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## INSIDE



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# Posted Prices: For Revenue Cycle, Headaches — and Opportunity

Posting charges for hospital services online, as hospitals are now required, sounds like a fairly simple job for IT. The aftermath is what is complicated.

"If people do try to compare prices across hospitals, they will get confused very quickly," says **Gerard Anderson**, PhD, professor at Johns Hopkins Bloomberg School of Public Health.

The posted prices are not what patients, insurers, or anyone actually pays. Hundreds of listed line items with dollar amounts, ranging from a half-hour of OR time to gauze bandages to single pills, are enough to confuse even health policy experts, let alone the general public. "The nomenclature is difficult for patients to understand," Anderson laments. "It differs from hospital to hospital, making comparisons almost impossible."

Price-shopping patients are eager to figure out which hospital offers the best deal. The posted prices are of no help. "Patients do not want to know how much each line item costs. They want to know the cost of the entire visit," Anderson says. Patients are not interested in average costs or hypothetical charges. What patients really want to know is the amount they are going to pay. Even if patients could simply total the costs of every line item, they would not find a satisfactory answer. Why? Patients do not necessarily know in advance what services or tests they are going to need.

Informed decisions might be possible if hospitals posted the actual cost of an MRI or an appendectomy. This information, says Anderson, "will be much more valuable. The information systems in most hospitals will permit this very easily."

To those who say the posted prices only serve to confuse and frustrate patients, a Centers for Medicare & Medicaid Services spokesperson says, "We recognize that at this time this step doesn't give patients all the information they need. We still believe this is an important first step, and there's no reason hospitals can't do more."

Comparing prices at different local hospitals sounds simple enough. Yet unlike prices of food, cars, or anything else, the connection between cost and quality is unclear in healthcare. "It's pretty clear that healthcare is not like other commodities," says **Pauline Rosenau**, PhD, a professor at UTHealth School of Public Health in Houston.

There are no guarantees in healthcare. Paying more for a surgical procedure does not always mean a better outcome. "A lot of assumptions we make about the relationship between price and quality in

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medical care are not necessarily true," Rosenau offers. Even the savviest price-shopping patient cannot really compare costs. If one hospital quotes a lower price, but the patient's health plan is out of network, it is not "cheaper" at all. Even "bundled" payments, which in theory include everything for a particular service such as a hip or knee replacement surgery, carry limitations.

"Much is unknown when a patient is admitted, prepped, and sent for surgery. Much is unpredictable," Rosenau explains. For instance, a patient may lose enough blood to require a transfusion. The cost of an identical surgery could vary for different patients.

Surprise bills for facility charges or anesthesia add to the confusion. "Discounts on prices are given by hospitals for all sorts of reasons," Rosenau adds. Some discounts are offered only to a specific person, as with charity care or prompt pay discounts, while others apply only to certain health plans.

For all these reasons and more, Rosenau concludes, "The posted prices are deceptive and meaningless."

Patient access department employees who spoke with *Hospital Access Management* reported surprisingly few calls about the posted prices. Possibly, this is because it is apparent the listings are of very little use to anyone.

Registrars at Genesis Health System fielded a few inquisitive calls. They took the opportunity to explain that the numbers were based on average charges.

"We make sure that patients understand everyone is unique, so their charges could be less or more," says **Aimee Egesdal**, manager of patient access for the Davenport, IA-based system.

**Myndall V. Coffman**, MBA, calls the new requirement "a disservice to patients." The question most people ask is, *"What will I owe?"* Posted charges do not answer this question.

"If transparency is the true goal, ensuring patients understand their benefits and true liability should be the point," says Coffman, system executive director of patient access, scheduling, and financial counseling at Baptist Health in Louisville, KY.

Hospitals are directing patients away from the posted charges and toward their employees who can actually give answers.

"We are providing estimates at scheduling. If they call with questions, they are routed to financial counseling," Coffman reports. ■

# Some Who Pay Chargemaster Prices Are Suing

It is common knowledge that chargemaster prices bear no resemblance to the reimbursement from health plans or what patients pay to hospitals. "The prices contained in these documents are fictitious," says **George A. Nation III**, JD, a professor of law and business at Lehigh University.

However, that is not altogether true. For some unfortunate people, the posted charges are all too real. "Many patients have their financial lives ruined by the aggressive efforts of hospitals to collect these exorbitant prices," Nation says.

Now, some patients are using the legal system to fight back. Nation expects to see more lawsuits for hospitals. Attorneys are demanding access to the real reimbursement amounts hospitals receive.

A recent Texas case involved an uninsured patient who was brought to

an ED after a motor vehicle accident. The patient received X-rays, a CT scan, and lab tests.[1] Because she was uninsured, the hospital billed the patient at the full chargemaster prices — more than $11,000. The patient's lawyer argued that the bill was unreasonable under the Texas Hospital Lien Act. The attorney requested discovery of the amount the hospital would have been paid from its in-network commercial insurers as well as from Medicare and Medicaid for the same care. The hospital objected to providing this information. "But the Supreme Court of Texas ruled that that information was relevant, even though the patient was uninsured, to determine a reasonable price for the care the patient received," Nation says.

