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INSIDE

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CARES Act Offers Mix of Relief, Confusion for Struggling Hospitals

Revenue cycle leaders are facing canceled elective services, a surge of newly uninsured patients, massive expenses preparing for an influx of COVID-19 patients, and largely discontinued point-of-service collections. Now, some hospitals are getting a much-needed boost of cash from the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[1]

The $100 billion in funding for hospitals and other healthcare providers sounds like a staggering amount of money, and it is. Yet, for some hospitals, the money they will receive "does not come close to addressing the shortfalls they are experiencing," says **Helaine I. Fingold**, JD, a healthcare attorney in the Baltimore office of Epstein Becker Green. Also, says Fingold, "certain operational burdens attach to providers that accept these funds." Some important requirements for hospitals:

• **Hospitals cannot balance bill patients for COVID-19-related treatment.**[2,3] "Importantly, the details matter. There are some open questions around the breadth of this requirement," says **Jack Hoadley**, PhD, a research professor emeritus in the Health Policy Institute of Georgetown University's McCourt School of Public Policy in Washington, DC. According to a Department of Health and Human Services (HHS) announcement, hospitals may not collect amounts from "a presumptive or actual COVID-19 patient" beyond what they would be charged for an in-network service.[4] "These terms are not specifically defined," Hoadley notes. For one thing, it is unclear if a patient who is not tested, but is undergoing treatment, counts as a "presumptive" COVID-19 patient. The same question pertains to someone whose test returns negative. It is unclear if balance billing is prohibited on that patient for services before the test returned negative, or if balance billing is allowed after the negative result returns. "Hospitals may be wise to avoid balance billing in any of these ambiguous situations," Hoadley offers.

For revenue cycle leaders, there is just too much uncertainty. Fingold says one basic issue must be cleared up: Does the patient's COVID-19 diagnosis need to be confirmed with a Centers for Disease Control and Prevention-approved lab test to be protected from balance billing? Or, is it enough if the doctor suspects a COVID-19 infection (but, perhaps, is ruling out other possible diagnoses)?

Many patients recover from COVID-19 but remain hospitalized with complications. "Does the prohibition on balance billing end when the emergency is lifted? Or, does

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it continue to protect these patients?" Fingold asks.

None of this stops hospitals from balance billing other patients. "That said, there are limits to what providers who participate in Medicare can balance bill," says **Jack A. Meyer**, PhD, an independent healthcare consultant and former principal in the Washington, DC, office of Health Management Associates.

One HHS announcement says the Trump administration is "committed to ending surprise bills for patients."[5] To date, four congressional committees have passed bills that would end surprise billing.[6] "Because there are significant differences across these bills, it may be hard to reach agreement on a long-term solution this year," Hoadley says. Still, he adds, "momentum is continuing to build toward action to prevent surprise billing on a permanent basis."

• Hospitals must certify payments will be used only to "prevent, prepare for, and respond" to COVID-19, and as reimbursement for lost revenues attributable to COVID-19. "We are working with clients to interpret this language so as to determine how they may use the available funds," Fingold reports.

Hospitals are wondering if they can use the funds to pay salaries of physicians or other employees. Another burning question is whether funds can be used to pay for care of all patients with COVID-19-like respiratory symptoms who end up being diagnosed with something else (e.g., asthma or chronic obstructive pulmonary disease). Even if people do test positive, it is unclear if the hospital receives reimbursement for the whole stay, or just the portion after the diagnosis is made. "Hospitals may wonder how to draw the line," Meyer adds.

Hospitals want to know if they can be reimbursed for costs associated with hiring additional nurses to care for non-COVID-19 patients if nurses who normally care for these patients were redeployed to the intensive care unit (ICU). "There may not always be a clear line between 'These dollars are for COVID and nothing else, while those dollars are not related at all to COVID,'" Meyer observes.

A prime example is hospitals booking hotel rooms for staff who do not want to return home and expose family members to the virus. Some hospitals are leasing entire hotels nearby just for this reason. "Those are not healthcare treatment dollars," Meyer acknowledges. "But it is certainly important to treating COVID."

In general, hospitals have good reason to worry about how they will fare under the CARES Act. **Robert A. Berenson**, MD, says the initial $30 billion given out was "rough justice. It went to everybody who did Medicare business last year."

Some providers' income plummeted due to COVID-19, but others were barely affected. The legislation did not target hospitals as opposed to other providers. In particular, the act did not target the hardest-hit hospitals. "It in no way distinguished between hospitals in hotspots that have been completely overwhelmed from hospitals that are really just watching and waiting," says Berenson, an institute senior fellow at the Urban Institute in Washington, DC. HHS has since announced that $10 billion would target hospitals in the hardest-hit areas.[5]

Hospitals' financial situations vary widely. "A lot depends on things like payer mix," Meyer says. Some hospitals see about two-thirds Medicaid patients, about 10% Medicare, a small percentage with private insurance, and the rest are uninsured. Other facilities are in an entirely different situation, with about 10% Medicaid and almost no uninsured, with the vast majority of patients commercially insured.

Likewise, some hospitals are seeing just a few coronavirus patients, while others are treating hundreds. In terms of the CARES Act, Meyer says the main question for hospitals is, "Are they pushing and scrapping to get some of that money? I am told that it's not easy to do."

