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AMERICAN HEALTH CONSULTANTS

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Hospital outsourcing ED financial counseling to reduce bad debt

In-house liaison facilitates vendor-staff relationships

When the University of Pennsylvania Medical Center-Presbyterian in Philadelphia turned its attention to addressing the facility's bad debt, it quickly became clear that self-pay accounts coming out of the emergency department (ED) were the root of the problem.

Getting those accounts paid was a losing proposition, notes **Raina Harrell**, business administrator for patient access, because "there was no way to collect. We would bill the patients numerous times, but they were self-pay patients with no resources, so eventually [the unpaid accounts] would go to bad debt."

The question, she says, became, "What can we do to reduce this or manage it better?" That led to another question: "What can we do to get some of those self-pay patients qualified for medical assistance?"

To find the answer, adds **Anthony M. Bruno**, MPA, MEd, director of patient access and business operations, the hospital turned to a Collingswood, NJ-based vendor called PATHS LLC, which the facility already was

Prepare your hospital for a very unusual flu season

Vaccine shortages may wreak havoc with hospital EDs, absenteeism

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments EDs and for staff shortages due to record absenteeism. After almost half of the United States' planned vaccine supply was contaminated, high-risk candidates — including the very young, the elderly, those with chronic illnesses, pregnant women, the immunocompromised, and health care workers with direct patient care — have been identified as those to receive the vaccine.

In response to the national shortage of vaccine, Thomson American

(Continued on page 134)

using to manage inpatient medical assistance applications and billing for those patients.

Two years ago, he noted, **Tony DiLuca**, a principal in PATHS, had also led an effort to bill the hospital's behavioral health accounts that "increased revenue substantially."

The decision was made, Harrell says, to "use PATHS to put a person in our ED — a financial counselor — to educate patients on the medical assistance process after they are seen by a clinician." **(See "Vendor outlines steps," p. 135.)**

While some hospitals do the same thing with their own staff, she explains, Presbyterian chose to go with a vendor for two primary reasons:

1. When an in-house financial counselor is in the ED, that person often gets pulled into performing other functions, such as registration, and ends up doing more of that work than actual financial counseling.

2. An outside company can provide data and feedback specific to what it is doing with the financial counseling program and can also talk about other options for health care.

A PATHS financial counselor was put on the most high-volume shift — 11 a.m. to 7 p.m. — Monday through Friday, Harrell says. "We started off with that so we could analyze the results. We set a target goal of [having the financial counselor] see 33% of the self-pay patients in the ED."

To avoid leaving out the ED self-pay patients who came for care during other shifts, PATHS established a reporting process that allows follow-up with those patients by mail, she notes. "So, in essence, we are managing all of our self-pay patients."

At that point, Harrell says, "we decided the process was good, but that it relied heavily on the relationship PATHS had with the ED staff and clinicians." With that in mind, she adds, the hospital put its own ED coordinator in place to oversee the process and make sure that PATHS received the

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Vendor outlines steps to providing ED service

New reporting schemes developed

When PATHS LLC took on the job of providing financial counseling to self-pay emergency department (ED) patients at Philadelphia's University of Pennsylvania Medical Center-Presbyterian, the vendor's first order of business was to distinguish the new program from work it already was doing for the hospital.

"We were already [providing inpatient services], so we had to separate the two," says **Tony DiLuca**, a Collingswood, NJ-based principal with the company, which provides accounts receivable solutions to health care providers in New Jersey, Pennsylvania, and Delaware. "This program is just for patients who come to the ED and leave the same day."

"The other things we had to do were to develop some different reporting schemes to allow us to monitor and report, to look at opportunities to expand the program if needed, and to look at financial feasibility," he adds.

When the PATHS representative registers the self-pay patients, DiLuca explains, the company's own computer and software are used, so that each account is loaded separately into its system. "At the end of the month, if there are 500 patients, we want to make sure we can reconcile, that we have 500 accounts in our system."

PATHS also needs to differentiate between the patients actually seen by a representative Monday through Friday during the 11 a.m. to 7 p.m. shift and those who come in at other times and whose information the company receives via a report, he says.

"We have to develop different tags in the system to compare our performance levels for the 'seen' vs. the 'non-seen' patients," DiLuca adds.

The company gives each ED self-pay patient, whether seen by a PATHS representative, a checklist of what the company needs and what the state needs to qualify the person for coverage, he says. "If we see them, we leave the list. If not, we send out a letter that includes the checklist."