Few would argue the chargemaster prices are fair to consumers or allow anyone to compare actual costs in a meaningful way. Nation says there are two important issues at play: the price itself and whether it is fair and whether consumers have enough advance notice of the price they are going to pay so they can compare that estimate to other hospitals.

Posting chargemaster prices is "a complete and utter waste of time," Nation argues. "It is completely useless to patients."

So what should be posted? The average reimbursement amounts hospitals receive from in-network commercial insurers, according to Nation. "This is readily available and could be easily disclosed by hospitals if they chose or were required to do so," he adds. Nation acknowledges that in-network health plans provide benefits to hospitals that self-pay patients do not. For one thing, hospitals can see many potential patients. For another, hospitals receive quick, reliable payment for services. Thus, it is reasonable for self-pay patients to pay more, says Nation. The question becomes: How much more?

Nation suggests a fair price for self-pay patients is in the ballpark of 10% to 15% over the average reimbursement paid by in-network health plans. "Under no circumstances should self-pay patients be expected to pay the exorbitant chargemaster-based prices," Nation offers.

Notably, neither commercial health plans nor Medicare and Medicaid use chargemaster prices to determine how much they pay hospitals. Rather, they use procedure-based pricing. This is based on all the goods and services involved during an entire episode of care. In this model, a single price is established for a noncomplicated appendectomy, gall stone removal, knee replacement, or other procedure.

For instance, a patient knows in advance if he is going in for a hernia repair. Right now, there is no good way to compare prices at local hospitals. Knowing the average reimbursement the hospitals agreed to accept from in-network insurers would be "very useful for determining which hospitals have the lowest price," Nation says.

By publishing an average, hospitals do not need to reveal any proprietary information. Since these reimbursement amounts are the actual amounts that hospitals have agreed to accept as full payment, comparing them tells patients which hospitals are most and least expensive, Nation explains. He would like to see hospitals do two things:

**• Publish procedure-based average reimbursement amounts that the hospital receives from commercial insurers that are in network.** "The reason that hospitals don't want to disclose these amounts is that it would force them to compete on price," Nation argues. "That could result in a reduction of their revenue."

**• Commit to self-pay patients that hospitals will charge no more than 110% to 115% of those amounts.** Reimbursement rates set by Medicare and Medicaid often are below cost for some hospitals. Therefore, the rates would need to be adjusted upward to create a fair price for self-pay patients. "As a general ballpark amount, somewhere around 125% to 150% of the Medicare reimbursement amount probably represents a fair price," Nation offers. ■

## REFERENCE


1. Supreme Court of Texas. In re North Cypress Medical Center Operating Co. (Opinion). On Petition for Writ of Mandamus, Nov. 9, 2017. Available at: https://bit.ly/2GhhN2n. Accessed Feb. 1, 2019.

# More Transparency Coming Soon; Posting of Contracted Prices Possible

The new requirement to post charges online is only the first step. According to CMS, more changes are on the way.

"We are just getting started as we work to increase price and quality transparency throughout the healthcare system. We have to do more," a CMS spokesperson says.

The spokesperson acknowledges the solution is not as simple as just posting prices: "We also need to make sure patients have the right information at the right time to make a decision."

There is growing awareness that the posted prices are meaningless to consumers. This likely means that much more information will soon be expected from hospitals. "Hospitals should begin to prepare for legal demands to post not just their chargemaster, but the amounts they agree to with private and government payers," says **Barak Richman**, a professor of law and business administration at Duke University.

Contracted rates are not usually made public. These are considered sensitive information and a trade secret. "This is information that hospitals are very eager to conceal," Richman says.

It is less of a concern for hospitals to list average prices negotiated with health plans overall rather than specific payers. Alternatively, hospitals could report average prices for standard and frequent services or a charge-to-revenue ratio for assorted payers.

"Hospitals ought to consider making prices for common procedures much more widely available — not just online, but posted in ERs and elsewhere," Richman offers.

Richman argues more meaningful price disclosure is necessary to protect healthcare consumers. "With adequate disclosure, hospitals could feel comfortable charging the prices they think are fair and competitive," he says.

Some specialty clinics have made price transparency a core strategic feature. "But I know of no large hospital or hospital system that does that," Richman adds.

Pricing has become so complicated that much is out of the hospital's control. "Surely, the current system is wildly complex and will be very difficult to change. But it is not impossible," Richman says. "The status quo hurts patients and insulates hospitals from necessary change."

Whatever changes are coming, hospitals need to recognize that transparency is not going away. "Hospitals should get away from relying on their chargemaster altogether and instead work toward engaging in meaningful price competition," Richman advises.

