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AHC Media

Stop loss of Medicaid coverage — $362K obtained in one case

Many beneficiaries lose coverage

A transplant patient at Cook Children's Medical Center in Fort Worth, TX, was eligible for coverage with the state's Children with Special Health Care Needs program, but no reimbursement was possible as funding for the program had run out.

However, financial counselors stepped in and assisted the family in qualifying for emergency Medicaid coverage.

"The hospital was able to get $362,494 in reimbursement for something that would have just been written off," reports **Andrea Ayala,** a financial counselor in patient registration.

Helping patients apply for Medicaid or the Children's Health Insurance Program (CHIP) can dramatically increase the amount of revenue obtained by the hospital, because many eligible patients otherwise wouldn't apply for the program, emphasizes Ayala. "Many get overwhelmed because they don't understand the process, or they perceive it as redundant," she says. "Once they have an understanding of the process, they are cooperative." Ayala often sees patients' Medicaid coverage terminated for these reasons:

• There is a variance in the family's income based on the month the family applied.

For example, an applicant might have received an end-of-year bonus in December or worked some overtime during a particular month.

"Families will assume they can no longer qualify for coverage. They don't

EXECUTIVE SUMMARY

Helping patients to apply for Medicaid can increase revenue dramatically, because eligible patients otherwise wouldn't apply. In one case, financial counselors obtained $362,000 that would otherwise have been written off.

- Tell patients they can reapply anytime there is a change in household income.
- Learn the reason why patients lost coverage.
- Contact patients to get the necessary paperwork submitted.

realize they can reapply anytime there is a change in household income," says Ayala.

• Families have an incorrect assumption that a child can't qualify for Medicaid if the guardian's income is over income limits.

"Grandparents or temporary guardians may apply for assistance," says Ayala. In situations in which Child Protective Service (CPS) is involved but the parent has agreed to a voluntary placement of children with next of kin or a family friend, the child can qualify for Medicaid.

"The assumption by the guardians is that CPS will apply on their behalf, and that is not the case. The temporary guardian must take the initiative to apply," she adds.

In these cases, the guardian's income is not counted. "The only countable income would be if the child is eligible for any income themselves, such as survivor benefits or SSI [Supplemental Security Income]," says Ayala.

• There are changing income levels for self-employed families.

"The state prefers the current tax return as it is easier to process, but this does not always benefit the parent," says Ayala. Households with income that vary greatly from month to month, such as individuals who do seasonal work, often are better off completing a 1049 self-employment form that reports income over a three-month period instead.

"This is often the best reflection of the parent's current earnings and can be a deciding factor in Medicaid and CHIP eligibility," says Ayala.

"Churn" is common

The average Medicaid beneficiary is covered for only part of the year, largely due to the problem of "churn," according to a new report.[1] Otherwise-eligible beneficiaries are often disenrolled and re-enrolled in the program because of paperwork issues, temporary changes in income, or changes of address.

Leighton Ku, PhD, MPH, the report's lead author and professor and director of the Center for Health Policy Research at George Washington University in Washington, DC, says, "Sadly, it is common that low-income patients who were on Medicaid lose their insurance and become uninsured."

Ku says churning hurts hospitals in several ways. "If they treat the patient as an uninsured person, they may incur uncompensated care losses," he says. "Even if they can successfully re-enroll the patient in Medicaid, the hospital has additional administrative costs for the application assistance."

Prevent revenue losses

Patient access leaders can work with state Medicaid agencies to identify ways to simplify enrollment, such as lengthening certification periods or requiring less documentation, suggests Ku. He offers these solutions:

• Let patients know what paperwork they need in advance.

"This can help make sure that the documents are ready when they enroll the first time," says Ku.

• Play a role in new health insurance "navigator" or "assister" programs, which are being developed to help people join the health insurance exchanges or Medicaid.

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• Have "outstationed eligibility workers" who can access Medicaid enrollment systems.

These individuals can find out whether a patient was enrolled in Medicaid at one time and, if so, what problems occurred to cause the patient to lose coverage. They then can contact the patient to help get the necessary paperwork submitted.

"In some cases, the worker may be able to get the required information from another source, such as obtaining a birth certificate from the state health department," says Ku.

Benjamin D. Sommers, MD, PhD, assistant professor of health policy and economics at Harvard School of Public Health in Boston, says that to prevent churn, patient access employees can do the following:

• Remind patients that they have to renew their coverage once annually and that failure to do so can lead to a loss of coverage.

• If the patient access department starts someone's application, schedule a follow-up phone call or meeting to be sure that everything has gone smoothly.

• Have information clearly indicated in patient waiting rooms that subsidized health insurance may be available, and that application assistance is available.

• Provide foreign-language assistance. "This is especially important in some populations with many non-English speakers, as this can be a major obstacle to getting or staying enrolled," says Sommers.

• Obtain retroactive coverage for Medicaid enrollees who have churned off the program but are still eligible.

"This can be a key way to help patients get insured and the hospital reimbursed for costly care," says Sommers. *(See related stories on why churn will continue under healthcare reform, right, the importance of verifying eligibility, p. 88, and how healthcare reform will affect patient access processes for Medicaid patients, p. 88.)*

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SOURCES/RESOURCE

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• To access the 2013 report, *The Continuity of Medicaid Coverage: An Update,* state-by-state maps detailing overall enrollment continuity ratios and rates broken out by population subgroups, go to www.coverageyoucancounton.org. At the bottom of the page, under "Related Documents," select the document's title. ■

Act now! Churn will continue

Much revenue is at stake

"Churn" — when otherwise-eligible Medicaid beneficiaries are disenrolled and re-enrolled in the program — is a frequent problem and will continue to be so under the Affordable Care Act (ACA), according to **Benjamin D. Sommers**, MD, PhD, assistant professor of health policy and economics at Harvard School of Public Health in Boston.

"The most helpful approach is to remind people that their coverage has lapsed and assist them in reapplying for coverage using the ACA's "single streamlined application," says Sommers. This application will determine if the patient is eligible for Medicaid, exchange tax credits, or neither.

