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INSIDE

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Patient Access Staff Also at Risk for Burnout

Successful patient access employees have two things in common: A customer-friendly mindset and plenty of compassion. "These attributes help us to provide excellent care and service. But it can also lead to burnout," says **Christina Harney**, vice president of access management at Indiana University Health. Usually, registrars are the first people who worried, anxious patients encounter. "Bearing others' burdens in a fast-paced, rapidly changing environment takes a toll on those who are committed to delivering a high-quality patient experience," Harney notes.

Patient access staff struggle with constantly changing health plan requirements and coverage options. "The pace of change is amplified by the significant number of changes. There are also new responsibilities resulting from the pandemic," Harney observes.

Hospitals continue to devote many resources to combating burnout among nurses and doctors.[1] "However, one cohort of healthcare employees they might not have thought of are those who work in patient access," says **Scott Andrews**, chief customer officer at Kyruus.

Although the problem of burnout in healthcare is well-known, the focus remains mostly on clinical areas. "The tide is changing on this front," Andrews observes. "Leaders are taking steps to address burnout across their organizations, not just with clinical staff."

As manager of a 900-person call center, Andrews saw many staff suffering from burnout after dealing with constant stressful interactions. Perpetual upheaval during the COVID-19 pandemic has only exacerbated this problem.

"Priorities change on a daily or even hourly basis. Testing locations are updated, vaccine protocols evolve, procedures are canceled or rescheduled," Andrews explains.

Andrews suggests leaders find some creative ways to help registrars de-stress in their daily jobs. One way is by holding walking meetings (in-person or remote) instead of sit-downs.

"This is a great way to get some exercise and break up the monotony of the day," Andrews suggests.

As the first contact point when people enter the building, the patient access team at Grand Rapids, MI-based Spectrum Health "has definitely taken the brunt of the feedback about visitor restrictions and mask requirements," says **Mallory McKnight**, a patient access manager at Spectrum.

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Patient access staff are uniquely at risk for burnout, says McKnight, "given the volume of patient interactions they have, and how often they're asked to deliver news that the patient might not want to hear."

Burnout creates a real problem for staffing in registration areas. Burned out staff are more likely to call in sick, refuse to pick up additional shifts, or leave the organization entirely.

McKnight looks for these red flags: Sustained dips in quality or productivity, resistance to feedback or change, sharp tones when interacting with patients or co-workers, and changes in the level of customer service. More often, staff are making comments like: "I feel like everything is constantly changing and I can't keep up."

"Making yourself available for conversations with your team is crucial so you can build rapport and adjust before staff burnout," McKnight says.

At Indiana University Health, burnout is becoming more apparent in patient access staff.

"Some of the red flags we've seen include increasing use of leaves and absenteeism, and more complaints to our leaders," Harney reports. These are a few ways the patient access department is addressing burnout:

• For existing staff: Some staff experienced burnout because they felt stuck in their roles, with no chance to move up. The next step in their career was unclear and seemed too complicated to attain. A new patient access career progression map offers staff the chance to advance to newly created senior and expert roles.

"It identifies achievable next steps," Harney explains.

The department has seen a 24% reduction in first-year turnover from 2019 to 2020.

• Before staff are hired: Poor fits for the department are more likely to end up with burnout. To hire the best possible fit, managers use an empathy- and values-based interview process. "This assesses whether someone is a good match for our team," Harney says.

The interviewer plays the part of a nervous patient registering for an MRI. "It provides a glimpse of how the candidate will connect with actual patients," Harney says. Ideally, the candidates provide reassurance that the radiology technician will provide great care.

• Shortly after staff are hired: Leaders make a habit of starting impromptu chats with new team members. The ratio of engaged to disengaged team members has markedly improved (from 3:1 to 4.5:1) in the past year. "It's important that patient access leaders know team members well enough to connect with them in meaningful ways," Harney offers.

The department also reduced the team member-to-manager ratio in patient access teams (from 50:1 to less than 30:1). Since leaders know team members well, they quickly pick up on behavior changes, such as uncharacteristic lateness or someone appearing depressed.

"We've empowered leaders to humbly approach team members to ask potentially awkward questions in the spirit of caring well for each other," Harney reports.

Leaders ask: How is your work/life balance? How are you doing on a personal level? What is something I can do to better support you?

"We have seen important work and personal issues raised that might otherwise have gone under the radar," Harney adds. ■

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Price Shoppers Want Information, But Some Kindness Doesn't Hurt, Either

At Maury Regional Medical Center in Columbia, TN, many price-shopping patients are calling.

