitals.

"While the premiums for these plans often seem affordable, the benefits that they offer are usually less comprehensive than other plans," says **Mary Mullaney**, director of hospital payment policies for the Association of American Medical Colleges in Washington, DC.

Patients often don't realize the limits of the coverage until they actually use it. Consumer cost-sharing under the newer, more affordable plans likely will increase.

"That can contribute to patients' reluctance to access services in lower-cost settings," Mullaney cautions. "This may result in an increased use of emergency departments, which results in higher costs."

Wolfskill says it's "imperative" for patient access departments to take these steps:

1. Monitor the new plans offered through the healthcare exchange in your service area. "Educate patient access staff to watch for new plans and payers that are not in the current insurance master," Wolfskill offers. "When adding them, create a mechanism to track volumes, payment patterns, and self-pay balances after insurance."

2. Ensure that when staff are verifying eligibility and effective date of coverage that they also verify benefits and limitations. Sometimes patient access confirms that the insurance is valid, and everything seems fine — until the claim is denied because of coverage limitations. Another possibility is that the provider is out of network for the patient, which means higher deductibles, copays, or coinsurance issues. "Yes, the patient may be eligible, but benefits are a separate issue," Wolfskill notes.

3. Create fresh plan codes for the new, affordable health plans. This gives revenue cycle leaders a way to track overall plan performance, including shifting of any dollars into self-pay.

"It makes it easier to track patient out-of-pockets for these plans vs. the traditional HMO and PPO plans from other commercial carriers," Wolfskill explains.

Revenue cycle leaders might discover that the new plans are less profitable due to increased bad debt or claims denials. If they do, says Wolfskill, "in future years, the provider has a solid history with which to negotiate rates with the payer."

Earlier financial discussions with patients is "good for both the bottomline and the patient experience," says **Christopher Lah**, senior director of patient access at Cincinnati (OH) Children's Hospital Medical Center.

This is even more important if the new affordable plans result in higher out-of-pocket costs for patients.

"Most revenue cycle leaders will agree that working with the patient on the cost of care, prior to or at the time of service, goes a long way toward eliminating 'sticker shock' at the time of patient billing," Lah says.

Price transparency is a hot topic with patients and hospitals alike, but good processes are needed. "There needs to be a coordinated effort with other service teams in the revenue cycle," Lah offers.

Just handing patients a price estimate isn't nearly enough. Most patients ask more questions, sometimes complicated ones, about what they owe and why.

"It only answers the question 'How much?' and leaves the customer hanging if they need more help," Lah says.

Patient access employees often notice that patients are struggling financially when they're provided with price estimates. That's the perfect time to connect them with financial counselors. "It's a powerful, but simple tool to add to your

scripting — that they may qualify for assistance or some other option," Lah says. He also recommends eliminating scripting that ends with employees stating something such as "you owe" or "you could owe" a certain amount. At that point, it's a great time to talk about some possible alternatives, such as financial aid or charity care screening.

"Giving your patients the options upfront can help eliminate the risk of the experience becoming a situation stressor instead of a service enhancer," Lah adds.

Transparency about costs is the future of healthcare, and patient access is front and center of this dramatic change. It's all about education.

"Patients are exploring innovative ways to manage their personal costs within their healthcare benefits in a rapidly changing environment," says **Myndall V. Coffman**, MBA, system director for patient access and scheduling at Baptist Health in Louisville, KY.

Patients need help understanding the costs associated with their newly purchased high-deductible health plans. "You would never go to the market and place things in the basket without understanding the cost, and healthcare is no different," Coffman says.

That's where patient access employees can step in to offer some explanations on insurance benefits and estimated costs.

"Price transparency and good patient communication are very important at Baptist Health," Coffman says. Accurate cost estimates are just one part of that. Good resources must be available anytime a patient would like to discuss potential or outstanding balances.

"We want patients to understand their insurance coverage and their individual responsibility as well," Coffman adds.

Some patients don't understand what out of network means. They'll need information to make good decisions. "Sometimes, this means working on an agreement with their insurance carrier to continue to provide care for the patient," Coffman offers. Sometimes, patients may decide to instead schedule their service at an in-network facility.

"While some patients fully understand their coverage and coverage limitations, many do not," Coffman explains. Most patients assume they can see any provider they want without worrying about costs. Coffman often hears patients saying things such as, "But I have insurance to cover it."

If hospitals don't engage in early financial discussions, patients won't understand the costs of their care until after they receive it. "This can mean huge surprises after service," Coffman warns. "It often causes anger and distrust toward the organization providing the service, as well as healthcare organizations in general."

When accurate cost estimates are given early in the process, patients have the information they need on the front end to make good decisions. "They understand the possible difference in cost and the quality of the services being offered," Coffman says.