If the patient churns off the Medicaid program and is moving to an exchange plan, this move doesn't necessarily mean less revenue for the hospital, he adds. "This depends on the payment rates in Medicaid versus exchange plans, which we don't know yet because the exchange plans aren't in existence yet," says Sommers.

If the patient becomes uninsured, however, Sommers says it is highly likely that many hospitals will get paid little or nothing. "Low-income, uninsured patients rarely have adequate savings to pay for a costly hospital stay," he says. "This becomes uncompensated care or bad debt."

Much of the old system is about to change, although this change will vary from state to state, notes **Leighton Ku**, PhD, MPH, professor and director of the Center for Health Policy Research at George Washington University in Washington, DC.

Under the ACA, the federal government and states are supposed to have integrated, simplified application systems online in which people can enroll for the health insurance exchanges and, at the same time, apply for Medicaid or CHIP by Oct. 1, 2013. "But there will probably be delays in some areas," says Ku. "And in states that don't expand Medicaid, the integrated application systems may just refer someone to the Medicaid program without additional support."

The advent of new simplified, integrated online application systems for Medicaid, CHIP and health insurance exchanges "can make a big difference in ensuring that people get coverage," Ku says. ■

Some `self-pays' already on Medicaid

Patient access staff at Trinity Regional Health System — Rock Island, IL put the first and last name and social security number of every self-pay patient into a verification website to see if they have Medicaid coverage.

"If you don't verify coverage, you may bill for something that will be denied, or you may overlook coverage that the patient doesn't know they have," says **Linaka Kain**, DE, disability examiner and Medicaid specialist. Here are the categories the patients fall into:

• The patient has active Medicaid coverage.

Sometimes patients insist they aren't covered by Medicaid, but the verification system indicates otherwise.

"They tell us, 'I'm not insured and don't have any money,' but they actually do have coverage. They just don't remember applying for it," she says.

• The patient doesn't have current Medicaid coverage.

If Medicaid is not active, the patient becomes a self-pay. The registrar then fills out a form that is faxed to financial advocates, so they can screen the patient further.

• The patient once had Medicaid coverage, but it is not active.

"It's interesting to see how people may have had coverage two weeks ago but this week, they don't have it," says Kain. "It is ever-changing."

Kain says the most common reason Medicaid enrollees lose coverage is because they don't update their information. "If it's just a matter of recertifying, we have the patient call right away. A lot of times it's a matter of [Department of Human Services] reinstating their coverage again, which is a quick fix," she says.

Patient access staff always emphasize to newly approved Medicaid patients that they will be asked to update their information periodically and they will need to do so to prevent a lapse in coverage.

• The patient is on temporary Medicaid.

This status can change from day to day, emphasizes Kain. "If they are deemed to have temporary coverage, they have the card to a certain date, but coverage can be denied within in that timeframe," says Kain. "Medicaid will tell the patient when the card is good through, but they will not tell us, the provider."

Verify every time

Illinois' Medicaid program switched to yearly cards instead of monthly, as a cost-containment measure.

"The cards may say the patient is eligible, but that doesn't mean it's current," says Kain. "We have to verify the patient's eligibility every time they come in, no matter what."

The same process is used for elder patients on Medicare, who often don't realize that Medicaid is available to them as a secondary payer. "If Medicare pays 80% and Medicaid picks up the remaining 20%, it's less out of pocket for the patient," says Kain. "We have to be vigilant to be sure we're checking all avenues of coverage."

Recently, members of the patient access staff had to verify coverage by phone because the computers were down, and they found they'd forgotten how to do things the "old-fashioned" way.

"Staff needed to know the [National Provider Identifier] number for each entity, because they weren't able to verify anything over the phone without it," says Kain. "Patient access should always have a plan B to know how to do something."

Verification is `huge' with Affordable Care Act

Like many patient access leaders, **Linaka Kain**, DE, a disability examiner and Medicaid specialist at Trinity Regional Health System — Rock Island, IL, is expecting a large influx of "newly eligible" patients coming on to the Medicaid program as a result of the Affordable Care Act (ACA) in 2014.

Kain says one process in particular will become particularly important for all patient access departments. "The verification piece is going to be huge," she predicts. "Everybody is going to need to have the means to verify coverage online and to have it give them an accurate verification."

Kain expects that the quicker Medicaid application

process itself will encourage many people to seek coverage. "The average application in Illinois is now 16 pages, and that will be down to three pages. There will be a single-page form for a single person," she says.

Members of the patient access staff already field many questions from patients about coverage choices, such as, "Should I choose the regular Medicaid plan through the state, or an HMO Medicaid plan?" "You cannot tell them which one to pick," says Kain. The reason is that each patient's situation is different, and patient access employees lack the necessary training to give this type of advice, she explains.

Similarly, patients on disability often ask patient access employees how much they will receive. "If you don't know what you're doing, you could misquote someone," warns Kain. "You may tell them they will get $2,000 a month and $10,000 in back pay, and when they actually get their determination letter, it isn't that."

Patient access leaders need to plan now for how they're going to handle the influx of questions about coverage that will come soon, urges Kain. "You need to determine how the flow is going to be," she says. "Are you going to have someone stationed in the immediate area to answer questions?"

While Trinity's patient access employees can answer some basic questions about coverage options, they'll direct patients with more complex Medicaid or insurance questions to Kain.

"You don't want the people upfront to give incorrect or inaccurate information to patients," she says. ■

Duplicate reg? Fix it right away

It's not uncommon for parents to give registrars the correct child's name but another child's birthday, due to the extreme stress of bringing their child to the hospital, says **Kira Bowers**, MBA, manager of patient access services.

"Another reason we see a lot of duplicate registrations is because registration staff select a patient that is close to the demographic information given to registration," says Bowers.

When patient access leaders Children's Hospital of Pittsburgh of UPMC began tracking duplicate registrations in February 2013, there were 36 a month. This number decreased to just seven in May 2013, due to changes in how members of the registration staff search for patients.

"Many duplicate registrations were due to human error," reports Bowers. "We looked at how a registrar enters a registration and what could reduce the risk of selecting the wrong patient due to close demographic information."