"Most requests are individuals without any insurance wanting to know expected out-of-pocket costs," says Preservice Manager **Jennifer Smith**. These are examples of questions posed to patient access staff:

• What laboratory testing service provider does the hospital use? What will lab work cost? Self-pay patients want to know if lab work is included in the price they are quoted. If not, patients want to know they are receiving the best possible price for the lab work. As for insured patients, they are worried about whether the laboratory is a covered facility, and whether the lab work is a covered test. "The patients do not want surprise costs. They really seem to understand what they are looking for," Smith observes.

• What will the scheduled surgery cost?

• What will screenings ordered by my doctor (colonoscopy, CT lung screening, AAA screening, mammography, or presurgical screening) cost?

• What will anesthesia cost for my upcoming scheduled surgery?

For all of these questions, staff follow a process:

• **Tell the caller what information is needed to run the estimate.** This includes insurance ID number, group number, the name and date of birth of the primary policyholder, the name of the study ordered and a copy of the order (if possible), what facility the caller is hoping to use, and the best contact number to reach the caller. Most people can recite this basic information easily. The trickier question is about CPT codes. "The CPT code is the most difficult information to identify," Smith notes.

Many people have never heard of CPT codes. In that case, staff have to conduct some research. First, staff contact the provider's office to ask for the anticipated CPT codes they will be using. If the provider cannot provide the CPT codes, staff calculate a "good faith" estimate (based on CPT codes that are associated with the procedure). "We use this time to educate the caller on the reason for accurate CPT codes," Smith adds.

• **Tell the caller how long it will take to receive an answer about the cost of care.** Assuming the caller knows all the information up front, the call takes only five or 10 minutes, and an additional three to five minutes for scheduling. If the caller does not know the information, staff ask for some additional time to research it and run the estimate. Those callers can stay on the call, receive a call back to discuss it later, or receive an email with the information. "If the caller is happy to stay on the line, we make small talk. We show them we care," Smith says.

• **Choose wording that empowers the patient.** "People get upset when they feel they have no control or say over what's happening," Smith says. To counter this, staff use specific wording: "For us to process your estimate today, we will need the name or procedure code of your exam. Are you ready to start? With your permission, I can call your physician to learn the information so we can proceed. Are you OK with me doing that for you?"

• **Explain the next steps to schedule the appointment.** "We coordinate a warm transfer of the call to get them scheduled," Smith says.

Some callers are worried about their insurance coverage. The preservice team provides reassurance, that the insurance has been verified already and that prior approvals are obtained before the procedure. "For self-pay patients, there are many questions about financial assistance," Smith says. "We connect them with financial counselors."

• **Thank the caller for considering the hospital as an option.** "We always ask them if what we have communicated to them makes sense, or if they need any clarification of the estimate," Smith says.

It is not just a dollar amount that is at stake. The calls are a chance for patient access to give a good first impression of the hospital.

"People skills are a must. We are polite, courteous, and timely with any commitments made," Smith says.

• **Set clear expectations about what will happen during the patient's stay.** The preservice staff see their role as more than just giving people information on insurance coverage and dollar amounts.

"We ease their fears of coming to the hospital," Smith adds. ■

Fine-Tuning Techniques for 'Shoppable' Services

In terms of making prices transparent to hospital patients, "we're really in the first innings as an industry in making self-searchable information available to consumers," says **Bill Krause**, vice president and general manager of connected consumer health at Nashville-based Change Healthcare. Krause says it is important for hospitals to properly execute the following:

• **Do everything possible to limit billing surprises.** If patients believe any

cost information was withheld from them, they are highly likely to be dissatisfied. "That's the first thing hospitals really need to work on," Krause says.

Many people find healthcare information confusing, and this can result in some surprises. "But it's important to note that emergency department services are not considered shoppable," Krause notes. "When you are having a heart attack or a stroke, you don't dig out your insurance information to make sure you understand your financial responsibility."

Current price transparency rules focus heavily on "shoppable" services, those that are nonemergent that can be planned for in advance, such as diagnostic tests or knee replacement surgery.

• Make price information available in many different formats. Posting prices on the hospital website is not nearly enough. Call centers, patient portals, and in-person financial counselors all are needed, too, depending on patient preferences. "Some people will want to speak to staff, and others will want a self-service option," Krause observes.

• Convey that even the best price estimate is only that — an estimate. Price estimates are based only on the information staff know before service. It is especially hard to identify the final prices for complex tests and procedures. "For everyday labs and office visits, there's low variability. Beyond that, it becomes more difficult," Kraus laments.

Communicating some kind of disclaimer that is understandable to patients is important to avoid confusion.

• Consider using two different approaches, depending on the complexity of the service. Posted prices are for shoppable services that generally are simple (e.g., an ultrasound or blood work). "That category is advancing much faster in terms of a retail consumer approach. There's more price certainty," Krause explains.

Surgeries and other complicated care are going to require more intensive support.