Price estimates don't tell the whole story. "Just because there may be a cheaper option available does not always mean the quality is the same," Coffman notes. For instance, poor image quality on a diagnostic scan sometimes can result in repeating the scan for an additional cost.

This kind of information avoids surprise bills on the back end. "It ensures that the provider can initiate financial assistance options if appropriate or offer options for payment arrangements for the patient," Coffman explains. If patients cannot pay, there are options available to ensure they can get the care needed for emergent procedures.

The department relies on insurance verification workflows, accurate price estimates, extensive staff education, and strong staff scripting to be as transparent as possible. "Patients and their families deserve these honest conversations prior to service," Coffman says. ■

For Employees, CHAA Means 5% Raise, New Title

A promotion to a "Certified Patient Access Representative," and a 5% salary increase. Those two events happen immediately after employees obtain their Certified Healthcare Access Associate (CHAA) certification at Greater Baltimore (MD) Medical Center.

"Certification is a way for the staff member to be acknowledged for their body of knowledge in the patient access field," Patient Access Operations Manager **Cherie Patterson**, CHAA, CHAM, explains. The next rung on the patient access career ladder is Team Lead; the first requirement is CHAA certification. "Obtaining their CHAA puts them one step ahead on the leadership track," Patterson says.

Several employees started as a patient access representative and earned their CHAA shortly afterward. They were promoted quickly to Team Lead, and eventually became supervisors. "While supervisory positions don't come along often, we always strive to promote from within when faced with a Team Lead or supervisor vacancy," Patterson says.

There is another less tangible benefit: After employees obtain their CHAA, they tend to stay in the department longer. "They are serious about their career in patient access," Patterson reports.

This means improved retention rates for the department. "Having obtained that certification gives them a sense of pride and confidence," Patterson

explains. To advance on the career ladder at Newport News, VA-based Riverside Health System from Tier I to Tier II, patient access employees must obtain their CHAA within two years of hire.

This requirement is included on the department's job descriptions. To emphasize its importance, the hospital pays for the exam application fee. "Upon certification, they move into the next tier of the career ladder if they have the experience required," says **Robin Woodward**, CHAM, system director of patient access. If the employee hasn't acquired the necessary experience to move to Tier II, he or she receives a one-time bonus of $500. "This is usually for new hires who have no previous revenue cycle experience," Woodward explains. Previous work scheduling, coding, billing, or registration are counted as part of the "revenue cycle experience" that's required in Tier II. If employees move to Tier II, the employee also receives an hourly pay increase, and is responsible to maintain their certification. Should it lapse, the employee reverts to the original tier level and pay grade.

"We have not had that happen," Woodward reports. "Their leaders also get notification and oversee that the employee maintains their CHAA." Many different types of patient access employees take the CHAA exam. Some work offsite and only perform scheduling or authorization of benefits duties, while others work at outpatient centers. The CHAA exam is more challenging for these employees. "I find that employees who are not exposed to ER processes, inpatient processes, or who work in scheduling and benefits find it difficult to know each area," Woodward says.

To help these employees, the department sends them links to flashcards and other resources to study for the exam. "We encourage individuals to have study groups to quiz each other prior to testing," Woodward says. "This seems to be received very well and many take advantage of this." After obtaining the CHAA, employees realize how much the patient access role includes. Almost all take a certain action right away after they find out they've passed. "Upon certification, nearly every employee will update their email signatures to add the CHAA behind their name," Woodward notes. ■

Early Financial Screening Could Improve Access to Mental Health Services

Access to mental health services is a concern for many healthcare organizations, and was identified recently as a top priority at San Diego-based Sharp HealthCare. Patient access and clinical leaders worked together to address this important issue.

"The objective was to decrease the number of patients not participating in therapy as a result of their inability to pay for services," says **Perla Pace**, manager of patient financial services. The organization's Community Health Needs Assessment unveiled that access to mental health services was a priority. The same report revealed that access to care or insurance were strongly linked to good healthcare outcomes. "Previously, lack of information about a patient's financial responsibility resulted in surprise bills months after a patient's registration had taken place," Pace explains. Leadership in patient access and the intensive outpatient program at Sharp Mesa Vista Hospital formed a team tasked with improving the admissions process for patients. The goal: Give patients greater clarity about their financial responsibility. "Each decision was scrutinized under the same test: Is this the best we can do to serve the patient?'" Pace says. After analyzing the current process, the team implemented these changes:

1. Unnecessary handoffs between the clinical staff conducting the mental health assessments and the Patient Access Services team handling the admissions process were eliminated;

2. The way patients are selected for individual programs, and length of stay estimated, was streamlined;

3. Additional options are provided to patients, including prompt pay discount, automatic withdrawals, and financial assistance;

4. "Affirmation" cards were created.