Political influence is a factor. "Hospitals should be asking, 'Who do we have that's good at state and federal relationships, that goes to our congressional delegation, that knows people at HHS, or that worked for the secretary of health at the state level,'" Meyer offers.

Out of necessity, hospital leaders are more consumed with problems of the moment than political maneuvering. They are converting regular inpatient beds to ICU beds, providing some quick training to allow additional nurses to work in the ICU, and finding creative ways to obtain urgently needed supplies.

"In many cases, they are more worried about all the components of meeting the demand, such as tests, masks, gloves, and ventilators, more than the decline in revenue," Meyer says.

The stakes are high for hospitals that already were struggling financially. "Due to postponement of all the elective procedures, and also some other factors, some are burning through their reserves," Meyer laments.

Some hospitals face large amounts of debt and sparse cash reserves, while others are performing quite well. "Some hospitals have billions of dollars sitting in cash and investments," Berenson notes. "On the other hand, some safety net hospitals are barely getting by." Here are some of the most pressing issues affecting revenue cycle departments:

• Some money in the CARES Act will pay hospitals for providing COVID-19 treatment to the uninsured. Hospitals will be paid for services provided to the uninsured. That is good news for uninsured people, and, to some extent, hospitals, since it means receiving at least a little reimbursement.

Yet it also means less money goes toward recouping all the money lost because of canceled elective procedures. "Use of these funds for treatment of the uninsured lowers the amount available to help shore up providers from the impact of lost revenue," Fingold says.

• Hospitals will receive 20% additional Medicare reimbursement for COVID-19 patients. "Many hospitals are saying that the increase will not fully address the costs of caring for the COVID-19 patients," Fingold cautions.

• Some revenue from elective services is going to be lost forever. Eliminating routine and elective services is the single biggest financial hit for many hospitals. "Elective surgery, which is sort of the basic engine of financial viability for hospitals, isn't getting done," Berenson says. Many patients will undergo procedures and surgeries once life returns to normal, but not all will. "You can't just move it forward six months and say all that revenue will come back. Some percentage of it will come back," Berenson predicts. "But certainly not all." ■

REFERENCES

1. HHS.gov. HHS to begin immediate delivery of initial $30 billion of CARES Act provider relief funding, April 10, 2020. https://bit.ly/2zxXEUt
2. Hoadley J, Lucia K, Keith K. Keeping surprise billing out of coronavirus treatment. *Health Affairs Blog*. April 2, 2020. https://bit.ly/35e7Zkq
3. Health Resources & Services Administration. COVID-19 claims reimbursement to health care providers and facilities for testing and treatment of the uninsured. April 2020. https://bit.ly/2YbJbbk
4. Schwartz K, Tolbert J, Pollitz K, Neuman T. Update on COVID-19 funding for hospitals and other providers. Kaiser Family Foundation, April 24, 2020. https://bit.ly/35bbg3Z
5. HHS.gov. HHS announces additional allocations of CARES Act Provider Relief Fund. April 22, 2020. https://bit.ly/3bLgcPw
6. Hoadley J, Fuchs B, Lucia K. Update on federal surprise billing legislation: New bills contain key differences. *To the Point* (blog), Commonwealth Fund. Feb. 20, 2020. https://bit.ly/2SdlLhQ

Waived Cost-Sharing Is Questionable Help to Hospitals

Hospitals may not charge patients with any type of insurance cost-sharing for COVID-19 testing and related services, according to the Families First Coronavirus Response Act.[1]

"This will certainly help patients," says **Helaine I. Fingold**, JD, a health-care attorney in the Baltimore office of Epstein Becker Green. For hospitals, it probably means more lost revenue. "Hospitals will have to decide whether to take a conservative or a more liberal approach," Fingold observes.

The conservative approach is to forgo collecting cost-sharing for a broad range of patients, even those who do not seek treatment for COVID-19, but may need testing for the virus. The liberal approach would be to continue to collect cost-sharing for people who are not evaluated for a COVID-19 test.

"This will require a heightened investment in compliance and oversight," Fingold says. An example of a gray area

would be someone with a sore throat who undergoes a strep test, but also is evaluated as to whether a COVID-19 test is needed. "The process for making these distinctions must be clear and appropriately interpreted and applied," Fingold stresses.

If high deductibles and copays are waived, it is not the health plan that bears the expense. "Those who eat the cost are the providers, which I'm not sure has been generally understood, and that's a problem," says **Robert A. Berenson**, MD, an institute senior fellow at the Urban Institute in Washington, DC. Insurance companies are obligated to provide cost-sharing reductions to people whose household incomes are below 250% of the federal poverty line. This obligation was included in the Affordable Care Act (ACA), which stated that the federal government would cover these costs for insurers. "This makes sense, as it is not really the responsibility of private companies to provide subsidies to lower-income people, but rather the government," says **Jack A. Meyer**, PhD, an independent healthcare consultant and former principal in the Washington, DC, office of Health Management Associates.

However, the Trump administration terminated the federal government's commitment under the ACA to reimburse the insurers. "The insurers' obligations to provide this cost-sharing reduction remains," Meyer adds. ■

REFERENCE

1. Congress.gov. H.R.6201 - Families First Coronavirus Response Act. https://bit.ly/3cQ7fUV

'Top-to-Top' Approach Needed on Relaxed Rules

Many health plans are waiving authorizations for specific diagnostic testing or services.[1] Clarity is needed on what exactly the waivers mean in specific cases.