"Some hospitals are pushing out a retail model, and a more complex care model," Krause says.

Even in the retail world, some purchases, such as a pair of sneakers, are straightforward, while others, such as buying a new car, are far more complex. "Look outside healthcare for good examples," Krause suggests. "Retail clinics and innovator models throughout the country are showing the way."

More complex care is enigmatic, from a financial standpoint, with greater financial burdens for patients. "That side needs to be pursued differently," Krause offers.

To be really successful with price transparency, says Krause, "hospitals need to take a more end-to-end view of the patient's financial journey as opposed to a point in time." ■

'Valid' Insurance Offers Little Coverage, Few Benefits

Certain patients present with valid insurance cards, but what they do not realize is their health plan covers next to nothing. At Phoenix-based Banner Health, this happens often with ED patients. "We are seeing a large number of employers that are offering this sort of limited benefit plan as their employee coverage," says **Amber Hermosillo**, revenue cycle education and quality director.

Some patients chose a limited benefit plan without realizing it would only cover a certain dollar amount. "Patient access can see these plans coming," Hermosillo says. "The cards are often overloaded with all the different 'network' logos the plan is partnering with."

Unlike other health plans, those with limited benefits are difficult to obtain electronically. "Some health plans cover a very low dollar amount per visit or per day," Hermosillo reports.

This leaves patients stuck with the rest of the hospital bill. Banner Health's patient access staff are seeing many more patients in this tough situation. "We knew we had to find a way to assist our underinsured patients in the same regard as an uninsured patient," Hermosillo says.

The revenue cycle department worked with vendors to offer these patients two new financing options: In-house payment plans (some interest-free) and a Banner Health-branded credit card. "We give an already-stressed out patient more time to pay," Hermosillo says.

At Huntsman Cancer Institute in Salt Lake City, more patients are arriving with short-term health insurance. Most plans cover little or nothing. "Oftentimes, patients do not know what they sign up for," says **Junko I. Fowles**, CHAM, CRCP-I, supervisor of patient access and financial counseling. The patients end up receiving a bill for almost all the costs. The root of the problem is many people still choose lower-premium plans with poor coverage. Every day, self-pay direct admissions come in with unexpected illness or injury. "Patients end up with enormous medical bills," Fowles notes.

Many do not qualify for charity care because their income is too high, or because they have too much savings. Even if they do qualify, charity only covers charges included in the bills. The patient still has to worry about how to pay for prescriptions, durable medical equipment, or care at skilled nursing facilities.

A few patients are eligible for Medicaid or COBRA (if it is within 60 days of the loss of employment and the patient was insured previously under an employer-based plan). Otherwise, says Fowles, "there really aren't many options. Some patients resort to crowdfunding."

One uninsured patient missed the annual enrollment deadline, but called an insurance agent and purchased a plan anyway. "It turned out it was one of the bridge gap policies," Fowles recalls. The plan would have paid $500 of the billed charges had it not been for the pre-existing condition. The plan ended up paying nothing.

As a regional referral facility, Huntsman sees dozens of plan issues in different states and regions. Clinic intake coordinators and schedulers watch for plans with limited coverage so patients can be warned at referral. "If a patient is referred for high-dollar treatments or is directly admitted to the inpatient unit, our patient financial advocates intervene," Fowles explains.

The patient is screened for Medicaid eligibility, payment plans, financial assistance, or the ability to enroll in a plan that offers comprehensive medical coverage. "This population is likely to require ongoing high-dollar treatments. Early intervention is the key," Fowles adds. ■

Rural Hospitals Automating Revenue Cycle: A Little Goes a Long Way

With ongoing concern about rural hospital closures, COVID-19 has resulted in even greater financial pressures. To learn more about what rural hospitals are facing right now, "our team took on a literature review," says **Anthony Slonim**, MD, DrPH, FACHE, president and CEO of Reno, NV-based Renown Health.[1] The revenue cycle "is so important a function for hospitals and health systems. Rural hospitals in particular are going to need to assure that their processes are tight," Slonim says. To survive, rural hospitals must "tap into all potential sources of revenue and reimbursement in a timely way moving forward," Slonim adds.

One way is through automation. "Rural hospitals benefit from embracing automation just as urban facilities do. But it's the direct impact that can differ greatly," says **David Shelton**, CEO of PatientMatters, a Firstsource company.

For rural hospitals, even minor increases in automation can lead to dramatic revenue cycle outcomes. These are two examples of how implementing even a single tool can produce a big return on investment for rural hospitals:

- **Automated price estimates.** Some rural facilities rarely, if ever, communicate with patients about prices or billing. Automating estimates leads to higher collection rates for those hospitals since financial expectations are clear and accurate. "Staff is no longer hampered by paper-based processes," Shelton explains. "In turn, quality and productivity improve, freeing up limited resources."
- **Automated prior authorizations.** "This is another area with big returns for rural hospitals with limited staffing resources," Shelton offers.