These are used as a communication mechanism between the admissions office and program leads. The card is presented to patients after they have met with the hospital's business office to understand their financial responsibility for care.

After, the program therapist asks the patient to share their affirmation with the group during their session. "The affirmation card validates to the program therapist that necessary financial education has taken place," Pace notes.

Patient access contributed to the new process by streamlining pre-verification. "This was done by consolidating benefit check requests to one central form and process owner," Pace recalls. The form was updated to provide patients with details about their designated program, available benefits, and payment arrangements — all in one document.

"This was paramount to the overall project, given that the program and length of stay information is the foundation for any estimate," Pace says.

Patient access also empowered its staff to provide solutions for patients who say they're unable to pay. The entire team

was trained in a new "financial responsibility visit process."

"Staff were encouraged to improve the patient's financial verification experience," Pace says.

Two real-time solutions have made this possible: prompt pay discount and auto-withdrawal tools. Many patients take advantage of these new options, who previously would have declined services due to their inability to pay.

"Patient access services was able to increase transparency of the financial responsibility for patients participating in therapy for long periods of time," Pace adds. The previous admission process included an intake interview by a program therapist during which basic demographic information was captured.

The program therapist submitted a benefit check to patient access services for insurance verification. Once the verification took place, patient access services would respond to the program therapist with the patient's benefit information.

Next, the program therapist would inform the patient about his or her available benefits and schedule a mental health assessment, which he or she would need to complete prior to their admittance to a program. On the day of admission, the patient would visit the hospital's business office to complete the registration process and begin therapy.

"The project team walked the process from a patient's perspective," Pace notes. "We identified what initial steps delayed treatment for someone who could be in a crisis."

The improved process includes immediate scheduling of a mental health assessment and a financial responsibility visit on the same day. "This allows for more timely access to care, and ensured the business office procedures were expedited," Pace says.

Along with a detailed estimate for services, patient access provides payment options. These range from the prompt pay discount to full financial assistance awards. "This has increased transparency of patients' financial responsibility, and reduced the number of visits the patient makes to and from the hospital," Pace reports.

The new process includes these steps:

Step 1: The patient calls to inquire about the program. A therapist performs an initial interview and recommends a program. A mental health assessment is scheduled, and the pre-verification information is obtained from the patient. A therapist sends the benefit check request to patient access services, who review the benefits and return the completed form to the therapist so it can be added to the patient's record.

Step 2: The patient visits the hospital for the assessment. The patient receives a tour of the facility and additional information about the program. The nurse gives the patient a welcome card with contact information, and escorts the patient to patient access services.

At this point, the second piece of the admission process is completed — financial responsibility. Patient access explains the patient's benefits, gives a price estimate, and completes the registration.

Patient access services secures a financial agreement with the patient that explains their responsibility. This ranges from payment in full, a prompt pay discount, auto-withdrawal payments, or another option negotiated with the manager's approval.

The reverse side of the welcome card is completed by the program therapist and patient access services, and includes the patient's financial responsibility and patient access office contacts.

Patient access services calls the nurse to inform the patient that their financial responsibility visit is complete. A nurse returns to pick up the patient, addresses any additional concerns, and escorts the patient back to the lobby.

Step 3: The first day of therapy. The nurse meets the patient and escorts him or her to the hospital's business office. Patient access services confirms the patient has attended the financial responsibility visit, and the visit is activated in the system. Patient access gives the patient an affirmation card, which is shared with the therapist. Under this new process, "we have seen a 30% increase in overall cash collections, and 86% of all new admissions have completed the financial responsibility visit," Pace reports. ■

New 'Office Tech' Role Assists Registration Team

For years, ED registrars at Rockledge, FL-based Health First's four acute care hospitals monitored the waiting room for patients arriving. Next, they conducted a "mini-reg" for each person.

"We realized we could improve our process to better serve our patients." says **Michelle King**, manager of revenue operations and patient access services at Health First's Cape Canaveral Hospital in Cocoa Beach.

The department decided to create a new registration role: the "office tech." This allows registrars to focus on completing registrations and collecting from patients. The office tech's responsibilities include: ensuring the proper patient is identified, creating a mini-reg account (using just the person's name and date of birth), arm-banding the patient, and identifying the patient's pharmacy of choice.

"We have become more effective and efficient since implementing this role," King reports. "Our productivity has increased." When interviewing candidates for the office tech position, King informs

them they're considered "gatekeepers" for the hospital. "They set the tone for a positive customer experience."

Covering all ED shifts with an office tech remains a challenge. Currently, the office tech only covers the first and second shifts. Marked improvements in productivity were noted on those shifts almost immediately. Understandably, the department wanted to get the same results on the third shift.

"We had to get creative and work within our existing FTE budget," King notes.

Support is offered as needed to the third shift by increasing the office tech's eight-hour shift to 10 hours. This way, the third shift is staffed midway through. "This allows the sole night shift registrar to focus on completing registrations accurately and handling collections," King says.