There is growing outrage over inflated chargemaster prices, which are many times more than what commercial and public health insurance plans pay. One recent well-publicized example: a $48,329 bill for allergy testing.[1] This is terrible public relations not just for the individual hospital but for hospitals in general. "Soon, hospital charges will be associated with exploitive revenue strategies," Richman predicts.

This gives revenue cycle leadership a very challenging problem to address. The biggest challenge, says Richman, "is developing pricing policies that do not exploit vulnerable patients." ■

## REFERENCE


1. Ostrov BF. That's A Lot Of Scratch: The $48,329 Allergy Test. *Kaiser Health News*, Oct. 29, 2018. Available at: https://bit.ly/2CVgnJc. Accessed Feb. 1, 2019.


# What Is Coinsurance? Many Have No Clue

Because of the Affordable Care Act, many people received health insurance who never enjoyed it before. Some assumed it would pay their healthcare costs in full. "The registrar says, *'You owe $2,500,'* and the person says, *'What? I have insurance,'"* says **Rick Gundling**, senior vice president of healthcare financial practices at the Healthcare Financial Management Association.

Many people do not understand the meaning of basic terms such as "copay" or "deductible." This soon becomes apparent when registrars try to talk to patients about their bills. Patient access employees need two things to talk about money with patients: empathy and training, according to Gundling. Many people bought health insurance without any education at all on what it covers. This is true whether the patient received coverage through an employer or purchased it online through their own means. "Registrars have to realize they're probably the first person to talk about insurance with the patient," Gundling offers.

Despite growing attention to the topic by policymakers, it is still unclear if price transparency factors into which hospital people choose. "We are still trying to understand how transparency

affects medical decision-making. It may not make a big difference at all," Gundling notes.

A person who needs knee surgery might go where their neighbor went for a similar procedure. Many people just choose the closest hospital, the one that is in network, or where their doctor has privileges. It is even possible that people will choose a hospital with higher costs if they view it as better quality for some reason. If a friend enjoyed a great surgical outcome, that might signal high quality in the eyes of the patient. "The patient might be willing to pay more to go to that hospital," Gundling offers.

Before patients can pick and choose hospitals with cost in mind, they need to be able to compare prices. Gundling recommends hospitals provide pamphlets on healthcare prices, how to avoid surprise bills, and what it means to be in network. Patients can be in network with the physician group, the hospital, and the surgeon — but not the anesthesiologist. "Now, they get stuck for a $1,000 bill they were not expecting, and they didn't even know to ask that," Gundling laments.

People who use mobile apps to buy everything from groceries to cars are baffled that they cannot do the same with medical care. Confusion breeds mistrust. "Patients don't understand why it has to be so convoluted," Gundling explains. Even two people with the same insurance who will undergo the exact same procedure can end up with dramatically different bills. For instance, two knee surgeries can cost vastly different prices because one person experienced unexpected complications.

Meanwhile, revenue cycle leaders are keenly aware that the financial side of care affects overall satisfaction, not usually for the better. Clinicians are ethically obligated to respect patients' autonomy, right to shared decision-making, and religious beliefs. "We need to also respect them financially," Gundling adds. "Patients don't necessarily want a treatment plan that's going to impoverish their spouse or family."

This is much easier for elective, scheduled services. Yet, the highest costs occur on the inpatient side, where care sometimes is unanticipated. This makes conversations exponentially more difficult. "People are not feeling well and are very anxious. It's probably the worst time to talk about money, but there you are," Gundling says. The alternative (and long-standing practice) is not to mention money at all while the patient is in the hospital. This means a surprise bill when it is too late to plan or delay care. "Once patient access tells them what is covered, there might be a different treatment option," Gundling says. For some, a zero-interest loan takes the pressure off. Some good detective work by registrars might reveal that half the patient's deductible was met recently, lowering a quoted $5,000 out-of-pocket cost to half that amount. "That's where technology can help," Gundling says.

One frustrating obstacle is that payer systems do not interface with hospital registration systems. This makes updated information hard to come by. "We are definitely going to see greater strides toward interoperability where all these systems can talk to each other," Gundling predicts.

Whatever tools, systems, and training are in place, financial conversations require a personal touch. This is where revenue cycle employees come in.

"There's still an expectation that you can have a conversation with someone," Gundling says. ■

## Educate Registrars Well; In Turn, They Will Teach Patients

When a man found a surprise bill for more than $5,000 in his mailbox weeks after successful surgery, he did not have to wonder who to call and complain to. After all, he was on the hospital's patient and family advisory committee.

The man was not shy about telling everyone how the unexpected bill made him feel. "He was very angry and felt we had not been truthful," recalls **Peggy Beley**, director of patient financial clearance and bed management at Yale New Haven Health. The incident happened several years ago, when hospitals were first seeing a surge in high-deductible plans. Suddenly, patients who previously had paid small copays owed thousands of dollars. Many were surprised at their large balances even after insurance coverage paid its share. "That's how it started for us. We decided to commit to transparency upfront, even if it's hard," Beley says.