"A lot of wheel-spinning can happen, where somebody gets on the phone and is on hold for half an hour," says **Jack A. Meyer**, PhD, an independent healthcare consultant and former principal in the Washington, DC, office of Health Management Associates.

Often, the payer rep cannot really solve the issue. The patient access employee, who has been on hold forever, does not need a policy recited verbatim. What is needed is for somebody to make a decision on whether an authorization is appropriate for a particular case. "Somebody who works for the health plan's medical director, or the pharmacy and therapeutics committee if it's a medication at issue, needs to sign off on any deviation," Meyer explains.

This labor-intensive approach is not going to cut it during a crisis. Instead, says Meyer, "the CEO of the hospital, or certainly a CFO or senior VP — but preferably the CEO, should get on the phone with the CEO of the health plan, boss to boss."

Then, the two executives could agree on some things, with the hope of avoiding unfairly denied claims. Meyer suggests the hospital CEO could make a case this way: "We argue all the time that we want more money, and you can't pay for everything. But this is an emergency. Rather than fighting it patient by patient, we need you to authorize a temporary relaxation or even set aside some of these rules, so that our patients in the hospital get what they need when they need it. I am asking you to issue a letter to all relevant staff in a position to make these decisions that until further notice, please relax the rules and allow these claims to be approved."

"The help has got to be top-to-top, and then top-down," Meyer adds. ■

REFERENCE

1. America's Health Insurance Plans. Health insurance providers respond to coronavirus (COVID-19). April 24, 2020. https://bit.ly/3aCMfzv

Auth Requirements Are Relaxed During COVID-19 Crisis — Or Are They?

Relaxed authorization requirements sounds like great news. However, payers are vague on the specifics.

For this reason, some patient access leaders are erring on the side of caution and continuing to secure all authorizations per usual protocol. "The same diligence taken pre-COVID should continue to ensure all necessary authorizations are obtained and denials prevented," says **Laura Burton**, director of patient access centralized services at Marriottsville, MD-based Bon Secours Health System.

Here are some issues patient access is seeing:

• In many cases, hold times with payers are ridiculously long. One recent authorization took three hours and 20 minutes to obtain. It normally would have taken about 20 minutes.

"Having these examples documented can help fight denials," Burton offers. "We're proving that due diligence was

done, but that it was not possible to navigate within the payer constraints."

• Some payers temporarily waived the clinical review process for certain services. When the claim actually is submitted, though, it is anyone's guess if the health plans will follow their own rules. Relying too heavily on the waivers "may result in a higher-than-normal number of medical necessity denials," says **Karan Levering**, CHFP, assistant vice president of pre-access services at Bon Secours Mercy Health in Cincinnati.

• Claims denials for COVID-19-negative patients are under close review to see if there is any basis to appeal them. Some patients present with COVID-19-related symptoms, but test negative, and are discharged with another respiratory-related diagnosis such as bronchitis.

"The order and documentation needs to clearly define that the patient was being tested for COVID-19, and that it was medically necessary," says **Tammy Stone**, BA, CHAM, CRCR, vice president of patient access and clinical services at Ensemble Health Partners, a Blue Ash, OH-based revenue cycle consulting and solutions provider.

Otherwise, health plans could refuse to pay claims for people with negative tests. Since the patient cannot be billed for his or her liability, the hospital could end up with no payment at all.

To protect against this possibility, "registrars are respecting the cost-sharing-waiving enacted by our state legislators for any patient presenting for COVID testing, especially in our emergency departments," says **Sarah Dresch**, senior director of patient access for Ardent Health Services' New Jersey facilities.

The worry that health plans will deny reimbursement for evaluation and testing of COVID-19-negative patients is legitimate. "I have personally experienced workman's compensation denying claims for patients who tested negative," Dresch reports.

For patient access, a full list of the approved ICD-10 codes for services where cost-sharing is waived is important so co-insurances, deductibles, or copays are not collected. "Patient access should be working with the back end so they are aware that these balances should be written off after the insurance pays," says **Kathy White**, AVP of virtual utilization review and bedded insurance authorization at Ensemble Health Partners.

• Patient access should keep close tabs on all payer updates. Waivers of requirements apply only to specific services, circumstances, and time frames. Successful appeals of claims denials can hinge on proving that at the time of service, the usual requirements were waived.

There is a simple reason why the waivers cannot be counted on: "Not all of the insurance companies will be able to update their systems for the codes that do not require prior authorization," Stone explains.

• Many payers claim to have relaxed authorizations for "most" or "many" services. What "most" or "many" means is anyone's guess. "Claims still require the same diligence in reviewing authorization requirements that were in place pre-COVID," Stone says.

The bottom line is that payer announcements could end up as more of a trap than a time-saver. "Don't take the bait," White offers. "Taking advantage of the payer leniencies for no authorizations may delay claims processing and cash flow in the long term."

For patient access, the safest bet is a "business as usual" approach. If no authorization is in place, health plans may take time to retrospectively review the entire record for medical necessity. "Also consider the amount of internal resources needed to process the medical records and appeals," White adds.