Now, registration staff sees the patient's address in addition to the name, date of birth, and social security number. "We also have built in logic that will give the registration staff a 'probability number' that the patient they searched for, and the results they are receiving, are in fact the same patient," Bowers says.

Duplicate registrations can occur for a variety of reasons, only some of which are avoidable, says **Lolita M. Tyree**, CHAM, MSW, patient access manager at Riverside Regional Medical Center in Newport News, VA. "Relying on patients to provide you with accurate information is a vital part of this position. When that process fails, the patients are put at risk," says Tyree.

Duplicates can occur when a patient presents as an unknown, when a clerical error is made in a name spelling or date of birth, and also when a patient purposefully presents false information. *(See related story, below, on how to address suspected fraud.)*

"Paying close attention to details is a major way of identifying these duplicates before they are able to compromise patient care," says Tyree. "It takes a registrar asking the right questions and stopping the registration process in order to make certain they have the correct patient every time."

Paying close attention to details is the best way to identify duplicate registrations before these errors compromise patient care, Tyree emphasizes. "It takes a registrar asking the right questions and stopping the registration process in order to make certain they have the correct patient every time," she says.

Education on errors

Following up with staff about errors resulting in duplicate registrations is critical, says Bowers.

"Leadership in patient access take errors that staff made and re-do a patient search with them to see what happened and what went wrong," she says. "This pre-

EXECUTIVE SUMMARY

Duplicate registrations decreased from 36 a month to seven, due to new processes at Children's Hospital of Pittsburgh of UPMC. To decrease these errors, registrars should do the following:

- Be able to view the patient's address along with name, date of birth, and social security number.
- Pay close attention to details.
- Ask the right questions.

vents errors in the future."

When patients fill out a sheet of paper with their information to check in, registration staff can misread the information or simply try to register the patient too quickly.

"When we find the error, we pull the staff member aside. We go through the registration again with them, to show how they can prevent the same mistake in the future," says Bowers.

SOURCES

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• **Lolita M. Tyree**, CHAM, MSW, Patient Access Manager, Riverside Regional Medical Center, Newport News, VA. Phone: (757) 594-3334. Fax: (757) 594-3069. Email: Lolita.Tyree@rivhs.com. ■

Patients giving false info in ED

Drug seekers that present to the emergency department commonly present with false information, says **Lolita M. Tyree**, CHAM, MSW, patient access manager at Riverside Regional Medical Center in Newport News, VA.

"There was one instance where we found a young lady had presented with more than five aliases in a few month's time," says Tyree. "The red flag presented when one of the registrars recognized her and knew her by a different name from a previous visit to the facility."

By paying attention to small details, registrars were able to identify that she had many similarities in her alias registrations, including next of kin information and dates of birth. "We also noticed she had a pattern of how often she would present to the emergency department and the times of day she frequented," says Tyree.

Registrars followed facility protocols for red flag alerts. "She was arrested on site and escorted from the facility," says Tyree. "It's my understanding she later was charged with providing false information."

If fraud is suspected, registrars ask patients "Have you been seen here before?" or "Is there another name you could have been registered by?" These questions often trigger the patient to repeat their information. "The registrars are able to notice the differences in how they may repeat their information, or if they're stumbling over their Social Security number or date of birth," says Tyree.

Staff recently started taking a photo of patients presenting with no identification. "This, too, has helped to deter many patients from giving false information," says Tyree. ■

Copay collections rose 30% — with help

Make nursing staff your allies

At Monroe Carell Jr. Children's Hospital at Vanderbilt in Nashville, TN, a discharge office is the last stop before families exit the emergency department (ED), but many don't stop there at all.

"The office is marked, but we knew we were not catching all families as they exited," says **Diana Bittle**, manager of admitting in the ED.

In June 2012, a process was piloted by patient access, with full support from the ED nurse manager. The nursing team now walks each family to the discharge office. "The nurse hands all discharge paperwork to our staff. We collect co-pays and give the family another opportunity to ask any questions," says Bittle. Patient access designed a special envelope for the patient's paperwork, so everything easily could be kept together.

"We anticipated a small increase in co-pay collections. We were surprised when we saw a 30% increase in collections over the previous year with a flat increase in visits," says Bittle. "We were very excited!"

In July 2012, patient access leaders were disappointed to see that collections decreased by 7% compared to the previous year's collections, with only a slight decrease in visits. "We talked with our discharge staff to see what insight they could offer," says Bittle. "We communicated the month's results to the nurse manager, so she could query her staff about obstacles they were encountering with this new process."

After it was determined that nurses weren't bringing

EXECUTIVE SUMMARY

Patient access employees at one facility were able to increase collections by 30% by having emergency department nurses walk patients to the discharge office so copays could be collected.
• Collections decreased when a supportive nurse manager left the organization.
• Collections increased again when nursing staff was educated on the importance of copays.
• It took time to establish a consistent increase in collections.

patients to the discharge office consistently, the nurse manager educated her staff on the importance of copay collections to the hospital. For the next two months, the department once again saw significant increases in collections. "While this may seem to be the end of our story, something happened the following month that highlighted why it takes a collaborative effort to make our new process work," says Bittle. The ED nurse manager, who was very supportive of the copay collection efforts, took another position, and her position stayed open for several months.

"Without her support and continuing education with her staff, we quickly saw our collections falter," says Bittle. "We were seeing a 13% decrease in collections, even with an 8% increase in visits compared to last year."

With a new ED nurse manager now supporting the initiative, collections once again increased by 30%. The moral of this story? "Collaborative projects take time and can be slow-moving," says Bittle. One year after the department's initial pilot, patient access is only now beginning to see a consistent increase in collections.

"You have to be willing to step back when necessary, check in with staff often, and keep the drive fresh with visible data," Bittle says.

SOURCES

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Offer patients fast and accurate estimates

Move is toward pricing transparency

If patient access employees can't quickly give patients accurate information about their out-of-pocket responsibility, this problem can directly threaten the hospital's bottom line.