Patients were finding out their costs too late. "We are the only industry where you go in blindfolded and don't know how much it will cost," Beley laments.

Hospital leaders knew their patients were unhappy with the way things were and decided to commit to price transparency. Leaders asked this important question: *How do we educate our patients while securing payment for our organization?*

Yale New Haven Health's financial clearance department provides estimates for high-cost services at the health

system's five hospitals. "We have taken the approach of what I call 'education estimates,'" Beley reports.

Financial counselors do more than give a dollar amount. Patients receive a good education on insurance terms and the "why" behind the amount. "We've found it beneficial to educate patients on the whole picture," Beley says. In contrast, many departments send printed estimates without an explanation. Taking all this time to educate patients "is probably the path less travelled," Beley offers. "But we believe it's the right way to go."

Talking to patients about insurance was brand new for some registrars. Most needed a fair amount of education themselves. "We needed to take a step backward and educate our staff on how insurance worked. It didn't come naturally to everyone," Beley recalls.

Previously, registration staff took insurance information, but that is where their involvement ended. Patients received a bill on the back end after services had been provided. With soaring out-of-pocket costs, this system no longer worked. The focus shifted to the front end, beginning with a small group of financial clearance specialists. "We built their confidence to the point where they can have these conversations," Beley says.

Employees give patients a breakdown of what is covered, what is not covered, and how much is owed. "This has gotten extremely complex in recent years," Beley says. "We took a layered approach to training." Training starts with terminology (deductible, copay, coinsurance, total out-of-pocket costs, in network, and other insurance terms). Next, staff take benefit information from payer websites and apply it to particular services. Staff need more than a rudimentary understanding of it. "They have to be completely comfortable with the information in order to explain it to patients who are typically very confused," Beley explains.

New employees shadow experienced financial clearance employees to learn how conversations unfold. Some cringed at the idea of talking about money because they hated math. After a while, says Beley, "they just rattle it off," she says. "They take the time to educate the patient on the phone, just like we took the time to educate them."

Some people avoided healthcare due to their high deductibles. With some financial education, they realize something can always be worked out.

"Probably the most rewarding thing is to help someone obtain access to care," Beley shares. Patients are more satisfied and end up with less bad debt.

"Providing our staff expertise in insurance benefits is priceless," Beley says. "It was a great investment." For obvious reasons, accuracy in price estimates is critical. It hinges on the department obtaining correct insurance information from patients, the right CPT codes from the provider's office, and appropriate benefit information from the payer.

"We've worked really hard at making sure our eligibility system is giving us back the latest and greatest results so we are using the most up-to-date information," Beley says. Estimates can still change for these two reasons: other diagnostic tests or procedures performed (increasing out-of-pocket costs) or other recent services the patient had paid for are submitted to the insurance payer in the interim and applied to the deductible. This makes the amount owed less.

Staff explain that the estimate is based on whatever specific test or service is ordered currently. If the physician or the radiologist changes it, the cost also changes.

"We educate them on the whole process, not just their particular test or service," Beley notes. There are many different variations of plans; not all are covered by the department's estimate tool. Sometimes, staff scour payer websites to find out certain things. "You have to actually dig for the information. That's something we struggle with. It's time-consuming and challenging," Beley says.

Every patient's financial situation is somewhat different. This makes scripting of limited use. "Everyone comes in with a different set of worries on their mind," Beley explains.

No one wants to hear they owe a lot of money. Most people come to realize that registration staff are sincerely trying to help.

"We've found patients are extremely grateful, even if the cost share is significant," Beley reports.

Recently, the man who received the surprise surgery bill was scheduled for surgery again. This time, he had something very different to report to the patient and family advisory committee. He raved about an employee who called to explain in great detail what his insurance benefits would cover. She provided him an estimate of his out-of-pocket costs a week before the surgery, giving him a choice about how to proceed.

"Although he still owed money, this phone call made a huge difference to him," Beley says. ■

## COMING IN FUTURE MONTHS

- Give your best registrars a great reason to stay
- Dramatically cut bad debt with easy payment plans
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# For 'Savvy' Registrars, Transparency Part of Narrative

Patient access employees interact with patients often for routine inquires, to schedule appointments, and at the time of registration. For each encounter, price transparency is part of the focus at Oklahoma City-based Integris Health.

"It's an integral part of the standard narrative for the patient access staff when communicating with patients," says **Susan Garcia**, system vice president of revenue cycle operations.

The patient's financial responsibility is outlined in plain language that is easy to understand. "Staff must be savvy in providing an estimate of charges and a comprehensible explanation of the patient's insurance benefits," Garcia notes. This includes any out-of-network benefits, copays, deductibles, and even outstanding balances.

"Tailored payment solutions help ease the financial burden patients are now experiencing," Garcia says. All staff are well-versed in creating personalized payment plans. Also, staff are updated constantly on payer changes. Still, financial discussions do not always go smoothly.

"Staff are aware of escalation protocols and initiate them when necessary," Garcia says.