The office tech role is a good "stepping stone" into the registration department.

"This position provides them with the basics of registration," King says. "It offers me a clear picture of their skill set and customer service ability."

Another recent change fostered some friendly competition in the department. The prior week's collections, productivity, and accuracy ratings are posted publicly so registrars can compare their performance against their peers.

"They have come to appreciate this information in order to keep themselves accountable," King says.

Managers' jobs are made easier because specific educational needs are pinpointed for each registrar. Mid-year and annual evaluations go smoother since there aren't any surprises. "Registrars are already aware of their strengths and weaknesses," King explains. Staff members receive a report card listing how they're performing on all requirements. A month-by-month breakdown makes it easy to track improvements or trouble spots.

"This opens the door for a conversation about educational opportunities or successes that may result in promotions," King says.

One area in which registrars struggle continually is collections. "Since this is such an important role for registration, we utilize our QA educational team for training," King says. The trainers provide shadowing, scripting, and one-on-one role-playing to improve collection skills.

Quality and accuracy is another area of focus. "On a daily basis, we can see the types of mistakes they make," King says. "Specific training improves their skills." ■

Collections More Than Doubled While Satisfaction Scores Remained High

In the past two years, ED collections at Rockledge, FL-based Health First have more than doubled. With results like that, one might imagine that patient satisfaction has suffered, but the opposite is true. "Through all this, we have maintained top-decile performance with our customer experience scores," reports **Kyle Crosswell**, manager of revenue operations and patient access. Here's how registrars do it:

1. Educate patients before collecting. "Having the conversation about payment is never easy, especially when someone is sick," Crosswell admits. Registrars start the conversation by educating the patient about their benefits. Next, registrars provide an estimate of out-of-pocket costs with a detailed explanation. "Patients are likely to pay if they understand what their benefits are, and can see it in writing," Crosswell offers.

2. Follow up with patients post-discharge. Many ED patients are unable to pay for many reasons. Most commonly, it's only because they did not bring a method of payment with them. "We have developed a follow-up team and process for patients to call back when they get home," Crosswell says.

3. Take partial payment. Many patients are unable to pay their balance in full, but registrars still collect something. "We work with the patients and ask for a good-faith deposit," Crosswell says.

Most patients want to pay their responsibility. "Offering the option of putting something down toward the amount keeps the patient engaged in paying off the balance down the road," Crosswell notes.

4. Secure buy-in from clinical team. "Over the years, we have worked with our nursing team to help everyone understand the importance of registration and collecting from our patients," Crosswell reports.

Educating the clinical side on the revenue cycle has improved more than just collections. Registration misses fewer patients, which prevents lost revenue.

"Registrars feel part of the team, and not just the 'money people,'" Crosswell explains. "Creating connections, regardless of your role, makes all the difference to the patient."

5. Offer to help patients. Registrars do more than collect; they also offer many types of assistance to help patients with costs. Even when they do collect, a patient-centered approach is used.

"We explain to the patient that this is a service we offer, so they do not have to worry about the bill later once they get home," Crosswell shares. If a procedure is elective and scheduled weeks away, it

gives ample time to engage in financial conversations with the patient. This is not true for the ED setting.

"It's always easier to have that financial conversation with elective procedures. The ED is very difficult," laments **Elkin Pinamonti**, MHA, assistant director of onsite access for Novant Health's greater Winston-Salem, NC, and northern Virginia markets.

Registrars must determine if the patient is too ill for a financial conversation. "Since our department is not privy to what is happening clinically with patients, the biggest challenge is to read the body language," Pinamonti explains. While registrars are expected to ask for copayments at the time of the ED visit, "we have to walk that line. If there's even a question about asking, we always say don't," Pinamonti says.

The biggest concern, says Pinamonti: "That we will make a patient or family worry about something financial when they are in the midst of crisis."

At OSF HealthCare in Peoria, IL, a recent project aimed at increasing collections focused on more robust scripting and additional training.

"My team has put a lot of effort into this," says **Jessica Chase**, patient access services manager for the outpatient financial clearance center. "We took the new scripting and training a step further."

First, Chase elicited feedback from team members regarding what barriers they encountered when speaking with patients about cash collection opportunities.

"I wanted to know what our patients were saying so that team members felt more prepared for the conversation," Chase says. Next, she asked top collectors to give some feedback on how to help patients through the financial part of the process.

"We've had tremendous success already this fiscal year with increasing our pre-service collections," Chase reports.

Above all, managers emphasize listening and empathy. The goal is for patient access to "really connect with our patients," Chase says. "We have found that if the great patient service is there, the collection results will follow."