In addition, all patients are provided with the number of a toll-free customer service hot line to call if they are confused and need additional help during the process, DiLuca notes.

"We also do follow-up with the state," he adds, "to say, 'Did Mr. and Mrs. Jones visit or send in their information?' On the back end, we follow up [regardless if the patient has been seen]. We send out several statements and follow up with a phone call. We also have the capability of doing electronic verification with the state — we check on a weekly basis through the whole population.

"Once we get the approval numbers," DiLuca says, "we provide them to the [Presbyterian staff] so they can do the appropriate billing to Medicaid.

After 90 days, if the patient is still not approved, he says, PATHS closes the file and the hospital follows that case as a bad-debt account. ■

information needed to do the job.

"The only way PATHS gets its information is by registrars giving [the financial counselor] a face sheet for each self-pay patient," Harrell says. "If that process falls apart, they don't get their 33% [of self-pay patients]."

If, for example, PATHS finds that it is getting face sheets for patients who already have insurance coverage, she says, that lapse is reported to the ED coordinator, who then works with the ED manager to make sure registrars are checking for insurance.

"The [reason the program] is successful," Harrell says, "is [because] we have this liaison who makes sure she oversees the process from the time the patient walks in the door, sees the ED registrar, sees the financial counselor and the bill goes out the door."

The program began in March 2004, and by late October, about 30% of the facility's self-pay ED patients were being seen by the PATHS representative, she says. About 13% of those patients obtained medical assistance coverage, compared to the goal of 15%.

Considering all ED self-pays, including those who come for treatment during shifts that aren't covered by PATHS, about 8% had obtained coverage by that point, Harrell adds.

"We didn't want to leave out the patients who come during other shifts," she says, "so we established a reporting process [whereby] PATH gets those patients' information and can follow up via

mail. In essence, we are managing all of our ED self-pay patients."

Of the 324-bed hospital's total ED population — some 2,600 patients a month — about 18% are self-pay, Harrell notes.

DiLuca points out that there is no way at present to link the 13% (or 8%, depending on how you calculate it) of former self-pay patients, who now have coverage, to the resulting financial benefits as they continue to use the health care system.

"If those patients come back a month later, they [will then] be on some kind of medical assistance [or] managed care insurance," he says. "Whether they're admitted, whether they need physical therapy, radiology, or surgery — they're covered."

Looking at the cost-benefit picture just from the standpoint of the ED service that is covered, DiLuca estimates, the program was "about breakeven" by late October.

From the beginning, the financial counseling effort has been about more than just increasing collections, Harrell points out. "When we started the program, our feeling was that it's not just about money, but also about customer service and educating our patients."

As a result of the initiative, she adds, "we have established a stronger relationship with our medical clinic. [Patients] whose care was not managed before now have a primary care physician who is managing their care."

The program has helped Presbyterian identify its "frequent fliers" — those patients who use the ED as a primary care facility and who, in many cases, suffer from chronic illnesses, Harrell says. "We identify them, and then we work out the relationship with the clinic, which is willing to take wound-care patients and patients with asthma, chronic obstructive pulmonary disease, and congestive heart failure."

These individuals are targeted as "hot patients" for medical assistance appointments, she notes. "We work with the ED physicians to get the appropriate clinical form filled out to say that this person has an ongoing condition and needs health care coverage, and then we tell the patients that they are to go to the clinic."

Normally the clinic staff would not accept self-pay patients, Harrell says, but because the process of getting coverage has begun, they agree to treat them.

Initially, there was a problem getting buy-in from ED physicians, who resisted filling out the unfamiliar state forms, she says. But after the hospital brought in representatives from the state Department of Public Welfare to do an inservice with the physicians and to answer their questions, Harrell adds, there were no further problems.

There are a number of success stories of patients who, without the program, likely would not have escaped their self-pay status, she says.

"One person came in and mentioned that she was getting food stamps, and the financial counselor said, 'So why aren't you getting medical coverage?'" The patient was talked through the application process, Harrell says, and now has medical coverage.

In another case, a patient previously had medical assistance coverage, but it had been terminated when she turned 18, she notes. "The nurse told the financial counselor the person was going to need surgery in the near future. A physician completed an employability assessment form, a clinical form [attesting to the patient's condition], and she was able to have surgery."

Otherwise, Harrell says, the patient might not have received the appropriate level of care because of her lack of health insurance, or would have accrued large medical bills trying to obtain the appropriate care.