Patient access employees are trained in multiple ways, including classroom lectures, virtual courses, observation, and real-time feedback. "Scripting for financial counseling scenarios assists the staff in fostering a consistent and successful patient experience," Garcia explains. Financial counselors are the ones who handle complex conversations. However, every registrar knows the basics.

"We understand that everyone is experiencing a different set of circumstances," Garcia explains. "We must be able to meet them where they are." ■

# Better Early Financial Clearance Reduces Surprise Bill Incidents

A preservice financial collection process has been in place since 2014 at New Orleans-based Ochsner Health System. "This doesn't include any add-ons or urgent procedures. But we do this for anyone scheduled out more than 48 hours," says **Stacy Collins**, assistant vice president of patient access for Ochsner.

Over the past few years, the process has been tweaked and improved. Coinsurance is included in price estimates. More than 90% of accounts are financially cleared ahead of time, either through full payment, a payment plan, payment at the time of service, or financial assistance.

Most patients are willing to settle their balance, but only if they are contacted. "Trying to get in touch with patients during the day is difficult," Collins laments. If phone contact is not possible, patients receive a message through the patient portal, which provides the option to pay for radiology services.

Some patients still have a small copay, but they are in the minority. A growing percentage owe hundreds of dollars or more. About 20% of patients pay over the phone. Another 250 pay through the portal each month. If patients cannot be reached ahead of time, registration engages in a conversation with these patients when they arrive for the appointment. "There are no surprises on the back end," Collins says.

Nobody wants to find out the patient is out of network when he or she arrives for a scheduled diagnostic test or surgery. However, this can happen if insurance information is not added at the time of scheduling.

"Some patients are put on the schedule with minimal information," Collins explains. The system is supposed to alert registrars if a plan is out of network, but the system does not include every single plan in the marketplace.

"Sometimes, it's just an employer group that doesn't participate, and we are not always able to catch it ahead of time," Collins explains. If the patient is scheduled for a high-dollar service and it goes through the regular preservice process, staff always catch the out-of-network status. "But it could be that the patient is scheduled for a clinic visit, and it may get through without us identifying it ahead of time," Collins adds.

This is not a great situation for anyone. First, registrars contact the payer to see if an exception can be made allowing the patient to obtain care in network. "If not, we work with the patient on the amount due," Collins reports.

It is human nature to want to save money. When patients select

insurance, they often choose the plan with the lowest premium without fully understanding what this really means.

"If you ask our financial counselors what they spend most of their time doing, it would be explaining benefits to patients," Collins says.

Patients want to know why they owe a specific amount and are quite upset sometimes. Revenue cycle leaders went so far as to create a video to tell them. Produced in collaboration with the hospital's marketing department, this video plays in lobby areas. The video, also available on the hospital website, covers terms such as copays and deductibles and how to understand a billing statement. "We are trying to do our part to educate patients," Collins offers. "We would love to work more with our payers so they could have a hand in that as well."

The department recently created a central pricing office staffed with phone representatives and internal consultants to field calls from price-shopping patients. Some callers were just scheduled for a diagnostic test but have not received a preservice call yet. Clinicians also call with questions on behalf of their patients.

"We are super excited about this and have gotten lots of positive feedback," Collins says, noting patients are informed of the phone number via the website and pocket-sized cards. "Registrars can point the patient there as well if they need an estimate." ■

# Revenue Cycle Takes Lead Distributing Information

Some revenue cycle leaders are not waiting to find out what new requirements for price transparency will come from regulatory bodies or governments. Instead, they are moving full speed ahead on their own.

"Online posted prices are complex and confusing" for patients, says **Kathy Delis**, administrative director of revenue cycle support services at the University of Utah Health in Salt Lake City.

The hospital created something much better for patients. The "See Your Out-of-Pocket Costs" tool combines chargemaster prices with an individual's insurance information.

"This tool provides a simple way for patients to understand the cost for their care," Delis explains. More than 40,000 patient estimates have been generated in the year and a half since the tool was developed. As word spread, use has doubled. As with all hospitals, the chargemaster prices are posted for all to see. However, when patients view those, they will find a link to the new tool. "This gives more meaningful information," Delis offers.

The patient selects a service and enters his or her type of insurance (commercial or government) and whether he or she has a copay, coinsurance, or deductible. The tool factors all the information, along with six months of similar cases and what they cost, to produce a highly accurate price estimate. The tool does not compute costs for complex services with a high degree of clinical variability. This is handled by the patient financial advocate team.

"We work through the complexities in service or payer coverage to ensure most accurate estimate possible," Delis says. ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

# OCR May Alter HIPAA Rules to Ease Compliance, Care Coordination

The healthcare industry has complained about the difficulty of complying with HIPAA since the law was enacted. Now, the HHS Office for Civil Rights (OCR) is asking for suggestions on how to make HIPAA more manageable. What changes might actually happen remains uncertain.