Mostly, this is a manual process. Staff might spend much effort obtaining a prior authorization when it is not required, or overlook essential documentation and end up with a denial. "Any number of things can go wrong in the process without an established system," Shelton observes. As the number of services requiring prior authorizations rises, rural hospitals must make a choice. They can add staff, which is difficult because of employee shortages. "Like any business in rural America, specialized knowledge and expertise can be tricky to come by. The same is true for revenue cycle experts in rural healthcare," Shelton says.

Rural facilities also lack enough patient volume to justify an expanded revenue cycle workforce. The other option is to automate prior authorization for fewer clerical errors and claims denials. "Few revenue cycle processes need improvement as urgently as prior authorization management," Shelton says. ■

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Coping with Aftermath of COVID-19 Reimbursement Changes

Patient access departments are dealing with many COVID-19-related reimbursement issues. San Diego-based Sharp HealthCare sees some self-insured plans assign coinsurance to the COVID-19 prescreen for surgeries. "We have opted to adjust the bill if any coinsurance is applied for this lab test," says **Laurel C. Achenbach**, manager of patient financial services.

Telehealth necessitated certain changes in many payer contracts at

Intermountain Healthcare in Salt Lake City. "We had thousands of telehealth claims that had been previously submitted. These needed to be reprocessed based on finalized payer contracts," says **Jeff Howes**, assistant vice president of the revenue cycle.

The payer contracts lacked specifics on payment rates, which services were covered, and what billing codes and modifiers had to be used. "Payers had different coding requirements that changed frequently," Howes notes.

A few COVID-19-related denials are trickling in. Overall, though, the proactive changes to payer contracts paid off. "Most denials now seem to be related to payer system issues. These are easily remediated with a call to the payer," Howes reports.

Health plans issued all kinds of waivers during COVID-19 — for authorizations, for copays, and for telehealth. But patient access departments soon found the devil was in the details, with varying time frames and stipulations all coming into play. The result: A flood of denied claims.

"It's an interesting time for the revenue cycle, given where we are with COVID-19. The landscape is certainly different," says **Geoff New**, vice president of provider solutions, revenue cycle of Ciox. Here are some issues:

• Surge of denied claims. "We are starting to see a lot of denials come back as it relates to COVID-19," New says.

Most of the time, the problem is missing or incorrect information. "It's our job as revenue cycle folks to tell the story of what happened with that patient while they were in our care. If we tell that accurately and completely, we will get every dollar that's rightfully coming to us," New argues.

Typically, the patient goes home, the claim goes out missing a key piece of documentation, and the denial happens months later.

"There's all these opportunities that we miss," New says. "Right out of the gate, we've got to say, 'Stop the train, we've got to get this information.' Otherwise, we'll get the denial."

• Many COVID-19-related denials are never even appealed, just because of lack of resources. "In 2021, we don't have the time or the dollars that we would have had a year or so ago to go back and do the rework," New says.

• Inpatients end up with denied claims because no one documented their positive COVID-19 status during admission. "Staff should document concurrently throughout the patient's stay. If we don't document concurrently, we're losing before we get out of the gate," New explains.

Without concurrent documentation of a positive COVID-19 result, it appears the admission had nothing to do with COVID-19. "Payors will say it was just an exacerbation of bronchitis or emphysema," New says. "We're got to have that extra documentation more than ever to keep those payers on track."

If they do not have it, hospitals lose reimbursement. Good, early communication between the clinical side and the revenue cycle side is crucial. "Previously, the clinical path and the financial paths never crossed. The 'clinically integrated revenue cycle' has taken hold," New observes.

In this model, case management and utilization review play a bigger role in patient access processes. Some hospitals have implemented a validation process in the clinical documentation improvement and/or coding areas. The medical record is reviewed while the patient still is in house to identify the presence of a COVID-19 test. "Patient access needs to switch the mindset to prevention as opposed to 'We'll take care of it later,'" New says. ■

COVID-19-Specific Codes Can Maximize Reimbursement

As many hospitals continue managing COVID-19 patients, six new ICD-10 codes will help facilities obtain reimbursement.[1] "Hospitals were pushing for these codes. Everybody wants COVID-specific data and codes right now," says **Sue Bowman**, RHIA, CCS, MJ, FAHIMA, senior director of coding policy and compliance for the American Health Information Management Association.