"Correct estimations could certainly increase patient satisfaction and loyalty. The converse is true, if estimates are inaccurate or not provided," says **John Woerly**, RHIA, CHAM, FHAM, senior principal at Accenture Health Practice in Indianapolis, IN.

However, less than 30% of patient access areas use patient liability estimation software, estimates Woerly. Continued growing numbers of underinsured and self-pay patients make this even more important for patient access to do well, he adds. "Accurate, patient-friendly estimates are essential to make patients aware of their financial responsibility before services are performed," says Woerly. "Pricing transparency is an expectation of healthcare reform. It is increasingly expected by healthcare consumers."

The information used to collect payments upfront and to establish payment plans must be accurate, he emphasizes. "Patient estimation tools provide confidence to the user that they are providing an accurate estimate to the patient, and patients perceive clarity in knowing their financial responsibility," Woerly says. The tool can assist in determining "propensity to pay" and segment patients who might qualify for charity care or other funding resources.

Without this automation, patient access employees must request a deposit or rely simply on information gathered at the time of insurance verification. As a result, they might not collect the full and correct amount, nor screen the patient appropriately for financial assistance.

"The correct estimation will minimize potential refunds resulting from inaccurate cost estimates and ensure compliance with charity care and uninsured policies to protect against litigation," says Woerly.

Maximize benefits

The Affordable Care Act (ACA) has resulted in pressure to drive reimbursement down, increase the complexity of the reimbursement process, and increase the size of the patient's copay, coinsurance, and deductible amount, says **Dan Schulte**, executive vice president of revenue cycle solutions for The Outsource Group, St. Louis, MO.

"The need for software to professionally and aggressively manage this aspect of reimbursement becomes very important," says Schulte.

However, less than 20% of The Outsource Group's customers use any kind of patient price estimator software. Schulte says to take these steps to maximize the benefits of patient estimator tools:

- **Decide which tool will work best with your**

EXECUTIVE SUMMARY

Less than 30% of patient access areas use patient liability estimator software, but this software is necessary to ensure patient satisfaction with growing numbers of underinsured and self-pay patients.

- Decide which tool will work best with your patient accounting or patient management system.
- Incorporate ability to pay functions and a presumptive charity care screen.
- Develop good financial policies for pre-registration and patient advocacy.

patient accounting or patient management system.

• Incorporate scoring and ability to pay functions.

It is not enough that patient access gives patients an accurate amount in the presentment letter, says Schulte: You also should be aware of the patient/guarantor resources to help the patient plan an appropriate payment strategy.

"The 'spirit' of the ACA and IRS 501(r) suggest that the provider understand the patient's financial situation before pressing for payment," Schulte adds.

• Incorporate a presumptive charity care screen.

"Prevent any customer service damage done by making demand on a patient who is indigent but not qualified for other safety net services, or who owes a share of cost, copay, or deductible and has no disposable income," advises Schulte.

• Develop good financial policies for pre-registration and patient advocacy.

It's important that patient access processes help patients with financial counseling, determine propensity and ability to pay, include electronic and online payment options, and reasonable payment arrangements, says Schulte.

"I don't see how a professional revenue cycle management team can do its job without a tool that manages the patient balance estimation process, even at a kiosk level," says Schulte.

SOURCES

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• **John Woerly**, RHIA, CHAM, FHAM, Senior Principal, Accenture Health Practice, Indianapolis, IN. Email: john.woerly@accenture.com. ■

Introduce access to clinical counterparts

Registrars more comfortable making calls

Registrars at New York Presbyterian Hospital/Weill Cornell Medical Center in New York City typically hesitated before calling a clinician with a question about a patient's bed assignment.

"They thought 'They don't want to talk to me, I am just a registrar,'" says **Brenda Sauer**, RN, CHAM, director of patient access. "Now, if I ask them to follow up with something, the response is, 'Let me call the charge nurse.'"

This change is due to the fact that the staff members now know each other personally. "I believe it is very important, on any project, that the participants meet each other," Sauer says. "This allows team building and helps with communication."

Recently, patient access employees became involved in a patient throughput initiative. Nurses and registrars assigned to bed assignment come together every morning to talk about potential discharges and admissions for their particular units.

"These meetings are run by the bed assignment staff. They are making decision on bed assignments, with input from nursing, as to where the patients need to be assigned and where the available beds are," explains Sauer.

The meetings always begin with introductions of everyone sitting at the table. "This allowed everyone to get to know each other. During the first couple of meetings, you heard many comments such as, 'Oh, you're Suzie from bed assignment. I talk to you all the time,'" says Sauer.

If a new charge nurse or registrar comes to a meeting, that individual is introduced to everyone present. These face-to-face introductions have greatly improved communication between the recovery room, emergency department, and bed assignment, reports Sauer.

"Staff are more comfortable in calling each other with issues, because they just spoke to them in the morning," she says.

Collaboration at triage

The partnership between clinicians and registrars has been particularly successful in the ED triage area, says Sauer. The registrar sits next to the triage nurse, so as the nurse is triaging the patient, the registrar is registering the patient.

"It has developed so well that if the registrar is busy and cannot review the sign-in sheet, the triage nurse will do it and ask for any clarification needed," says Sauer. The patient's handwriting might be illegible, or there might be missing information on the sign-in

EXECUTIVE SUMMARY

Registrars have become much more comfortable calling clinicians with questions due to face-to-face meetings that take place at New York Presbyterian Hospital/Weill Cornell Medical Center in New York City.
• Bed assignment meetings begin with introductions.
• Registrars are seated next to triage nurses.
• Nurses obtain demographic information from patients presenting by ambulance.

sheet, for example.

The partnership is also helpful in the ambulance triage area, where nurses obtain the patient's date of birth, telephone number, and other demographic information. "The triage nurse, during their assessment, will get any information the registrar needs," says Sauer. "This is especially helpful when the patient is very sick."

SOURCE

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Stop long waits due to invalid orders

Missing diagnoses or ICD9 codes often cause delays

Although many physician offices have converted to electronic medical records at Riverside Regional Medical Center in Newport News, VA, orders often are not completed or lack enough information to process. Members of the patient access staff then need to contact the physician offices to obtain a valid order.