Tone of voice and the speed in which something is said is very important, and so is consistency in asking for payment so patients know what to expect. "Most importantly, we listen to the needs of the patient," Chase adds. "We find the best option to help them if it's needed." ■

Patient Access Needs Conflict Resolution Skill Set

Conflict management is an essential skill for anyone who works in patient access, in light of angry patients, frustrated clinicians, and sometimes even trouble-making colleagues.

"Many times, it is a misunderstanding, or can be resolved by meeting with whomever the conflict involves," says **Marion Knott**, clinic access manager at Tampa, FL-based Moffitt Cancer Center.

Here are some recent examples from the patient access department:

• Patients sometimes arrive early or late for appointments, and want to be seen. "These are handled on a case-by-case, clinic-by-clinic basis," Knott says. Patient access staff work with the patient's provider to determine how to handle these situations.

• Patients complain about long wait times. "Patients are anxious already," Knott says. "When the provider's clinic day is not running on time, we are many times left with upset patients." Keeping patients updated is the main approach patient access staff use to defuse tension.

• Requests for same-day add-ons for diagnostic tests can't always be accommodated. "Many times, we are the middle man between the clinical team's request and the imaging center who cannot accommodate," Knott explains. Patient access is in the position of explaining the process to both sides.

• Staff spread misinformation about colleagues. Recently, changes were made to the areas covered by supervisors, because one supervisor transferred to a new area. Another supervisor was hired to cover that area. "Regardless of how transparent you make the change, rumors start — in this case, about things that one supervisor supposedly said about the other," Knott says. To defuse the conflict before it began, the two supervisors met face to face. "They know they are both on the same page," Knott says. "Going forward, they have established a unified front to any rumors or allegations."

• Patient access staff are wrongly blamed by colleagues. An issue arose involving staffing during the last two hours of the day at one clinic. "In this particular area, we normally have three people 5:00 p.m. until 7:00 p.m. for late clinic support," Knott explains. However, on a particular day, there were two callouts, so there was only one employee available.

"When this sort of thing happens, we have a process in place to put up the appropriate signage at the checkout area," Knott notes. This directs the patients to the part of the clinic where that person works for follow-up scheduling.

On Monday morning, Knott received an email from one of the clinic managers, stating that patients were left without direction. The clinic supervisor wasn't included on the email, so Knott contacted him to obtain the facts. The supervisor assured her that the correct

process actually had been followed, and the employee who was present at the time confirmed this. Knott added the supervisor to the email loop and advised the manager that the supervisor would be responding with the details. "When he did, the only response back from the clinic management was that we may need better signage," Knott recalls.

When interviewing potential new hires, **Sandra Rivera**, RN, BSN, CHAM, always asks them to give an example of a conflict they've had with a patient, a coworker, or a supervisor at their current job. "This lets us know how the candidate views the work environment, and how they problem-solve," says Rivera, director of patient access. If the applicant gives the example of a patient getting angry because someone asked him or her for payment, Rivera probes further. "We are looking at how they describe the issue. Did they listen to the patient? And how did they resolve this issue? Did they go to a manager?"

To improve conflict resolution skills in patient access employees, Knott routinely questions staff about why they believe someone acted a certain way.

"I truly don't think that many times people are intentionally trying to cause conflict," she says. "Everyone is different, and we all need to be mindful of that." ■

Make Great First Impression on Patients

Registrars are one of the first people visitors encounter in the ED or admitting department. "It is very important that we are maintaining a positive demeanor while delivering care," says **Aubrey Ratliff**, registration supervisor at Genesis Medical Center in Davenport, IA.

Registrars do some very simple things to make a great impression. "We greet every individual by making eye contact and supplying our undivided attention," Ratliff says.

The department uses a patient experience tool called Acknowledge, Introduce, Duration, Explain, and Thank. For example, registrars start by stating, "Hello, my name is Aubrey. I'm here to register you today, and it will take about five minutes."

Registrars thank the patient for their time after registration is complete.

"We escort our patients to their destination, to give reassurance that they will arrive to the correct location and be on time," Ratliff says. "We offer wheelchair rides to all of our patients and visitors." In the ED, registrars supply children with coloring activities to keep them busy, and blankets to keep patients comfortable.

"We also use the term, 'My pleasure' instead of 'You're welcome,'" Ratliff notes.

Some practices that are well-known to give a bad first impression are surprisingly common in registration areas. Ratliff gives these examples: not acknowledging the patients or visitors, not making eye contact, giving the impression that you are in a hurry or annoyed, not explaining why you are asking so many questions, and not offering extra assistance like a wheelchair or escort. Another common pitfall is "managing down," pointing fingers at a co-worker or other hospital area.