OCR issued a Request for Information (RFI) seeking public input about how the HIPAA Privacy Rule could be changed to promote value-based and better coordinated care. *(Editor's Note: The RFI is available at: https://bit.ly/2iVERG4.)* OCR's effort to resolve frustrations with HIPAA is long overdue, says **Joseph A. Dickinson**, JD, partner with Smith Anderson in Raleigh, NC.

"HIPAA, as it has evolved, has gone too far. It is inhibiting the sharing of information for purposes of healthcare treatment," he argues. "We see it every day with doctors including fears of HIPAA liability in their healthcare process, sometimes not fully sharing information with other healthcare professionals that might actually be pertinent and needed to provide the best care."

Meanwhile, there is a serious problem in the industry with data breaches and healthcare organizations not taking their obligations seriously, Dickinson says. OCR's challenge will be to change the law in ways that ease the unreasonable burden without letting organizations off the hook if they do not make reasonable efforts to comply.

"I think OCR is going to cut back on the fundamental obligations to protect patient privacy up front, but making some changes on the other end so that once they have that protected data they can share it with other providers to get the best care for the patient," Dickinson says.

The OCR's RFI focuses on how HIPAA rules can be revised to facilitate coordination of patient care among and between providers, explains **Eric D. Fader**, JD, an attorney with the Rivkin Radler in New York. Although HIPAA became law in 1996, Fader says not everyone understands certain aspects of the rules. Thus, some healthcare providers, particularly their clerical employees, sometimes find it easier not to cooperate promptly with a patient's or another care provider's request for records while using HIPAA as an excuse.

The Treatment, Payment, and Healthcare Operations (TPO) exception to the Privacy Rule continues to be difficult to grasp for some, Fader says. The TPO exception permits (but does not require) the sharing of patients' protected health information (PHI) for purposes of care coordination. Fader says requests for PHI from one unrelated provider to another often are not handled with the same degree of urgency.

"The OCR has surely heard anecdotally of many instances where requests for information for treatment purposes were either not complied with at all, whether through a misunderstanding of what HIPAA allows or for workload reasons, or due to an unwillingness to cooperate with the requesting party," Fader says. "It appears that the OCR is considering how to make sharing PHI for purposes of treatment ... more mandatory than permissive, a goal with which I agree."

The other sections of the RFI are mostly variations on the same theme, Fader says. They include consideration of shifting some provisions of HIPAA from "disclosure of PHI is permissible if ..." to "disclosure is required under these circumstances."

Fader predicts care coordination, case management, quality assurance, and other activities will be easier if healthcare providers understand that they do not need to be concerned about disclosing PHI to another party that is subject to HIPAA already while also recognizing the need to handle requests promptly.

"Just as the OCR continues its enforcement activities when healthcare providers inexplicably still fail to comply with HIPAA after all these years, and just as they continue to put out press releases regarding settlements that are clearly intended to be educational for the provider community, the OCR has clearly recognized that more education is necessary to improve

sharing of patient information so that the system will work better overall," Fader says. "[OCR] seems to be prepared to make this a priority in 2019."

HHS started an initiative to enhance care coordination, but HIPAA has proven to be an obstacle, says **Richard Trembowicz**, JD, associate principal with ECG Management Consultants in Boston. Healthcare providers are hindered by cumbersome documentation of authorization to share and fear of extensive liability if information is inappropriately shared with third parties, he says.

"Simply put, the cost of documentation of authorization of access and delivery of PHI and risk of error in information management both increase if more individuals are authorized to have access to PHI, especially if the rules have lots of exceptions or nonstandard processes," Trembowicz explains. "CMS is also concerned that the time period within which a provider must respond to an individual's request for the sharing of PHI is too long, making the information value stale by the time it is shared."

HHS has posed 54 subjects for public comment to obtain insight on how changes to the rule could affect all involved in the care delivery process. Trembowicz notes that several questions seek feedback on the additional provider burden should HHS require providers to respond to individual requests for PHI faster than current law and regulations require. This will necessitate providers to devote additional resources to searching for, copying, and delivering the requested information to the individual, he says.

"It also begs the question of whether format of delivery, such as electronic, will be required, and whether the provider has a responsibility to deliver the information to other third parties as directed or requested by the individual," Trembowicz says. "All of this will cost money, and HHS provides no guidance on whether it will compensate providers for the additional costs." In addition, HHS is seeking feedback on the authorization process to release information, various exceptions, and effects on business associates with which the provider conducts business, including the security practices and documentation of authorizations to release information.

"The greatest concern of providers is that HHS will issue new unfunded mandates that increase the cost of medical care without compensation," Trembowicz says.

Several proposals for which OCR seeks feedback deserve special mention, according to **Kristen Rosati**, JD, an attorney with the law firm of Coppersmith Brockelman in Phoenix. First, she says the focus on including nontraditional providers and social service agencies in data sharing is important to managing care. There is an increasing recognition that the social determinants of health, such as the availability of food, counseling, and secure housing, significantly influence an individual's ability to manage a chronic condition or to improve after an acute health episode.