"If offices are busy or are closed for lunch, patient access cannot immediately obtain necessary information. Therefore, patients must wait or be asked to come back later," says **Robin Woodward**, CHAM, director of patient access.

Patients sometimes are given a posting sheet, only to find the practice amended the order set without notifying patient access. Therefore, patients must come back for the additional test prior to procedures.

"We have a liaison that works with all our affiliated Medical group practices, and educates offices using examples provided to them," says Woodward. For example, some patients came in for preoperative testing but had to return for additional testing from amended orders. "Patients were upset that the information was not changed timely, as they were inconvenienced to return," says Woodward.

When patients perceive that patient access employees are unprepared and aren't expecting them, says Woodward, this perception results in low survey scores for customer satisfaction. "Practices need to be diligent to complete the orders while patients are in the office. We have really moved away from faxing and papers," says Woodward.

Patient access leaders continue to educate all physician practices to post orders using the online scheduling portal, which requires ICD9 and diagnosis codes. "This drastically reduced our paper and fax orders," says Woodward. "A major improvement to the process is for physician offices to contact our scheduling department or use online scheduling, which requires ICD9 and diagnosis codes."

Missing orders or ICD9 codes often cause waits in laboratory and X-ray areas at Mercy Medical Center and St. Elizabeth Hospital in Oshkosh, WI, says Connie Campbell, director of patient access. Depending on how busy the provider is, the patient then has to wait an additional five to 30 minutes, she says.

"To reduce the number of missing orders, we started to scan them in. We are now going to a product which converts an incoming fax to your desktop," says Campbell. "That way we will be looking online, instead of for a lost piece of paper that could be sitting on anyone's desk."

SOURCES

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EXECUTIVE SUMMARY

At times, patients face lengthy wait times due to missing or invalid orders in registration areas. These long waits decrease satisfaction scores for patient access.
• Educate provider offices on situations in which patients were inconvenienced.
• Have physicians use online scheduling, which requires ICD9 and diagnosis codes.
• Scan orders so they can be located online.

Patients happier if they are `connected'

Mobile phone chargers can decrease anxiety

"What one thing would help to decrease your anxiety?" When hospital employees asked patients and family members this question when developing a "concierge cart" for inpatients, the most com-

mon answer, by far, was "a cell phone charger."

"It never occurred to me that this was the number one answer they would report. Who knew?" asks **Fé R. Ermitaño**, RN, BSN, project manager for the patient experience, patient relations, and service at Virginia Mason Medical Center in Seattle.

Patient relations staff and volunteers stocked the chargers in the cart, but these were only available to inpatients during limited hours, and not in registration areas.

Shortly afterward, Ermitano noticed a kiosk with cell phone chargers in an airport. "I thought it would be awesome if we could put this in the hospital at very strategic points, where people are waiting," she says.

Ermitano contacted a vendor and obtained approval for the plan. "We decided to put the chargers in areas where they would do the most good, which ended up being the registration areas," she says. Three kiosks are in registration areas, one is in a family waiting area, and a fifth is being added in an outpatient registration area.

The infection control, engineering, security, and legal departments all were involved in the process. "The number of hurdles I had to go through to get this in medical center was much more than I expected," she says.

Opportunity to help

After the kiosks were implemented, patient access employees were given quick in-services on what to tell patients about them.

"Every member of the registration staff knows the kiosks are part of the menu of services we provide patients and families," she says.

For example, if the spouse of a patient tells a registrar, "I just dropped off my husband at the ED, and my cell phone battery is low. Do you know where I can charge it?" the registrar can respond, "Absolutely, we have a cell phone charger on the wall behind you. If you need assistance in using it, please let me know." Here are some benefits that patient access has seen from the mobile charging units:

- Patient relations staff, who are located next to a main registration area, no longer field continual requests from patients asking for cell phone chargers.
- Patient access employees appreciate being able to use the chargers themselves.
- Patients' responses to knowing that the chargers are available to them has been positive.

The evidence is anecdotal, as the kiosks are still newly implemented, but Ermitano plans to survey patients and family more formally in the coming months.

Members of the hospital's volunteer staff will conduct 50 hours of observation of the kiosks over two weeks to monitor usage, answer users' questions, and ask users questions such as, "How do you feel about our cell phone charger kiosks?" and "How can we improve this service for you?"

"It's not just a cell phone charger; it's a lifeline. It's really more about keeping the patient connected with the outside world while they are in the hospital," says Ermitano. "It shows we are supportive of all their needs, not just their medical care."

SOURCE

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EXECUTIVE SUMMARY

Patient access leaders added mobile cell phone chargers to registration areas at Virginia Mason Medical Center after patients requested these chargers to decrease anxiety.

- Staff members don't have to field constant requests from patients for cell phone chargers.
- Patient access employees appreciate being able to use the chargers.
- Patient responses have been positive.

What are the priorities for patient access?

Hospital leaders struggling to increase revenue are looking to patient access for solutions.

"In the 1990s, the focus was largely on the performance of the back end of the revenue cycle. This has largely paid off, and hospital leaders have turned to the front end for further improvements," according to Ronnie Dail, managing director of Huron Healthcare in Chicago. Dail says patient access requires an increasingly integrated approach for scheduling of appointments, sharing information with clinicians, and validating coverage. Here are three processes Dail says are top priorities for patient access:

- **Estimating the cost of services.**

"Hospitals will need to be more transparent about pricing. Many patient access departments lack tools to address the needs of cost-conscious patients," Dail says.

In addition to investing in more tools, hospitals

EXECUTIVE SUMMARY

Estimating the cost of services, integrating scheduling and health information systems, and ensuring that coverage is identified for patients are top priorities for patient access departments. • Hospitals will need to be more transparent about pricing.
• Hospital will need more timely access to data and more robust financial counseling programs.

need to develop the appropriate communication pathways to provide cost information to patients prior to service where possible, he adds.

• Integrating scheduling and health information systems.

"Automation will help eliminate unnecessary touches and rework within patient access," Dail says. "Hospitals are not as integrated today as they would like to be."