The alternative is to set normal authorization processes aside and go by the relaxed requirement rules. Hospitals risk increased accounts receivable days and the hassle of appealing denied claims. "This would be very problematic at a time when hospitals need claims to process cleanly and quickly," Burton says. ■

Some Big Revenue Cycle Changes Are Here to Stay

In the patient access field, some changes with COVID-19 are just temporary. Registration will be performed on site again at some point, and elective surgeries will be rescheduled. Other changes probably are going to be permanent, says **Richard L. Gundling**, FHFMA, CMA. Here are some new practices with long-term implications for revenue cycle operations:

• Long-standing barriers to reimbursement of telehealth are gone. The desire for more telehealth always has been there, but payment was problematic. "It was hard to put a lot of resources into telehealth," says Gundling, vice president of healthcare financial practices at the Healthcare Financial Management Association in Washington, DC. With new waivers of restrictions, telehealth patients do not need to be in medically underserved areas. Practitioners do not need to use costly, Health Insurance Portability and Accountability Act-compliant systems. "It can be done with FaceTime or Skype now," Gundling says.

Revenue cycle leadership can (and should) promote this change at their organizations, Gundling urges. The first step is to become fully informed

about all the changes in telehealth billing requirements. These differ somewhat for Medicaid, Medicare, and commercial payers.

"Once CMS [Centers for Medicare & Medicaid Services] and the public sees that this can be done, that you can have some reasonable assurance on privacy and security, that's something that can help facilities even after the coronavirus," Gundling says.

• Departments are making a major push to assist those who are financially struggling. Educating patients with questions on insurance coverage or hospital bills is a perfect task for the new army of remote workers in patient access. "Working with payers to clarify which requirements are modified is also important," Gundling adds.

While Medicare waivers cover a large group of patients, smaller health plans are more numerous. Each is going to provide its own answer on waivers regarding cost-sharing or prior authorizations. Asking health plans for clarification does not need to be contentious. "The message should be that we want to work together," Gundling offers. He suggests that patient access start out by stating: "Let's make a good faith effort that we're going to keep the patients out of the middle of this."

Advocacy for patients keeps the hospital financially viable. "People who have a great feeling about a hospital that tries to help them are more likely to pay in the future," Gundling observes.

• Patient access is moving to touchless encounters. The typical onsite registration includes loads of hands-on interactions. People sign consents with pens or styluses handled by previous patients and staff. They hand insurance cards back and forth to be scanned, and fill in demographic information at registration kiosks using touchscreens.

"When we do get back to providing elective services, people are going to have a new perception of what's appropriate now. They're going to be much more concerned about what they touch," predicts **Kristine Anderson**, vice president of project services at Pelitas, a Plano, TX-based provider of healthcare patient access technology solutions.

Compliance always is a top worry with touchless processes for consent. Some hospitals switched to asking registrars to obtain verbal consent from inpatients via phone. They also may have directed nurses to obtain an actual signature at a later point, with witnesses. Of course, documentation would exist for all of this.

However, moving forward, it is unclear how regulations will accommodate processes like these. "The challenge is to remain compliant. Not having an actual signature, whether it's electronic or on paper, poses a problem," Anderson notes.

Obviously, controlling the spread of disease is not unique to COVID-19. "This just created a more significant and severe response, one that could permanently change how we do things moving forward," Anderson says.

For the revenue cycle, touchless ways to obtain signatures, collect patient liability, and gather insurance are top of mind. "Patient access and their vendor partners will need to be creative to find ways to do their jobs without requiring touch," Anderson adds. ■

Massive Remote Work Arrangement Going Well (Mostly)

Few patient access departments had successful remote work programs in place before COVID-19. Since the pandemic began, facilities have made some major adjustments. The following is a review of how the field is faring with these unusual arrangements:

• Departments that already employed some people working at home transitioned a little easier. At St. Luke's Hospital in Chesterfield, MO, 10 patient access employees already were working remotely on a limited basis. "This made the conversion to full-time remote work relatively simple," says **Laura Holt**, senior director of network revenue cycle management.

Well-established processes for supervision and productivity monitoring made for a relatively smooth transition. The first step was to ensure proper connectivity and security for each employee working remotely. "The internet services department provided assistance to roll out the necessary hardware and access," Holt reports.

Just before the pandemic hit, patient access leaders at Tufts Medical Center in Boston were gearing up to implement a remote work program. "We had just presented our plans to roll out a flex-work policy for our patient access team members," reports **Kaylin Fogarty**, director of patient access.

The plan was to allow strongly performing employees to apply for flexible hours or work-from-home capability. "As soon as COVID started to ramp up, we began transitioning everyone off site," Fogarty says. The department's planning came in handy now that all patient access staff (about 80 full-time employees) are working at home.

• A few employees still are needed on site. One of Tufts Medical Center's financial counselors is on site every day. "They address any urgent financial concerns for our inpatients to avoid any barriers with discharge," Fogarty explains.

• Issues with technology caused headaches initially, but those problems

have since been resolved. At Tufts Medical Center, the biggest challenge was quickly setting up everyone on the registration system. Most registrars worked on desktop computers onsite, and only a few had been issued hospital-owned laptops. "They had to get their personal computers configured," Fogarty adds.