Before these codes, which became effective on Jan. 1, hospitals could not identify that certain conditions were caused by COVID-19. A specific code for COVID-19 (U07.1) was implemented on April 1, 2020. However, there was not a code specifically for pneumonia caused by COVID-19 or multisystem inflammatory syndrome (MIS). Before Jan. 1, 2021, if the patient developed pneumonia caused by COVID-19, hospitals would assign codes for COVID-19 and other viral pneumonia (J12.89).

"You could still identify the patient as a COVID patient from the U07.1 code, but the pneumonia code didn't specifically indicate that the pneumonia was due to COVID," Bowman explains.

In the case of MIS, if the patient also had current COVID-19, code U07.1 would be assigned first. The problem was that if a patient was admitted with MIS and had a history of COVID-19 before Jan. 1, 2021, the patient would not have been identified as a COVID-19-related admission. "The personal history code was not specific for COVID," Bowman says. "It was just a general code for

personal history of other infectious and parasitic diseases."

That code did not specifically describe MIS, a serious, complex condition associated with some COVID-19 patients, both children and adults. "The new MIS code [M35.81] in particular is really going to improve hospital data. It was a very vague code before that really didn't explain what it was," Bowman reports.

The new code for MIS will help maximize reimbursement for these patients. Some patients with MIS no longer had COVID-19 at the time of admission. This made it harder to justify the admission and secure the appropriate reimbursement. "The MIS code explains that this is something that's related to the previous COVID condition. Before, with the vague, nonspecific code, there was nothing to connect it to COVID," Bowman says.

Also, some health plans follow specific reimbursement policies related to COVID-19 admissions. With the new code, hospitals can make it clear the patient with MIS falls into this group. The "personal history of COVID" code (Z86.16) allows hospitals to give more information on the patient's overall condition. This can be used to justify the need for inpatient admission. "Even though the COVID has resolved, the code is used to explain that there is an after-effect or lingering effect," Bowman explains.

Previously, nonspecific codes were used for patients with MIS and other COVID-19-related conditions. Staff need to understand how to use the latest codes. For example, the code for pneumonia (J12.82) caused by COVID-19 cannot be used as a principle diagnosis. "It has to be coded as secondary, with COVID [code U07.1] coded first as the principle diagnosis," Bowman stresses.

For outpatients, the codes most likely to cause confusion are those for screening (Z11.52) vs. exposure (Z20.822). The exposure code is for everyone who is tested for COVID and the results are unknown or negative. However, if someone is known to have tested positive, then the code for COVID is used. "Official coding guidelines stipulate that during a pandemic, hospitals should not be coding any encounters for screening," Bowman says.

Staff should use the "exposure" code instead. If someone arrives to be tested and does not report symptoms, staff might think of it as a screening. "That could create some confusion," Bowman says.

The issue is the patient really is not "screened" when the virus remains so prevalent. The patient is tested because he or she may have been exposed to the virus. Thus, during the pandemic, the "exposure" code should be used. "The screening code is waiting in the wings until the pandemic is declared over," Bowman says. ■

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The Mystery of COVID-19's Financial Impact

One year into the COVID-19 pandemic, revenue cycle leaders continue sorting out how it affected hospital reimbursement. The authors of a recent paper examined the financial strain COVID-19 has put on hospitals.[1]

"The implications for revenue cycle departments in the hospital setting may be latent or not fully understood until the pandemic is controlled or its effects are eliminated," explains **Adel Elkbuli**, MD, MPH, director of clinical research, trauma at Kendall Regional Medical Center in Miami.

The revenue cycle impact is going to vary, depending on many factors. These include geographic distribution (metropolitan, urban, or rural), type of hospital settings, severity of COVID-19 and number of surges, and extent on ED visits and elective surgeries/ procedures. For revenue cycle leaders, says Elkbuli, "short- and long-term evaluations of the COVID-19 pandemic impact are necessary to make sound conclusions and determine any future actions/directions."

Hospital revenue and reimbursement was affected in myriad ways. Many hospitals postponed elective procedures to expand capacity, resulting in significant net losses in revenue. Hospitals took action to respond to the pandemic (e.g., buying extra PPE).

Telehealth services expanded dramatically. Timely implementation of the Medicare Section 1135 Waiver affected the financial burden placed on patients and, in turn, affected the revenue cycle of many facilities.[2] "Further studies are needed to accurately measure the exact impact of telehealth revenues," Elkbuli says.

Hospitals took steps to educate trainees, physicians, and hospital billing and coding staff on proper ICD-10 coding for suspected COVID-19 patients. "This likely affected hospital revenue," Elkbuli offers.

A confirmed COVID-19 diagnosis was the first step to invoking the 20% inpatient diagnosis-related group bump reimbursed by CMS for Medicare beneficiaries.