For example, an integrated system will tell an insurance verification representative that a patient has previous bad debt. "Having more timely access to data in an integrated system will lead to more collectable revenue and decreased overall cost to collect," Dail says.

• Ensuring that coverage is identified for patients.

"Health reform will provide access to care to a large portion of the uninsured population," Dail says. "These new entrants to the healthcare market will present a huge challenge to hospitals."

Patient access needs more robust financial counseling programs to help patients navigate healthcare insurance exchanges, he advises. "Hospitals will need to bear the burden of educating patients about their various insurance options in a confusing and evolving marketplace," Dail says. ■

Open-enrollment season will be the biggest on record

At the Silver State Health Insurance Exchange in Carson City, NV, workers have been counting down the days until Oct. 1 on an office corkboard, according to a report in *Kaiser Health News*.[1] Now it is only days to the deadline for opening the online marketplaces that are a linchpin of the federal health law known as Obamacare, the report said.

"We certainly will need every one of the days that we have left," said **Jon Hager**, executive director of the Nevada exchange. "But I am confident we will be ready to go."

Nevada is one of 15 states racing to launch their own marketplaces where consumers can compare plans' prices and benefits, and find out if they are eligible for a federal subsidy or Medicaid. Those marketplaces, also called exchanges, are key to expanding insurance coverage to an estimated 25 million Americans over the next decade. The other states are relying on the federal government.

The coming days "are the sprint to the biggest open-enrollment season we've ever seen in this country," said **Ceci Connolly**, managing director of PricewaterhouseCoopers' Health Research Institute, told Kaiser Health News. "We know that this will be a real crunch period."

Opening the marketplaces on time represents the Obama administration's biggest opportunity to fulfill the law's promise to extend coverage to uninsured Americans, including those who have been denied coverage in the past because of health conditions. Since the Supreme Court upheld the law in June 2012, though, officials have had to overcome many hurdles, from states' reluctance to participate, to critics' predictions of unaffordable coverage, to unexpectedly tight money.

A quirk in the law gave generous funding for consumer outreach in states with their own marketplaces, but little for states with a federal exchange. That quirk could be a problem since polls show that most Americans know little about how the law affects them.

There are also technical challenges: Obamacare supporters like to compare shopping on the exchanges to buying an airplane ticket on Travelocity or Expedia, but building the back-end system is far more complicated, requiring computers at state and federal agencies to be able to talk to one another in real time to verify an individual's income and citizenship status, and determine eligibility for federal subsidies or Medicaid. That system also needs to connect with the computers run by insurance companies.

The biggest questions, though, revolve around who will show up and whether they will be able to afford coverage that takes effect Jan. 1 — especially the

COMING IN FUTURE MONTHS

- Answers to the most challenging coverage questions
- Make it a "no-brainer" for staff to stay in patient access
- Revamp processes for Medicare as secondary payer
- Must-have technology for health care reform

young and healthy, who will need to buy insurance in significant numbers to balance the costs of insuring the sick, who can no longer be turned away. The law requires most Americans to carry insurance in 2014, but some fear that the first-year penalties of $95, or 1% of income, won't be a strong enough inducement. If mostly older, sicker people show up, insurers will pass on their healthcare costs in higher premiums that will make coverage for all individuals less affordable over time.

Political backdrop

All of these challenges are occurring in a politically charged environment in which both parties are already spinning developments to buttress their positions on the law. While the law's effectiveness won't truly be known for several years, underwhelming enrollment and high premiums could turn public opinion against Democrats before next year's elections.

President Obama insists the exchanges will open on time and coverage will be affordable, although he acknowledges there will be bumps along the way, as there would be for any new program. The administration relaunched healthcare.gov, the web portal for the federally run exchanges, and opened a 24-hour-a-day call center to help consumers prepare for open enrollment by calling a toll-free number at (800) 318-2596.

Short on money and worried about starting outreach during the summer vacation period, the administration won't launch its major public campaign until at least mid-September. But at press time, supporters of the law, such as the nonprofit Enroll America, were planning to start their own efforts.

Several states running their own exchanges, including Connecticut, Colorado, and Kentucky, have begun airing television commercials about the new options that will be available Oct. 1, for coverage that begins in January. Open enrollment runs through March.

Carrie Banahan, executive director of the Kentucky exchange that recently rebranded itself as Kynect — Kentucky's Healthcare Connection, said, "People need to know this is coming so they can start thinking about it. Insurance is complicated, and we wanted to try to make it easily understandable as possible."

REFERENCE

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HIPAA Regulatory Alert
Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Don't let the broader meaning of business associate trip you up

Downstream data companies especially affected by new definition

Business associates have been required to comply with the HIPAA Privacy Rule since February 2010 as a result of the HITECH Act, but the Office for Civil Rights (OCR) held off on any enforcement activities. That position is changing this summer.

On Sept. 23, the HITECH Act requires enforcement of business associate agreement (BAA) policies, and the definition of business associates has been broadened in a way that means healthcare providers might have more than they thought, especially when it comes to data contractors who work with protected health information (PHI).

The definition of business associates was expanded to include more "downstream" entities, including subcontractors, data transmission companies, and personal health record providers, explains **Careen H. Martin**, JD, an associate with the law firm of Nilan Johnson Lewis in Minneapolis. Under the recently released HIPAA Omnibus, the definition of a business associate has been expanded to include organizations that provide data transmission of PHI to covered entities and that require access on a routine basis to that PHI. The new definition of business associate also includes any subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.

Prior to the new HIPAA Omnibus, the definition of business associate did not explicitly include organizations that provide data transmission and did not include all downstream subcontractors, Martin notes. "HHS had indicated that entities that act as mere conduits for the transport of protected health information but do not access the information other than on a random or infrequent basis, such as the U.S. Postal Service or United Parcel Service and their electronic equivalents, such as Internet service providers, are not business associates," she says. "However, now HHS has indicated that a data storage company or personal health record vendor may qualify as a business associate, even if the entity does not actually access the PHI or only does so on a random or infrequent basis. HHS has emphasized that the difference is between transient verses persistent nature of an opportunity to view PHI."