"Pushing blame on their co-worker or another department to a patient or visitor, instead of focusing on how they can help find a solution, gives a negative experience every time," Ratliff says. ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

OCR Concerned About HIPAA Contingency Plans

Developing a good HIPAA contingency plan is critical to ensuring a facility can access data during a disaster or cyberattack, and it also is required for HIPAA compliance. Creating that plan may require more assessment and planning than one might imagine, and it's the kind of thing that can be lacking in an otherwise good HIPAA program.

The HHS Office for Civil Rights (OCR) recently urged healthcare organizations to develop contingency plans for crises that that could compromise protected health information (PHI) covered under HIPAA.

"Contingency plans are critical to protecting the availability, integrity, and security of data during unexpected adverse events. Contingency plans should consider not only how to respond to disasters such as fires and floods, but also how to respond to cyberattacks," OCR said. "Cyberattacks using malicious software such as ransomware may render an organization's data unreadable or unusable. In the event data is compromised due to a cyberattack, restoring the data from backups may be the only option to recover the data and restore normal business operations."

The OCR reminder, along with multiple sources for guidance in developing contingency plans, is available at: https://bit.ly/2uF0ap4.

A contingency plan is required under 45 CFR Section 164.308(a)(7), which established HIPAA. Covered entities must establish and appropriately implement policies and procedures for responding to an emergency or other occurrence that damages systems containing electronic protected health information, notes **Lucie F. Huger**, JD, an officer, attorney, and member of the healthcare practice group at Greensfelder, Hemker & Gale in St. Louis.

An emergency or other occurrence includes an unforeseen event, such as a natural disaster or a cyberattack, she says. Huger explains the necessary elements of a HIPAA-compliant contingency plan should include:

1. Data backup: Figure out how to create and maintain retrievable, exact copies of protected electronic health information;
2. Disaster recovery: Create procedures to restore any data that are lost;
3. Emergency mode operation: Produce procedures to enable the continuation of critical business processes to protect the security of protected electronic health data while operating in an emergency mode.

Other items to address in a contingency plan include procedures for periodic testing and revision of contingency plans, and assessing the relative criticality of specific applications and data in support of other contingency plan components.

"You need to first start with performing a risk analysis to identify your organization's risks and vulnerabilities. In developing a risk analysis, the organization should identify the potential threats to their data, identify the associated risk to the data, and note preventive controls," she says. "The [OCR] has provided guidance to entities suggesting that entities prioritize their critical systems and critical information to help them to focus on developing a contingency plan."

Different organizations face different risks because they maintain varying systems and implement contrasting controls, Huger notes. What may be a risk for a hospital system may not be the same for a small physician's office, she says.

"An effective contingency plan can be a game changer in the event of a ransomware attack because if an entity can use its backup data to get its operations back up and running, it minimizes the impact of the attack," she explains.

The clear identification of plan objectives is critical to the success of any contingency plan, along with ensuring those objectives include measurable and purposeful processes designed to achieve those goals, says **Ryan Buckner**, JD, principal with Schellman & Company, an independent security, privacy, and standards compliance assessor.

"Simple and clear objectives tend to be more effective at enhancing compliance and controls over time vs. designing a plan that does everything on day one. Many organizations fall victim to overly complicating their contingency plans," he says. "While it is important to ensure your organization achieves meaningful and desirable outcomes, oftentimes, organizations simply get in their own way by primarily focusing directly on process or IT solutions without first addressing the key questions regarding the plan's objectives."

Often, this requires a level of discipline and planning from those who are used to accomplishing tasks quickly, Buckner says.

"Focus on a risk-based set of contingency plan objectives, establish the measurable processes designed to meet those objectives, test the plan against those objectives, and improve the plan based on those results over time," he advises.

The requirement for contingency plans is broad, notes **Elizabeth Davidson**, PhD, professor of information technology management at the Shidler College of Business at the University of Hawaii at Manoa. All HIPAA-covered entities, such as hospitals, physician practices, health insurers, and home health services providers, as well as their business associates such as cloud-based electronic health record (EHR) vendors, must maintain a contingency plan for protecting, recovering, and restoring protected health data in the event of a business disruption.

A contingency plan begins with a risk assessment that identifies all information systems that handle protected health data, including computers, laptops, mobile devices, software, and databases, she says.

"This survey must be comprehensive, because not all PHI are contained in one EHR," she says. "Many health services providers big and small still have vital PHI in paper records, specialized computerized systems, or even Excel spreadsheets."

The risk assessment classifies the sources, probability, and implications of adverse events, such as hardware malfunctions or natural disasters. This allows the organization to prioritize and focus its plan based on the probability and cost of an adverse event.

"For instance, brief power outages may happen several times a year, but the impact on PHI is generally not high. Conversely, a once-in-a-100-year weather catastrophe has low probability of occurring, but could lead to wide-scale loss of protected health data," Davidson says. "In Hurricane Katrina in 2005, many medical facilities and physician offices in New Orleans were flooded, and patient health records were destroyed and permanently lost."