ED visits, and hospital admissions for stroke and heart attack dropped precipitously.[3-5] The sudden decline in preventive medicine, care of chronic conditions, and healthcare in general "were far larger than could have been anticipated," Elkbuli says. "There was a climate of public

fear, leading patients with medical conditions to avoid seeking care."

Hospitals saw a surge of uninsured patients (many with COVID-19) who lost their employer-sponsored coverage. "The ramifications of this pandemic will be felt for years," Elkbuli predicts. "A number of hospitals and outpatient centers might not survive." ■

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Revenue Cycle Staff Needs Education on Cures Act

Soon, revenue cycle staff must be prepared to answer this question: How do I access my medical records?

Starting April 5, patients must be able to access all the health information in their electronic medical records without delay, as required by the ONC Cures Act Final Rule.[1,2]

"Most organizations will be able to leverage their existing technology to make records available to patients," says **Julie Ingraham**, managing director at Huron.

Revenue cycle departments will need to review scripting to ensure it aligns with the new rules.

"Revenue cycle departments, particularly individuals who interface directly with patients, should know what is mandated by the Cures Act," Ingraham stresses.

To assist patients, revenue cycle staff will need training on how to navigate the patient portal or other processes for accessing records. "Scripting should use patient-friendly terms to respond to anticipated frequently asked questions," Huron offers.

While revenue cycle staff are not the ones answering clinical concerns, they do need to know how to respond when asked those questions.

"Scripting will allow staff to respond clearly and, when appropriate, facilitate a 'warm handoff' to the care provider team," Ingraham says. ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Lessons Learned from Overturned $4.3 Million HIPAA Penalty

A covered entity's victory over proposed penalties from the Department of Health and Human Services (HHS) was good news for those responsible for HIPAA compliance, showing that good faith efforts and a willingness to fight the allegations can pay off.

In January, the 5th U.S. Circuit Court of Appeals overturned the $4.3 million civil monetary penalty (CMP) imposed by HHS on The University of Texas M.D. Anderson Cancer Center.[1] That decision is a "game changer," says **Erin Dunlap**, JD, an attorney with Coppersmith Brockelman in Phoenix.

"While the decision is limited in its precedential authority, I think it will impact how HIPAA-covered entities and business associates view HIPAA's encryption rule, evaluate a loss of protected health information [PHI], and engage with HHS in determining settlement amounts, particularly if the alleged violations relate to a loss of PHI," Dunlap says.

HHS' Office for Civil Rights (OCR) imposed a CMP on M.D. Anderson in June 2018 after a lengthy investigation into three data breaches reported by the hospital in 2013 and 2014.[2] The breaches involved the loss or theft of an unencrypted laptop containing the PHI of 29,021 individuals and two unencrypted USB drives containing the PHI of 5,862 individuals.

OCR concluded M.D. Anderson failed to implement encryption or adopt an alternative and equivalent method to limit access to electronic PHI (ePHI) stored on electronic devices and to prohibit unauthorized disclosures of ePHI.

OCR also found that M.D. Anderson had "reasonable cause" to know it was in violation of the HIPAA rules, Dunlap says. OCR imposed penalties in the amount of $1.3 million for the of lack of encryption and $3 million ($1.5 million per year) for the impermissible disclosures of ePHI.

M.D. Anderson unsuccessfully sought two levels of administrative review, including with an administrative law judge (ALJ) who sustained the imposition of the CMP.[3] M.D. Anderson then petitioned the 5th Circuit to review the ALJ's ruling.

HHS Acted Arbitrarily

The important part of the decision is found in the 5th Circuit's reasoning. The justices ruled HHS acted arbitrarily and its decision was capricious and contrary to law for four independent reasons.

First, the court found M.D. Anderson had implemented a mechanism to encrypt ePHI, as required by the HIPAA Security Rule,[4] and OCR failed to show M.D. Anderson had not done enough to secure the ePHI of its patients. The court explained M.D. Anderson required employees to acknowledge in writing that portable devices storing ePHI must be encrypted, furnished employees with IronKey devices to encrypt portable devices, and trained employees how to use them. The center implemented a mechanism to encrypt emails and various other mechanisms for file-level encryption.

"According to the 5th Circuit, those steps were sufficient to establish a mechanism, even if three employees failed to encrypt ePHI. The court basically took the position that the encryption specification was not a strict liability rule, and perfection, or 'bulletproof protection,' was not the standard," Dunlap says. "This is helpful for HIPAA-covered entities and business associates trying to prove they took appropriate steps to comply with the

encryption rule, or other HIPAA requirements, even if they could have done more."

Second, the court ruled the definition of "disclosure" under the HIPAA rules requires "an affirmative act of disclosure" rather than "a passive loss of information." To be a disclosure, someone outside the covered entity would need to access the ePHI. "This interpretation turns OCR's longstanding position and prior guidance on the loss of PHI on its head. OCR has always taken the position that the loss of PHI is an impermissible disclosure," Dunlap explains.