"Second, the industry should support OCR's focus on sharing information with family members and caregivers to address the opioid crisis and serious mental health issues," Rosati offers. "Family members and caregivers play an essential role in getting people with additional problems to treatment and in helping them manage their care. They often are as important to the treatment team as the physicians and nurses."

However, Rosati notes that OCR also solicits feedback on a proposal that would increase obstacles to data sharing. OCR has asked for comment on requiring HIPAA-covered entities to include information in an "accounting" about disclosures from electronic health records that are made for treatment, payment, and operations purposes. An accounting is a list that covered entities must provide to an individual on request, which includes information about disclosures of that individual's health information for purposes other than treatment, payment, and operations, Rosati explains.

"It's incredibly burdensome even under the current scope of the rule. Adding to that requirement creates more burden without much benefit. It also is not technically feasible to do automatically, as electronic health record systems do not capture the information that would be required in an accounting," she says. "We hope the industry pushes back on this proposal."

It is always difficult to predict how HIPAA regulations might change, says **Roy Wyman**, JD, partner with Nelson Mullins in Nashville, TN. Agencies like HHS generally avoid making changes to regulations, as such edits require lengthy administrative and public review and can end up causing as much damage as good, Wyman says.

However, the Trump administration emphasizes reducing the burdens of regulations. For example, the 21st Century Cures Act requires HHS to develop a plan to reduce regulatory and administrative burdens on the use of health IT and electronic health records. The Cures Act mostly targeted areas outside HIPAA, but the draft strategy for the Cures Act includes criteria that also could be used in any HIPAA simplification, Wyman explains.

The draft strategy says changes should be achievable within the near-to-medium term (a roughly three- to five-year window). It also says HHS should be able to either implement these strategies through existing or easily expanded authority or should have significant ability to influence the implementation of these strategies.

HHS may be reticent to take any actions perceived as watering down privacy protections, but some provisions may be ripe for change because they are not related to individuals' rights, Wyman explains.

"For example, the rules for when a hospital or provider can disclose information are complex and often require professional judgment," Wyman says. "More common sense and bright-line rules would simplify the process for sharing information with relatives and friends of patients and understanding when another individual or estate can act on behalf of the individual."

Other areas are largely invisible to individuals and privacy advocates but are complex. Such areas can cause unintentional violations. Some examples include sharing health information for "healthcare operations," public health, and research purposes.

"The ability to disclose information for these purposes is more complex and limited than sharing information for treatment or payment purposes," Wyman explains. "A simple guideline allowing entities to share information for operations of the sender or the receiver or for public health and research purposes, subject to the other rules of HIPAA, is a relatively simple fix that might receive relatively narrow complaints from privacy advocates. Such simplification also might promote the quality and efficiency of patient care."

Similarly, Wyman notes that the rules and definitions for Affiliated Covered Entities, Organized Health Care Arrangements, and hybrid entities create a legal tangle. These rules permit various types of arrangements and entities to comply with HIPAA, yet they can create administrative and training burdens. "Simplifying these rules could largely eliminate these definitions while permitting covered entities and business associates to be joined and divided in ways that seem most appropriate to the entity so long as those receiving health information comply with HIPAA and maintain the security of the information," he says.

Wyman believes the Security Rules also need a significant overhaul. "Many of the requirements overlap, contain confusing terms, and are mostly useful to assure consultants remain in business. The regulations could use a good review to reduce and consolidate many of the requirements, make sure that the requirements are understandable to the technologically naïve, and are more user-friendly," Wyman offers. "For example, the Security Rules include three different sections that address access control. Some sections of the regulations are deemed 'required,' and others are 'addressable,' yet all of them must be considered. A clearer description of what is required would eliminate a huge amount of confusion."

While technically outside of HIPAA, Wyman says rules about the protection of information held by mental health and substance abuse providers have created enormous burdens. The "Part 2" rules (42 C.F.R. Part 2) originally predated HIPAA as well as the internet. Although these rules were updated recently, they remain burdensome, according to Wyman.

"Unfortunately, the increased burden on these providers has made it very difficult for them to share information with other providers, participate in health information exchanges, or generally function in a data-intensive world," he laments. "A wholesale annexation of Part 2 into HIPAA seems unlikely, but the two sets of regulations could be better harmonized. For example, Part 2 could create an exemption that would allow sharing of data with a covered entity or business associate of a covered entity under HIPAA based either on a written agreement or particular requirements on the receiving entity written into the regulations. The requirements on the receiving entity might be similar to how covered entities treat psychotherapy notes under HIPAA."

OCR is asking the public for ways to modify the HIPAA regulations specifically to drive cost savings and value, which are most commonly expected to come from the development of coordinated care platforms, says **Jeff Drummond**, JD, an attorney with Jackson Walker in Dallas. HIPAA is naturally obstructive to care coordination. Any efforts at care coordination naturally assume ready exchange of patient information among providers, payers, and others involved in the care of the patient (or the patient population). Meanwhile, HIPAA's focus on privacy and security generally limits information sharing, according to Drummond. HIPAA allows for such sharing of patient medical records, but Drummond believes too many people in the healthcare industry do not understand HIPAA and are afraid of it. Thus, they refuse to share information even though HIPAA would allow it.