At Winston-Salem, NC-based Novant Health, "we had laptops that needed to be reprogrammed, and laptops running with outdated software that needed to be upgraded," says **Jennifer Love**, assistant director of scheduling and previsit services. Some team members lacked laptops and needed loaners on short notice. "There were also issues related to our phone system that we had to quickly resolve," Love says.

Staff also needed access to high-speed internet and the department's videoconference application. "We also had to develop procedures to print and mail documents in a secure manner," Love adds.

• Setting early standards for productivity prevented problems. Tufts Medical Center's remote workers knew their productivity would be monitored closely. Frequent check-ins via Zoom, with ad-hoc meetings as needed, help with morale. "It gives them a chance to see and connect with their coworkers who they normally sit in the same office with every day," Fogarty says.

The department really has not experienced issues with productivity. "The team realizes that the success of our ability to work remotely post-pandemic depends on how well we do during this time," Fogarty notes. With work queues monitored throughout the day, Novant Health has seen "little to no" issues with quality and productivity, Love says. "But their volume of work has taken a huge hit," she adds. "This has been addressed with scheduling changes."

St. Luke's Hospital's revenue cycle team is monitored for productivity (through volume dashboards) and quality (through supervisor audits). "Staff who were already working remotely understood that this benefit could be compromised if their productivity or quality suffered as a result of their home working arrangement," Holt says.

The same stringent standards apply wherever the job is performed. "For the most part, staff have shown a higher level of productivity in their work-from-home environments," Holt adds.

• Not all registrars like working from home. "Working from home is an extreme satisfier for some, and not so much for others," Love observes.

Some staff initially were thrilled to work from home, but changed their minds after they found it hard to complete tasks. "Some who pushed to work from home now find it much less attractive than working on site," Love says.

• Staff are performing different functions, and working different hours, than they did on site. Just a few on-site registrars see patients for scheduled tests at St. Luke's Hospital. "All registrars are now working four 10-hour days, which reduced the number of people in the work area," Holt explains.

All other registrars are handling different jobs than normal. "They were redeployed within the revenue cycle department to assist with other project work, mostly related to back-end functions," Holt says.

The remaining 25 patient access staff who are not in registration positions are working at home now. They are scheduling, obtaining authorizations, verifying insurance, and collecting copays. Some staff took on entirely new roles. "For others, this involved minimal training to help out with special projects," Holt notes.

Overall, patient access leaders have become more comfortable with remote work arrangements. "It's been a good test for us to see how things would go with a remote work policy for our team," Fogarty offers.

This could work both for the people who love working at home, and the ones who miss coming to work every day. "Ideally, I would like to get to a place where we could offer remote work to those who are interested in it on a part-time basis to start," Fogarty says.

If some jobs are performed 100% remotely, it could help recruitment. The department could hire highly qualified people from outside the immediate geographic area. "With the appropriate technology, policies, and good communication, full-time remote positions for patient access are a strong possibility," Fogarty says. ■

Registrars Working Same Jobs, But in Different Spaces

None of the patient access employees at Brewer, ME-based Northern Light Health's 10 hospitals had ever worked from home. Many are now, but exactly how it happened varied depending on the facility.

"In making the decision of whether to send staff home, we tried to honor employee preferences as much as possible," says Revenue Cycle Director **Jennifer Cox**. Some hospitals found ways to keep registrars on site safely by relocating them to other spaces that became open because other hospital departments had been sent home. For certain registrars who already worked in offices or cubicles with dividers, no change was needed.

The state's executive order limiting gatherings to fewer than 10 people also factored into decision-making. A few departments had only four registrars, while others had dozens.

"We have spaced people out to increase the distance between colleagues in their work spaces," Cox reports. Other changes:

• For financial counselors.

Some remain on site to help assist patients, but many now work from home. "This is a very big change," Cox notes.

Typically, financial counselors meet with patients in the hospital, review applications in person, and help them understand their bills in face-to-face conversations.

"They are now off site and doing their best to walk through the information over the phone," Cox says.

• For schedulers.

All are working from home. "You can truly schedule from anywhere," Cox says.

Scheduling remains paper-based at certain facilities, which complicated things to an extent. One hospital solved this by directing three schedulers to work from home and one scheduler going in two days a week. The on-site scheduler faxes documents to outside providers sending patients to the hospital, and handles payments submitted by mail.

• For other patient access employees.

This group can either work in another building or from home.

Some said right away that they were not comfortable working on site. Others really felt a need to be physically present in a time of crisis. "We did our best to make it the staff member's choice as much as possible," Cox explains.

Every hospital still needed a small core group of registrars to greet arriving patients and family. Volumes are much smaller with elective services canceled. "But we still have patients coming to the hospital. We still need to check people in," Cox observes.

A few people still come to the hospital asking to pay bills.

"We are asking them to pay online or by phone," Cox explains. "But they show up because they know the front end people and want to see them."

At press time, patient access employees had been working at home for six weeks. It could continue indefinitely for at least some of them. Regarding the shift to at-home work, says Cox, "it's impossible to believe that there wouldn't be a massive change for healthcare."

Still, the patient access role always has involved highly personal, face-to-face encounters. From a morale perspective, says Cox, "there is a huge benefit to having staff on site to being a part of the organization."