That guidance on the mere conduit exception can be tricky to apply, cautions explains **Stephen Wu**, JD, a partner with the law firm of Cooke Kobrick & Wu in Los Altos, CA. The final rule explains that a data company, such as a host that holds PHI on its servers, is a business associate if it maintains that data for any period of time. Data simply passing through a company's servers, such as when a phone company's systems are used to transmit PHI from one place to another, would not necessarily make the vendor a business associate.

"The issue for HHS seems to be the fact that it is permanently or indefinitely there, rather than passing through on a wire," Wu says. "Sending an e-mail through a server isn't like that. Once you pull an e-mail from a server, it disappears from that server."

The question can get murky. What about a phone company that also provides voicemail? If a doctor leaves PHI on a voice mail message that is not automatically or manually deleted after a certain time period, at what point does that count as PHI "storage?" Indefinite storage of such messages is a bad idea and could be reason to consider any voicemail provider a business associate, Wu says. By the same logic, a webmail provider almost certainly would be a business associate, Wu says.

New BAAs may be necessary for some vendors

The new definitions might require some healthcare providers to implement BAAs with contractors with which they have previously never had such an agreement. Additionally, healthcare providers should review and amend existing BAAs to include the new definitions and ensure the business associate agrees to implement its own business associate agreement with all of its subcontractors, who are now directly responsible for complying with HIPAA.

HHS has also indicated it will be performing compliance audits of covered entities and business associ-

ates, Martin says. Failure to comply with the HIPAA privacy and security regulations could lead to monetary penalties.

Determining who is a business associate always has depended on the HHS guidance, which specified that certain types of vendors definitely were but still left it up to covered entities to make the decision in other cases. The new definition of a business associate adds to the previous list of contractors always considered business entities, Wu says. That list now includes claims processing, data analysis, utilization review, quality assurance, vendors that de-identify data or create limited data sets, transcription companies, and software vendors that host PHI off site or accessing it on-site.

No type of vendor was removed from the existing list of business associate, but new ones were added. Among the new additions is "an entity performing patient safety activities that are regulated."

The biggest change is that the definition now includes subcontractors of covered vendors, creating the possibility that a covered entity will have a long chain of business associates that could create a privacy breach, Wu explains.

HHS also specifies that certain types of workers are not business associates, including janitors, plumbers, electricians, and photocopy repair workers.

Cloud storage is now a concern

A covered entity's consideration of who its business associates need not change dramatically if you already used a broad definition, says **Brad Rostolsky**, JD, a partner with the law firm of Reed Smith in Philadelphia. Ultimately a business associate is any person or business who is not a member of the covered entity's workforce and who receives, accesses, or creates PHI for or on behalf of the covered entity. However, he says there are some important aspects to the HITECH Final Rule that are worth consideration from a compliance perspective as well as a business perspective.

The advent of business associates and their subcontractors becoming directly regulated might have an impact on covered entities' overall cost of doing business, Rostolsky says, with many of these vendors reconsidering the extent to which they will provide significant indemnification in light of their own direct exposure. They also might question whether their services are appropriately priced for a post-HITECH business environment.

Covered entities also will need to give serious consideration to the compliance exposure associated with the use of cloud storage vendors, Rostolsky says. Cloud providers generally have resisted the position that they are necessarily business associates, and though the final rule make it clear that any vendor that stores PHI — regardless of whether the vendor ever looks at or accesses that PHI — is a business associate, this push-back from cloud vendors continues, he says.

"Adding to the dilemma, the Office for Civil Rights [OCR] seems inclined, as least for the foreseeable future, to focus its enforcement efforts in this regard on the covered entity side of this equation," Rostolsky says. "So covered entities who store PHI with a cloud provider that has not signed a business associate agreement will likely be the primary — if not only — target of OCR."

On the flip side, Rostolsky says covered entities who have engaged cloud providers over the past number of years face a significant logistical challenge. These covered entities will need to weigh the risk associated with using a cloud provider who will not sign a BAA against the challenge of moving all of their cloud-based information to a HIPAA-compliant vendor.

"Although an audit may certainly shine OCR's light on this issue, everyone knows that breaches happen," he says. "And a breach by a vendor who has not signed a business associate agreement will likely be viewed by OCR as a significant failing."

SOURCES

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Privacy rules are being enforced aggressively

The government is taking a more aggressive approach to enforcing HIPAA and the HITECH Act, and healthcare providers should expect significant enforcement action in 2013, a Philadelphia attorney warns.

While enforcement of PHI rules have been lax in the past, the Department of Health and Human Services (HHS) recently has imposed penalties of more than $1 million against companies found in violation of HIPAA, warns **Christopher Ezold**, JD, partner with the Ezold Law Firm. For example, the Alaska Department of Health and Social Services agreed to pay a $1.7 million fine to settle possible violations. Blue Cross Blue Shield of Tennessee agreed to pay $1.5 million to settle potential HIPAA violations. Smaller employers also have found themselves on the receiving end of a HIPAA audit.

"This is a strong reminder for businesses to revisit their compliance programs," Ezold says.

HHS's Office for Civil Rights (OCR) has stepped up HIPAA audits of covered entities that are subject to HIPAA, Ezold notes. OCR has begun levying significant

monetary penalties for violations of HIPAA's privacy rule. In practice, Ezold says, OCR is not interested in small fines; it has levied penalties in the hundreds of thousands and even millions of dollars for what appeared at first glance to be small issues.

To protect your organization, Ezold advises holding an annual internal review to ensure that the privacy requirements are being met. OCR will not consider a once-and-done review to be sufficient; annual reviews provide better protection than merely doing an initial assessment. "If OCR comes knocking, you may be able to avoid significant liability by showing that you have engaged in a good faith attempt to meet your obligations," says Ezold.

Ezold recommends taking these steps:

- Designate a HIPAA compliance officer.
- Create privacy and security policies that comply with HIPAA and HITECH.
- Determine which employees have access to PHI.
- Limit access to PHI operationally and in policy to those employees who "need to know."
- Review physical and encryption security for PHI.
- Schedule annual reviews of policies, operations, and regulations.
- Create annual risk analyses and security plans.
- Have policies in place regarding breaches of PHI security.
- Schedule annual computer network security reviews.
- Safeguard all physical/documentary PHI in a locked location.
- Create policies for reviewing and shredding old documents.
- Ensure that no one keeps PHI on any mobile digital device.