In fact, in OCR's breach reporting form, "loss" is listed as one of the options. But apparently the 5th Circuit does not agree with that interpretation, accusing HHS of trying to "transmogrify" the regulation. "I imagine some HIPAA-covered entities and business associates will point to the 5th Circuit's interpretation of 'disclosure' when evaluating whether there was an 'unauthorized disclosure' of PHI under HIPAA's breach notification rule," Dunlap says.

Inconsistent Decisions

Third, the court ruled OCR's decision to fine some covered entities for loss of PHI incidents and not others was inconsistent. The court noted that under bedrock principles of administrative law, agencies like OCR must "treat like cases alike."

"OCR has always taken the position that it will evaluate each case on its individual facts," Dunlap says. "But, in light of this decision, I imagine a more comparative standard will come into play in OCR investigations and settlement discussions moving forward." Fourth, justices determined OCR's calculations of penalties were wrong. Under the "reasonable cause" penalty tier, which is the second tier under HIPAA's three-tiered penalty structure, the maximum fine for violations of an identical provision during a calendar year may not exceed $100,000. Before this decision, OCR had acknowledged it misinterpreted the statutory caps and published a notice that it would exercise its enforcement discretion to follow the $100,000 cap.

"While I don't think OCR will exceed the statutory caps moving forward, I think this decision may prompt HIPAA-covered entities and business associates to push back on OCR's penalty calculations and hefty settlement offers," Dunlap says.

Refused to Interpret

The 5th Circuit criticized the ALJ who initially heard the case and the HHS Departmental Appeals Board, notes **Arielle T. Miliambro**, JD, partner with Frier Levitt in Pine Brook, NJ. The court ruled both "steadfastly refused to interpret the statutes at all."

Miliambro notes the 5th Circuit interpreted the HIPAA Security Rule narrowly. The text of the regulation states a covered entity must "implement a mechanism to encrypt and decrypt" ePHI. Moreover, encryption is an addressable standard rather than a required one.

"The court found that while M.D. Anderson implemented various mechanisms to encrypt information in accordance with the requirements of HIPAA, certain employees did not use those mechanisms," Miliambro says. "The court held that the regulation does not require that all [ePHI] be encrypted. Instead, the court reasoned, a mechanism must be in place to do so. In the court's view, M.D. Anderson undisputedly had a mechanism, even if it could've or should've had a better one."

Regarding whether loss of control of ePHI, such as through the misplacement of laptops or USB drives, constitutes a disclosure, Miliambro says the 5th Circuit adopted a largely textualist approach to interpreting the regulation. It held the government did not establish that a "disclosure" of PHI was made because the government could not show anybody outside the covered entity received the information on the lost devices.

"The court's interpretation of 'disclosure' is narrow and, in the case of lost devices or records, serves to place a nearly insurmountable burden on HHS, establishing that someone outside of the covered entity actually received the information contained within," Miliambro says. "This rationale has potentially significant ramifications."

The 5th Circuit decision shows HHS does not have the final word when imposing penalties, according to **Richard Sheinis**, JD, partner with Hall Booth Smith in Charlotte, NC.

Sheinis says perhaps the best news for providers is the 5th Circuit's clarification of the disclosure rule.[5] Losing control of PHI does not necessarily mean the PHI was disclosed. "This will be an important factor for determining if there was a HIPAA breach when a medical provider loses control of PHI, but there is no evidence that it was accessed by an unauthorized person," he says.

Focus on ePHI

Although there is good news in the 5th Circuit ruling, it also shows healthcare providers must pay close attention to ePHI and the changing expectations for protecting it, says **Maria D. Garcia**, JD, partner with

Kozyak Tropin & Throckmorton in Miami.

"Providers have to be increasingly careful with how they safeguard ePHI to make sure they do not run afoul of any of the HIPAA rules," Garcia says. "The interpretation of the HIPAA Privacy and Security Rules may vary. It is a good idea to make sure you have individuals in your provider organization who can tackle the understanding of those HIPAA rules so that your electronic information is protected as much as possible."

The M.D. Anderson case highlights OCR's focus on ePHI and the difficulty in protecting it.

"It is the best practice now to be cautious and try to find ways to protect electronic health information," Garcia says. "The decision gives us guidance to everyday issues that we may face now, because so many employers carry health information on their person on their cellphones, laptops, or a USB device. Those devices should be encrypted, and it is important that providers work with experts who can analyze their specific situation."

One of the Largest Penalties

The $4.3 million was one of the largest amounts imposed or secured in a voluntary settlement, notes **Amy Leopard**, JD, partner with Bradley in Nashville.