With patients instructed to register, pay, and schedule remotely, it is unclear how it will affect satisfaction over the long term. It is giving our patients a very different experience," Cox says.

Meanwhile, detailed productivity metrics are in place for at-home workers.

"What you do on site is not necessarily what you need to do at home," Cox acknowledge.

For example, experienced staff normally educate new hires on how to register patients. Now, that training is handled via Skype. In certain cases, experienced employees set up individual times to go over challenging topics with new hires.

"But it doesn't really work as well as when you catch that person right as they are asking for help," Cox says.

Staff have shifted to performing any tasks that can help secure revenue. Following up on unpaid claims is a prime example.

"There is plenty of work to do," Cox notes. "Every hospital should be utilizing this time to do clean up." ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

COVID-19 Changes HIPAA Compliance, But Caution Necessary

The Department of Health and Human Services Office for Civil Rights (OCR) has issued waivers and notices of enforcement discretion for several issues related to Health Insurance Portability and Accountability Act (HIPAA) compliance, but healthcare organizations still must be careful to comply with the privacy law even during the pandemic.

As the COVID-19 impact begins to wane and healthcare operations return to normal, it will be important to reframe HIPAA expectations, experts say. Remember that even with waivers and relaxed requirements, OCR still expects HIPAA compliance, says **Lucie F. Huger**, JD, an officer with Greensfelder in St. Louis.

"OCR is taking this pandemic very seriously and trying to be helpful in providing guidance and clarification on enforcement. But make no mistake — HIPAA is still here," Huger says. "Compliance is still very important. Even though we have a pandemic, HIPAA still should be a significant concern."

Covered entities must tread carefully, says **Mark R. Ustin**, JD, partner with Farrell Fritz in Albany, NY. OCR has emphasized the concepts of "minimum necessary" and "good faith," he says.

"We have fewer rules than we used to have in this period. But you still want to ensure that you're breaking the usual rules only to the extent that you need to break them so you can provide good patient care, and no further. That's the minimum necessary concept," he says. "OCR is also saying it won't enforce where there's a good faith breach, but they're still reserving the ability to enforce where there has been some bad faith. This is not the opportunity for you to gather up someone's healthcare data and sell it to someone."

Some waivers did not apply to all hospitals and do not last for the duration of the pandemic response, says **Melissa A. Borrelli**, JD, LLM, CHC, CHPC, director of healthcare consulting with Mazars USA, a consulting firm in Sacramento, CA.

"OCR's COVID-19 blanket 1135 waiver issued on March 13 was in fact very surgical. It only applied to hospitals for 72 hours after the hospital implemented its disaster protocols, and it did not waive all HIPAA requirements," Borrelli explains.

Instead, the 1135 waiver concerns requirements to secure a patient's agreement to speak with friends or family involved in his or her care. The waiver also allows the patient to request confidential communication and privacy restrictions, to opt out of the facility directory, and receive a notice of privacy practices.

More broadly, OCR eased its stance on communications technology, specifically in telehealth, Borrelli notes. This guidance allows flexibility in the tools providers use to communicate with their patients, permitting providers to use technology that does not currently comply with the HIPAA Security Rule but are not "public facing." For instance, FaceTime and Skype are allowed.

"Also, OCR provided business associates the freedom to share certain data for public health purposes only," Borrelli says. "That is, a business associate may previously, by contract, not have been allowed to disclose data to the CDC [Centers for Disease Control and Prevention], but under this guidance, they can."

Laura Peth, CHC, CFE, principal in healthcare consulting with Mazars USA, recommends two major focus areas to help covered entities be sure they are complying with HIPAA in extraordinary times. First, she says, stay the course as much as possible. Maintain and follow the organization's existing privacy structure, policies, and procedures to maintain compliance with HIPAA, and only deviate from those standards when absolutely necessary.

Before operating outside normal privacy-related procedures, ensure the existing blanket waiver and enforcement discretion is applicable to the organization by reviewing source materials and guidance from the Centers for Medicare & Medicaid

Services, OCR, and state regulators, Peth advises.

"When it is absolutely necessary to operate within the new limits of the waiver and/or enforcement discretion environment, documentation of the reasoning for operating outside your existing policy is paramount. Even a quick memo-to-file noting the temporary change in procedure, the time period during which that change will be effective, the criteria considered for that change, how protected health information is continuing to be safeguarded, how staff are informed and monitored of the new process, and including review approval by authority figures within your organization will aid you in the future," Peth says. "Documenting this type of information, including the reasoning and criteria behind such decisions, will assist your organization in showing good faith per the OCR announcement guidance."

Regardless of any changes to processes, waivers, or discretion in enforcement, adherence to the minimum necessary standard always is the best course, Peth says. The minimum necessary standard calls on healthcare professionals to make reasonable efforts to ensure any protected health information disclosed is restricted to the minimum necessary information to achieve the purpose for which the information is being disclosed. Be sure to include in any documentation how the organization is continuing to use the minimum necessary standard.

"Now is not the time to let any of your proactive controls or monitoring processes fall by the wayside. Preventive controls, detective monitoring, and auditing activities are more important than ever," Peth says. "For example, given the likely increase in public figures in medical facilities, ensure any proactive medical record lockdown of high-profile patients is working well, and continue to monitor audit logs for inappropriate access of medical records. It is vitally important to maintain these processes as they can be your first indicator that a recent change to your privacy processes is creating issues."