"Another major problem is that given the combination of the Facebook and other social media platform privacy issues all over the news, as well as the daily reports of major breaches of personal and medical information, many people are too afraid that their medical record privacy will be abused," he explains. "People fear for their privacy, so they don't want their information released, even though releasing the information in an appropriate manner would actually improve their healthcare and the overall cost of healthcare."

Drummond says these problems cannot be fixed by changing HIPAA because as currently structured, HIPAA would work to allow appropriate information exchange for care coordination and value-based healthcare. "Thus, I do not see any major changes being made to HIPAA," Drummond says. "However, given the push for regulatory change, and the need to be seen as doing something, I would expect some tinkering around the edges." Here is how Drummond expects to see OCR change HIPAA:

• Minor tweaks to the definition of "healthcare operations" to clarify and

possibly expand the ability to share PHI for population health, emergencies, and value-based care initiatives;

• Minor clarifications regarding "personal representatives" and when parents are (or are not) treated as such;

• Specific language (more likely guidance than changes to the actual text of the regulations) addressing uses and disclosures in the mental health and substance abuse arena;

• Revisions to the "accounting of disclosures" requirements to streamline the process by eliminating much of the requirement;

• Finalization of the rule allowing individuals to share in the fines levied by OCR for a HIPAA breach;

• Specific language addressing when a ransomware attack (or similar technology-driven incident) is a reportable breach.

Drummond says some commentators will ask for removal of the requirement that directs patients sign an acknowledgement receipt regarding the Notice of Privacy Practices when they first go to their doctor. However, he does not think that will occur. "It would definitely remove a noticeable burden on both providers who have to print out notices, ask for signatures, and keep track of them. Ultimately, that's a small burden to make sure that providers actually provide the notice," he says. Patients have an opportunity to think about how their information is going to be used and disclosed. Ultimately, I think [OCR will] leave it in place as is." The biggest effect from any changes may involve the increasing use of technology in the transmission of patient data from one healthcare provider to another, says **Patrick Pilch**, managing director and national leader for BDO Healthcare Advisory's Center for Healthcare Excellence & Innovation. "We're seeing more care being directed over smartphones, for example, so OCR may change the requirements for providers who have not been connected electronically in the past," he offers.

"That could have a big impact and would change HIPAA in a way that acknowledges how healthcare delivery has changed in the past 20 years. It's that kind of thing that frustrates people who are trying to comply with HIPAA but the law doesn't seem to fit with how things are done in the real world." ■

# HIPAA Requires Security for Printers, Just Like Other Servers and Endpoints

HIPAA security requires protection for servers and various endpoint devices. However, many healthcare organizations do not realize printers need the same attention.

Most covered entities and business associates do not appreciate how printers have evolved from "dummy copiers" to today's complex business machines that include multiple servers built directly into them, explains **Jim LaRoe**, CEO of Symphion, a software and services company in Dallas. The competition among printer manufacturers has driven the inclusion of web servers, file transfer protocol servers, fax servers, huge hard drives, and many other advanced capabilities, he notes. Yet, printers, unlike standalone servers, are maintained outside of data centers without the physical and technical safeguards that are common to data centers.

"They are also managed by nonsecurity, non-IT professionals, not the heavily credentialed system administrators like in data centers, and are not included in IT policies and procedures," LaRoe adds. "Moreover, printers, like laptops, are mobile throughout the enterprise. They are often on wheels."

HIPAA's general mandates require covered entities to ensure the confidentiality, integrity, and availability of PHI the business creates, receives, maintains, or transmits. HIPAA also requires covered entities to protect against any reasonably anticipated threats or hazards to the security or integrity of information. "Printers in hospitals clearly 'create, receive, maintain, and/or transmit' electronic PHI," LaRoe notes. "Moreover, even the most cursory examination of reasonably anticipated threats and hazards to the security and integrity of that ePHI trigger the HIPAA mandates to protect printers."

Specifically, HIPAA requires covered entities and business associates to assess current security and risks for ePHI in the entire enterprise. That includes the risks presented by the printers and implementation of a security plan, policies and procedures, and controls that address vulnerabilities and risks. The entity must monitor, record, and evaluate implemented security settings to ensure the security plan and controls are maintained vigilantly, according to LaRoe.

"Neither hospitals nor enterprises are dealing with network printers correctly. That makes them one of the biggest security threats for 2019, especially considering that breaches are getting more costly," LaRoe warns. "Since every printer on a print fleet can provide hundreds of vulnerabilities, and many hospitals can have thousands of printers, the message is clear. Even though printers have been here for years, they ... must be protected like the servers that they are, with automated IT asset life cycle management and continuous cyber hardening." ■