HHS had considered several factors in determining the CMP. First, the center's 2011 security risk analysis indicated downloading ePHI was high risk and that no enterprise-wide encryption solution was in effect for laptop and mobile devices. Second, annual security reports in 2010 and 2011 showed the center had not mitigated the high risks for mobile media with encryption. Third, in 2011, the center reported lost or stolen mobile devices with ePHI to the University of Texas Police Department on 19 separate occasions. Fourth, unencrypted devices were used after the center had actual knowledge that encryption was needed to secure ePHI on mobile devices.

Leopard says the Fifth Circuit reasoned that under the disclosure rule, "disclosure" suggests an affirmative act, and it defied reason for HHS to argue that a covered entity acts to disclose information when someone steals it. The court allowed that HHS may issue a regulation to redefine the word, but not in an administrative adjudication.

The court also ruled that under the HIPAA encryption rule, the center was not required to warrant that ePHI was protected by encryption; rather, the obligation is limited to implementing a mechanism to encrypt ePHI. When HHS imposed the CMPs on M.D. Anderson, many large breaches reported to OCR (those affecting 500 or more individuals) involved the loss or theft of laptops. Since then, hackers have become responsible for many large breaches with their cyberattacks on healthcare systems.

"During the timeframe of these breaches, OCR investigated hundreds of large breaches involving the loss or theft of ePHI, most without penalty. This matter was hotly contested, and the center was willing to take the risk and endure five years of administrative adjudications and litigation to get this result," Leopard says. "HIPAA enforcement actions will continue to be resolved primarily by informal means or settled through resolution agreements. OCR limited the HIPAA CMP amounts in 2019 under its Notice of Enforcement Discretion and has entered many resolution agreements at lower thresholds over the past year."[6]

Safe Harbor Possible

Leopard also notes that on Jan. 5, Congress amended the Health Information Technology for Economic and Clinical Health (HITECH) Act to require OCR to consider whether covered entities and business associates implemented certain recognized security practices regarding cybersecurity during the prior 12 months.[7] If so, those entities may fall within a safe harbor requiring consideration of smaller penalties and mitigation of remedies in resolution agreements.

"These developments provide welcome relief to entities who have implemented robust compliance safeguards but still face imminent and increased cyberthreats," Leopard says. "But this case will influence strategies for dealing with investigations that occur after a large breach. We are going to question allegations of noncompliance with the disclosure rule and make arguments to the effect that the entity did not disclose or 'lose control' of the ePHI when those breaches involve lost or stolen PHI. We will continue to offer OCR mitigating factors and affirmative defenses to ensure any penalty discussions will be fair and consistent with similar violations."

OCR recently released its HIPAA audit findings showing significant gaps in security rule compliance.[8] OCR likely will have to pursue many more cases and continue focusing on security fundamentals until industry findings improve. "We hope to see more entities adopt recognized security practices such as NIST [National Institute of Standards and Technology] to thwart these attacks," Leopard says. "The game plan should be security management of these

cyberthreats by adopting recognized security frameworks and having effective security incident and breach response plans in place should those risks materialize." ■

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OCR Audit Findings Show Where to Focus HIPAA Compliance

Covered entities should take note of some key findings from audits conducted by the OCR in 2016 and 2017. OCR assessed covered entities' and business associates' compliance with selected provisions of HIPAA rules.[1]

OCR found material noncompliance with HIPAA's Notice of Privacy Practices (NPP), along with right of access, breach notification, security risk analysis, and risk management requirements, says **Jennifer L. Urban**, JD, CIPP/US, partner with Foley & Lardner in Milwaukee.

The audit findings were published only recently, even though the noncompliance findings were from a few years ago. They remain relevant to today's HIPAA compliance efforts. "A lot of organizations still struggle with doing risk analyses and building in the vulnerabilities and identified risks into their risk management plans," Urban says. "That's been a focus for many years, and that's where most organizations failed in the audits."

Implementing a good security program with risk analysis, security practices, and risk mitigation can be a safe harbor from penalties. "What's most interesting to me in the findings from the audit is that people aren't doing a very good job with the security analysis and risk mitigation plan, and they really should be focusing their efforts on those pieces," Urban says. "The M.D. Anderson case and some recent legislation show that you can create a safe harbor if you put enough effort into that, even if it doesn't make your HIPAA compliance foolproof."

The audit findings also suggest covered entities should review their NPPs. Urban was surprised to see only 2% of those audited met the full content requirements. Access requirements were another area of concern. "OCR has been focusing a lot on patients being able to access their records. Under some proposed changes to the HIPAA rules, they're focusing on providing broader access in quicker time frames," Urban says. "OCR has had this information from the audits for some time now, and I think that's one reason they have this access initiative now." ■

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