Continuing to perform these tasks also allows the organization to show good faith, Peth adds.

The second focus area involves educating staff and communicating well. Remind both remote and on site staff about existing privacy-related policies, especially those most important given the current situation, Peth advises. However, now is not the time to drone through every single small procedure. Focus on what will affect staff right now on a daily basis. For example, Peth suggests addressing these issues:

- Review the overall privacy and security rules, any state-level laws and regulations, and contract requirements at a high level as they relate to the organization.
- Review the employee conduct code.
- Review how employees can contact the chief compliance officer and/or privacy officer directly.
- Review how employees can use any anonymous reporting mechanism, such as a hotline.
- Provide examples of issues staff may see right now that would be of concern and should be reported.

By using relatable examples that are unique to staff, this education will not only help prevent staff from inadvertently making these mistakes, but alert them to report any incidences they observe, too. Use current and real-life examples to make sure the message hits home.

Those examples might include pictures on social media of remote workspaces, pictures on social media of the facility environment, unsecured remote meetings with discussion of protected health information (PHI), frustrated remote workers going around existing information technology controls to access files and information they need to do their job if there are technology issues, and record snooping. "Keep records of this additional training and communication, including attendance, and save them with the memo-to-file," Peth says. "This will assist you in evidencing good faith per the OCR announcement guidance."

Employees should be trained on the temporary exceptions so that they can apply them during the emergency, says **Cori R. Haper**, JD, partner with Thompson Hine in Dayton, OH. "Employees should also be reminded that protecting patient privacy, even the privacy of public figures who may be patients, is still required," she says. "In the midst of a pandemic, it is easy for employees to become distracted and inadvertently disclose PHI."

Healthcare organizations should make a point of educating their employees about HIPAA waivers and changes in compliance expectations, says **W. Reece Hirsch**, JD, partner with Morgan Lewis in San Francisco. "There is misunderstanding, and it can be a lot for people to try to digest as they're trying do their jobs in these conditions. It's important to be very clear about whether the waiver provisions have been triggered for your organization, and what is considered the minimum necessary deviation for your organization," Hirsch explains. "It should not be left to the rank and file personnel to assume there are certain waivers."

Even though hackers still are trying to break through security protocols, the biggest threat to privacy and security remains human error, Borrelli notes. "For example, healthcare administrative staff working remotely sharing a picture of their new home office set-up on social media with protected information visible on their computer monitor or within paperwork on their desk," she says. "Or, clinical staff sharing photos of a facility setting to show the world what

their day-to-day work is like or ... they may accidentally include the face of a patient in the background."

Remember that even with enforcement discretion, OCR requires covered entities to act in good faith to comply. Part of that is maintaining the highest HIPAA compliance when necessary and not unnecessarily taking advantage of OCR's response to the pandemic.

"If you are a small entity that is not seeing patients, is it OK for you to relax your standards? I would argue no, there is no exigent circumstance here that would mean shutting down security systems or not requiring staff to verify the identity of those on the phone that would qualify as acting in good faith," Borrelli says. "If you are a large hospital struggling from the weight of treating multiple COVID-19 patients, the answer may be different."

Also beware of online threats to HIPAA security. Hackers see the COVID-19 crisis as an excellent opportunity to take advantage of people and systems that are occupied dealing with the crisis, Borrelli says. People are distracted and stressed, their critical thinking is not as attuned as it usually is, so they are more susceptible to phishing and other online attacks. "Add to that a large part of the workforce that has not worked remotely before and the lack of time to deal with the security and privacy controls needed in those environments. It's a perfect storm for fraud, breaches, and cybercrime," Borrelli says.

Huger suggests this is a good time to review HIPAA policies and procedures to look for ways they might be improved. "We are seeing situations that we did not even imagine before, and now they are becoming very real," Huger says. "This is an opportunity to reassess what you have on paper in light of what your doctors, nurses, and administrators are actually facing right now." Educating those on the front line about what they can and cannot do regarding HIPAA compliance also is important, Huger says. "There is a very real human element here. Sometimes, people don't have the luxury of referring to the policy and keeping up with how requirements have changed," she explains. "Providing some easy-to-understand education is going to be important through this period. The policy might be there, but you might need to help your people understand how it applies now."

There is a higher risk of some types of HIPAA violations during the pandemic response, says **Kristen Rosati**, JD, an attorney with Coppersmith Brockelman in Phoenix. "One of the HIPAA compliance problems that likely spike during a healthcare crisis is increased incidence of curiosity viewing," she notes. "Healthcare personnel want to know if a patient on the floor has tested positive for COVID-19. It's tempting to look at a patient record, even if the personnel member is not involved in treating the patient. It's also tempting for personnel with access to the electronic health record to look up neighbors, family members, or perhaps ex-spouses interacting with children. But unless there is a valid treatment reason to have access to the patient's record, personnel shouldn't be in the record."