Based on the risk assessment, the contingency plan includes a data backup procedure for all electronic PHI, a disaster recovery guide specifying how lost or damaged PHI and associated information systems will be restored, and an emergency mode operation policy detailing how the organization will function during an emergency while also protecting PHI, Davidson explains.

"The plan should specify procedures to periodically assess and update the contingency plan and to test the plan occasionally," she says. "An untested, out-of-date contingency plan is like driving around with a flat spare tire in the trunk. It won't help if you have a tire blowout on the highway."

Contingency planning begins with understanding PHI management regulations and the organization's objectives and priorities, she says. Fortunately, risk assessment and contingency planning steps are well-understood processes, which most large organizations can undertake with their own IT and clinical staff.

Small-to-medium-sized organizations may need to contract with consultants who are experts in data security and contingency planning to work with the managers and clinical staff.

"Finally, the plan should include training and education of all staff members, who will carry out the plan should the need arise," Davidson says. "If you don't know how to change that flat tire, having a spare in the trunk won't be of much help when a tire blows."

The complexity and scope of a contingency plan will reflect the complexity and size of the organization, Davidson says. The plan for a multi-location healthcare services network will necessitate orders of magnitude more complex than for a small physician practice. However, a well-developed plan is just as important for a small organization, she notes.

"Imagine a solo physician practice that has all its patient medical records in an EHR on a computer server in the back office. Now, imagine that the server is stolen or lost in a fire or flood," she says. "Without a plan in place, this small practice would be out of business and also legally liable for having lost the medical records. A contingency plan would ensure the PHI data were backed up off-site, specify how to restore data, and instruct staff how to deal with patients until the EHR and data are restored."

Many organizations find it hard to justify spending resources to prepare for adverse events that may never happen, Davidson says. However, not creating an adequate plan means hoping that risks won't happen and that if they do, things won't be all that bad.

"The reality is that failure to plan for disruptions that can impact PHI

puts patients' safety and well-being at risk. The organization may face fines for lack of compliance and be held financially liable to patients whose PHI are lost," she says. "If the loss is severe, the organization may lose patients whose trust in the organization's ability to keep their PHI data safe is lost."

Typically, developing a contingency plan will require forming a committee of stakeholders, says **Alaap B. Shah**, JD, an attorney with Epstein Becker & Green in Washington, DC. That committee should include, but is not limited to, individuals with responsibilities related to compliance, information technology, facilities management, finance and administration, human resources, and communications.

"This committee will need to work together to define recovery requirements relative to key business functions; document the impact of an extended loss to operations and key business functions; and evaluate options for disaster prevention, impact minimization, and orderly recovery," he says. "It ultimately will develop a written contingency plan that is understandable, easy to use, and easy to maintain, with clearly defined triggers and response roles and responsibilities."

Shah also emphasizes that a contingency plan should not sit on a shelf and collect dust, but rather should be tested and improved over time.

The recent message from OCR shows that contingency plans are on the table when the office looks at any organization's HIPAA compliance, notes **Nick Merkin**, CEO of Compliagent, a company in Los Angeles that advises healthcare companies on compliance and data security issues. OCR hasn't created any new requirements, but it is making known its concerns that covered entities may be giving short shrift to this one.

Merkin also notes that contingency plans should cover a wide range of potential ways PHI access could be compromised, from the catastrophic natural disaster to more mundane problems.

"It could be something high-tech and dramatic like a ransomware attack, or it could be something as simple as a leaky roof that damages your servers, and your servers go down," he says. "The OCR was specific about that, reiterating that you need a disaster recovery plan that will tell you how to restore or access that data no matter what the cause of the problem."

The goal is to ensure that you can continue to provide quality care even when PHI is compromised in some way, he says.

"One of the problems I see is that a lot of organizations are still newly adopting things like EHRs and making the transition from a paper record. There is sort of a slow realization that protecting that data is important and how you protect it may be different from how you protected data when it was stored in a file cabinet in your storage room," he says. "A lot of organizations make the mistake of just downloading something off the web or depending on an employee who used to work in an organization sort of like yours. What you end up with are templates and not policies and procedures tailored to your organization, which can make a big difference in a breach or an emergency." ■

Legal Case Shows Risk of Improper Patient Info Disclosure

An ongoing legal case illustrates the risk healthcare providers face when they do not properly safeguard patient data and make it available to third parties without consent, even when complying with a subpoena.

A recent legal ruling allows patients in Connecticut to sue any healthcare entity for damages related to a HIPAA violation, and the same theory would hold in many other states.

The Connecticut Supreme Court recently ruled that patients in the state can sue doctors and other healthcare providers for the disclosure of their confidential medical records without the patient's consent. The ruling involved a client represented by **Bruce Elstein**, JD, an attorney with the law firm of Goldman Gruder & Woods, who explains that *Byrne v. Avery Center for Obstetrics & Gynecology* has been in litigation for 12 years.