"Given that most businesses review their policies at the end of the year, this is an ideal time to have your counsel or compliance officer examine your own policies to ensure that you would not become an unfortunate victim of an OCR audit," Ezold says. "A small investment in time now could prevent extremely painful repercussions down the road if you are not in compliance."

SOURCE

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Notices of privacy practices must be updated soon

The HIPAA Omnibus requires that covered entities update their Notices of Privacy Practices by Sept. 23, 2013, and it is important to make sure you have complied by the deadline, says **Gregory W. Bee**, JD, a partner with the law firm of Taft in Cincinnati, OH.

"The changes aren't that dramatic, but there are elements that you must include now that you did not before," Bee explains. "With some issues like using PHI for fundraising, there previously was some less precise language about how it could and could not be used, but the final rule makes it clear that patients must be given the ability to opt out, and they must be notified of that."

One change that could cause headaches for some providers involves the right to restrict disclosures. Previously, a patient could request that PHI not be disclosed in certain circumstances or to certain entities, but they could not insist that PHI not be disclosed to insurers or others involved in the payment process. Now the rule clarifies that if the patient paid out of pocket, he or she can request that the PHI not be disclosed to insurers.

"It's a way for the patient to keep some information confidential if they've paid out of pocket," Bee says. "There will be a lot of questions about how to operationalize that."

Bee provides this summary of the updates that healthcare providers are required to make to their Notices of Privacy Practices under the Final Rule:

- A statement that the covered entity must obtain an authorization for the use and disclosure of psychotherapy notes, marketing, and the sale of protected health information. (Covered entities that do not record or maintain psychotherapy notes are not required to include a statement about the authorization requirements for uses and disclosures of psychotherapy notes).

A statement informing individuals of their right to opt out of receiving a covered entity's communications to raise funds for the covered entity (if the covered entity intends to contact individuals to raise funds for the covered entity).

A statement informing individuals of their right to restrict disclosures of protected health information to a health plan in which the individual pays out of pocket in full for the healthcare item or service.

A statement of the right of affected individuals to be notified following a breach of unsecured protected health information. (The specifics regarding the covered entity's procedures regarding breach notification do not have to be specified in the Notices of Privacy Practices).

SOURCE

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HIPAA case settled for $400,000

Some of University's clinics subject to privacy law

Idaho State University (ISU) has agreed to pay $400,000 to the Department of Health Human Services (HHS) to settle alleged HIPAA violations. The settlement involves the breach of unsecured protected health information (PHI) of about 17,500 patients at ISU's Pocatello Family Medicine Clinic.

ISU operates 29 outpatient clinics and is responsible for providing health information technology systems security at those clinics. Between four and eight of those ISU clinics are subject to the HIPAA Privacy and Security Rules, including the clinic where the breach occurred.

The HHS Office for Civil Rights (OCR) opened an investigation after ISU notified HHS of the breach in which the PHI of about 17,500 patients was unsecured for at least 10 months, due to the disabling of firewall protections at servers maintained by ISU. OCR's investigation indicated that ISU's risk analyses and assessments of its clinics were incomplete and inadequately identified potential risks or vulnerabilities. ISU also failed to assess the likelihood of potential risks occurring.

OCR concluded that ISU did not apply proper security measures and policies to address risks to PHI and did not have procedures for routine review of their information system in place, which could have detected the firewall breach much sooner, according to OCR Director **Leon Rodriguez**.

"Risk analysis, ongoing risk management, and routine information system reviews are the cornerstones of an effective HIPAA security compliance program," Rodriguez said in a statement announcing the settlement. "Proper security measures and policies help mitigate potential risk to patient information."

ISU has agreed to a comprehensive corrective action plan to address the issues uncovered by the investigation and its failure to ensure uniform implementation of required HIPAA Security Rule protections at each of its covered clinics.

The Resolution Agreement can be found on the OCR website at http://tinyurl.com/ISUagreement. ■

Mass email breaches privacy of 10K patients

Protected health information (PHI) of 10,200 patients of Dent Neurologic Institute in New York was inadvertently sent to more than 200 patients recently in an email attachment. The healthcare provider acknowledged the error publicly soon after it was discovered.

"The list was mistakenly attached to a routine email that was being sent to patients by a clerk in the DNI administrative office," CEO **Joseph V. Fritz Dent** said in a statement. He called the breach an "inexcusable event." The institute has offices in Amherst, Orchard Park, Derby and Batavia.

The PHI, which included patients' names and home addresses, their doctors' names, last appointment dates and their email addresses, was contained on an Excel patient spreadsheet. The information did not include specific information about the patients' medical conditions, birth dates or Social Security numbers.

Institute officials contacted the 200 patients who received the email and asked them to delete the message, Dent said. They notified the state Department of Health and stated that the clinic will send a letter of notification and apology to all the patients involved in the breach. ■

Hospital chain to pay $275k for privacy violations

Hospital chain Prime Healthcare Services, which owns or operates 23 hospitals in California and four other states, has agreed to pay $275,000 to settle a federal investigation into alleged violations of patient privacy.

The case stemmed from allegations that Prime Healthcare and its Shasta Regional Medical Center violated patient confidentiality by sharing a woman's medical files with journalists and sending an email about her treatment to nearly 800 hospital employees. These violations allegedly occurred as the hospital responded to a story published by California Watch, a nonprofit news organization that featured patient Darlene Courtois and allegations that the hospital was overbilling Medicare. The alleged breach of confidentiality was revealed in a January 2012 column in the Los Angeles Times.

In 2012, California regulators fined the Ontario-based hospital chain $95,000 for the unauthorized disclosure of medical information in this matter. The company is appealing that state fine.

In the federal settlement announced recently, Prime Healthcare did not admit to any wrongdoing. The company and hospital said they "firmly believe that they would have prevailed in this matter based upon the merits." ■