There also may be a desire to share COVID-19 infection information to protect others, such as fellow employees, first responders, or family members, from becoming infected, Haper says. "This can be accomplished under the new exceptions, but healthcare providers should understand the boundaries of the exceptions so that they can properly apply them at the time an issue arises," Haper says. "Another issue is the unique situation where the employer is a covered entity that provides testing for COVID-19 and wishes to use the information that one of its employees tested positive to protect other members of the workforce from contracting the disease. Again, this can be accomplished within the boundaries of the public health emergency exceptions, but it raises interesting issues when a company is both an employer and a covered entity."

Even in the chaos of a pandemic, covered entity providers should try to implement their privacy procedures and adapt those procedures as necessary, says **Thomas E. Jeffry, Jr.**, JD, partner with Arent Fox in Los Angeles. For instance, the minimum necessary rule requires that steps be taken so that persons only have access to the minimum amount of health information necessary based on their role and association with a patient.

"Only key personnel and those directly involved in the treatment and care of COVID-19 patients should have access to the identity of patients and their complete medical record. Because COVID-19 patients are separated from family members upon their admission to the hospital, the hospital should do its best to identify their designated personal representative and health decision surrogate. Communications about the patient should be channeled through that representative."

While it may not be possible to engage in a private conversation with a patient who is in a hallway because there are no other beds, providers should do what they can to minimize others from hearing, Jeffry says.

Covered entities and their business associates should track disclosures; report any unauthorized uses and disclosures; maintain administrative, physical, and technical safeguards to protect the security of electronic PHI; and limit internal uses and disclosures consistent with its minimum necessary policies. Jeffry says covered entities should plan now for recovering from the pandemic.

"Covered entities should think about the transition back to meeting all HIPAA requirements when the public emergency is removed, particularly with respect to telehealth security requirements," Jeffry offers.

Huger agrees, saying it will be important to bring employees back to the "normal" HIPAA compliance expectations once OCR revises its requirements after the pandemic slows or ends.

"If OCR is going back to business as usual, how is that going to impact the guidance we gave our staff members during the pandemic? That was then, and this is now. How are we going to get back to where we were with HIPAA compliance?" Huger asks.

Covered entities should plan for additional HIPAA training as soon as the pandemic subsides enough to allow it, suggests **Stephanie Winer Schreiber**, JD, shareholder with Buchanan Ingersoll & Rooney in Pittsburgh.

All communications about HIPAA compliance during the pandemic, especially any regarding a change in policy or procedures, should emphasize that it applies only "during the period" and "until further notice," she says.

"It would be a very wise endeavor for healthcare providers to engage in some additional HIPAA training post-COVID 19," Schreiber recommends. "Start thinking now about what you will need to tell your employees about rolling back to the way you previously addressed HIPAA compliance, what you learned about your program during the crisis. Maybe people can tell you about how your policies and procedures worked." OCR's response to the COVID-19 pandemic may yield some long-lasting benefits, says **Rose Willis**, JD, with Dickinson Wright in Troy, MI. She expects OCR to consider maintaining some of the telehealth changes even after the pandemic subsides.

"We are going to see ... OCR making the rules a little more flexible for telehealth, with things like allowing the use of Skype to conduct a telemedicine consultation," Willis says. "Before, it may not have been technically compliant from a security perspective, but I think as long as we don't see any huge problems come up as a result of that, I think we're going to see more of the flexibility continuing in the future." ■

Tips for HIPAA Compliance During a Pandemic

Remember that the pandemic response may create unique Health Insurance Portability and Accountability Act (HIPAA) compliance risks, says **Victoria Vance**, JD, partner with Tucker Ellis in Cleveland.

Time, staffing, and focus are at a premium, she says, but staying cognizant of patients' privacy remains important.

Vance offers reminders on how the pandemic response can increase HIPAA compliance risks:

• Use caution when deploying staff from other departments, offices, or facilities within a health system. This includes bringing back retired healthcare workers or volunteers to work in unfamiliar surroundings.

These individuals may need a refresher on the electronic medical record (EMR) systems and the facility's unique HIPAA policies and resources.

• In the press of patient care, remember not to share EMR passwords or forget to close patient encounters.

• Be mindful of the media interest in hospital operations and patient treatment experiences. Designate a point person to serve as the media contact for press statements. Also be careful about the use of photography and videotaping in areas where patients may be identified.

• Likewise, be cautious in phone encounters. Identify the caller, know with whom you are speaking, and share only minimum necessary information with designated individuals with a right to know about a patient's condition and status.

• Remember that compliance with HIPAA may not be enough. Local and state rules could provide additional protections for patient privacy and limitations on disclosure that are more restrictive than HIPAA.

In many instances, treating COVID-19 patients has meant working in conditions that are far from ideal for HIPAA compliance, notes **Raymond Krncevic**, JD, counsel with Tucker Ellis in Cleveland. Care is provided in overcrowded hospital units, drive-through testing sites, and other suboptimal situations where providers cannot communicate with patients in typically private settings.

"It sounds simple, but in these situations, common sense goes a long way," Krncevic says.

He offers these suggestions:

• Talk to patients in hushed voices if there are others standing nearby.

• Log out of a patient's medical chart if you are working in an area where the computer screen could easily be viewed by others.

• Do not share computer passwords.

• If treating a patient via telehealth link, make sure no one else is within earshot on your end.

• Even if you are using or disclosing protected health information where patient consent is not required, such as obtaining a consult or submitting data to a local health board, make sure to use only the minimum amount of information necessary to complete the tasks. ■