Elstein's client, Emily Byrne, received prenatal care at the OB/GYN practice in Westport, CT. In 2004, she specifically told the practice not to release her records to her former partner, Andro Mendoza. The following year, she moved to Vermont.

"She had broken off that relationship with the father of the child and informed the office to provide to him no information," Elstein says.

Mendoza filed paternity actions against Byrne in Connecticut in May 2005 and sent the OB/GYN practice a subpoena requesting all of Byrne's medical records. The practice mailed the records to the New Haven Regional Children's Probate Court,

which made them available to the public as part of the legal record.

"The subpoena demanded the office produce the entirety of her file. HIPAA regulations have specific regulations for what to do when there is a civil subpoena, which first requires notifying the patient and also obtaining satisfactory assurance from the party issuing the subpoena that the patient has been notified," Elstein explains. "Then, they are to show up in court with the documents and provide the minimum amount necessary for the issue at hand."

The OB/GYN practice did not call a lawyer, a consultant, or even consult its own HIPAA manual before responding to the subpoena, Elstein says. Instead, someone at the practice called the lawyer issuing the subpoena and asked how to comply with the request, he says.

"The lawyer said, 'why don't you stick them in an envelope and mail them to the court?' So, that's what they did," Elstein says. "The entirety of the patient's record was copied, cover to cover, and mailed to the court. The clerk received the envelope and stuck it in the file."

Byrne's lawsuit claims that after seeing the records, Mendoza began to harass Byrne and tried to extort money from her. Byrne was successful in her request to the court to seal her medical records in September 2005.

"He read her records cover to cover and then went on a campaign to inflict some serious emotional distress upon her, using the information to embarrass her, extort her, and to extort others, namely her employer, the chief of police, and the town in which he lived," Elstein says.

Byrne sued the OB/GYN practice for negligence, claiming it violated HIPAA by releasing her medical records. The superior court rejected the claim, saying such private suits involving HIPAA were prevented by federal law.

The state supreme court upheld the lower court's ruling, and further wrangling continued at the trial level. But recently, the Connecticut Supreme Court reversed its earlier position and ruled that a physician-patient relationship creates a "duty of confidentiality" and that a covered entity's "unauthorized disclosure of confidential (medical) information … gives rise to a cause of action sounding in tort against the health-care provider, unless the disclosure is otherwise allowed by law."

Justice Dennis G. Eveleigh, JD, wrote the court's opinion, which was based on reviews of relevant laws from South Carolina, Massachusetts, Missouri, and other states. The opinion noted that liability for breaches of confidentiality is consistent with sound medical practice under both state and federal law.

Elstein says the case illustrates the need for more than just superficial efforts to comply with HIPAA. When the law first became effective, physician practices typically sent an office manager or another representative to a seminar hosted by a consulting company. Typically, they were left with a manual for how to comply with HIPAA, he says. That likely is not enough of a HIPAA compliance program for any covered entity; however, at a minimum, Elstein says, read that manual.

"The lesson of this case is that HIPAA means what it says. You can't make up your own private method of answering a subpoena and complying with HIPAA," he says. "HIPAA spells out the right way to respond. It requires making sure the patient has been notified, and it requires going to court, not putting everything in an envelope and sending it off, unless there have been specific authorizations. Even when all parties agree to how the records will be provided, HIPAA still requires that you produce the minimum necessary to address the issue at hand."

In this case, the paternity of the child was the only issue pertinent to the paternity case for which the subpoena was issued, Elstein explains. The patient's complete OB/GYN history was not relevant and should not have been provided.

"The medical office is still arguing that this is what they do whenever there is a subpoena, and it was proper," Elstein says. "Our supreme court has said it is not the proper way to respond, but they continue bringing in experts to say there are lots of ways to respond to a subpoena and mailing it all in to the court is one way you do it. I think medical providers who consult with lawyers and experts in HIPAA would completely disagree."

Elstein notes this legal reasoning is not unique to Connecticut. Other state supreme courts have issued similar rulings. While it is true that there is a pre-emption of private causes of action under HIPAA, meaning a plaintiff cannot sue in federal court for a HIPAA violation, there is a strong trend among states that HIPAA can establish the standard of care for a state cause of action alleging negligence, Elstein explains.

"The Connecticut Supreme Court ultimately decided that there is a private remedy for violating that standard of care, and you are exposed to damages for the harm you caused by breaching medical confidentiality. That is the majority trend across the United States, although it is not absolute," Elstein says. "If a surgeon severs the spinal cord, he or she can expect to pay for damages if it was negligent. The same is now true for the medical information we provide our doctors, hospitals — all medical providers." ■