"In the past," she adds, "[obtaining the coverage] wouldn't have happened because there would have been no one to guide her through the process."

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No stone unturned in self-pay initiative

90% of Medicaid-eligible gain coverage

Responding to a rising number of self-pay patients — particularly those coming through the emergency department (ED) — Children's Healthcare of Atlanta (CHOA) pulled out all the stops to expand and improve its financial counseling program.

As a result, CHOA — which comprises Scottish Rite and Egleston children's hospitals — now gets coverage for 90% of all patients who are eligible for Medicaid, says **Benna Gilkey**, manager for financial counselors for CHOA and patient access manager for the day surgery and main

admission areas at Egleston.

The 10% of patients who aren't approved are those who don't follow through by bringing in the necessary information, she notes. "If we take the application, the likelihood of being approved is close to 100%."

"What's really behind our success rate is that we changed the whole mindset, and became more proactive as we added team members," Gilkey says. "We became true gatekeepers, and to do that you have to be equipped to tell the customers what their next step is."

CHOA recognized the increasing financial counseling workload and realized much of the self-pay volume was coming through the ED a little more than two years ago. Therefore, they added ED financial counselors at each of the hospitals, and a part-time person who works 1 p.m. to 5 p.m. Saturday and Sunday at Scottish Rite, she notes.

They joined the two existing inpatient financial counselors, one at each facility, and one financial counselor who works with outpatients at the Scottish Rite clinic, Gilkey adds. "On the main campuses, the inpatient counselor works 7 a.m. to 3:30 p.m., and the ED counselor works 1 p.m. to 8:30 p.m., so they complement each other, time-wise."

The financial counselors' job, she says, "is to ensure that all self-pay inpatient, observation, and ED registrations — as well as any self-pay accounts more than $1,500 — are evaluated for third-party coverage." That includes diagnostic, laboratory, and rehab services, she says. "We also [work with] anyone else who expresses interest in obtaining coverage."

On-site DFCS representative tool

A big part of CHOA's success in gaining coverage for its self-pay patients is because there is a representative of the state Department of Family and Children Services (DFCS) on-site at each hospital campus, Gilkey notes.

"Both on-site caseworkers are there Monday through Friday, 8 a.m. to 6 p.m.," she reports. "Our financial counselors can clear the applications and turn them right over to [the caseworkers]. Our turnaround time is quick. We get the applications prior to discharge and they are completed and handed over to DFCS to load [onto the state web site]. We have that capability right in our office."

In many cases, financial counselors do an assessment with a family member, get the application processed by DFCS, and are waiting for approval all while a patient is in surgery, Gilkey points out.

"As long as [families] provide the information that is required, we know they will be approved, because DFCS is there to complement the financial counselors," she says. "It's a great relationship. Our financial counselors are very familiar with state requirements and policies for approval, and they ensure that every piece, every document required, is available."

Financial counselors work very closely with patients' families in making the application for assistance, Gilkey notes. "It's hands-on. We have a checklist, and we make sure everything on that checklist has been completed. We do our applications here — it's basically a hand-held process. We make sure we're satisfied with the application."

Because of that close attention, financial counselors are able to determine during the initial assessment whether a family is going to be noncompliant (meaning they don't bring in the necessary documents or otherwise appear unwilling to pursue coverage), or if the patient's condition is a disability that may be covered under the Supplemental Security Income program, she explains.

If so, the case is referred to an outside vendor agency, that, as part of its contract with CHOA, will continue to try to get coverage, doing home visits if necessary, Gilkey says. If the vendor is unsuccessful, she adds, the account is turned back over to the hospital, which may send it to a collection agency.

The comfort level that is established between CHOA's counselors and the patients they serve is such that patients often come back to them about concerns that are not related to obtaining financial coverage, she points out.

"We have had families show up with letters they had received from other caregivers and ask my team to explain what's needed and what they're supposed to do," Gilkey says. "In most of those situations, it's just a matter of providing their insurance or Medicaid information to those providers, which results in a 'win-win' for everyone."

Another plus for the CHOA program is that three of its financial counselors — one at Egleston and two at Scottish Rite — are bilingual, she says. "In the beginning, [speaking Spanish] was a plus," she recalls. "Now it's *really* a plus, but it's not a [requirement], because we do have translators. It's a good asset that makes the process a whole lot faster."

Taking the extra step is part of her team's normal operating procedure, she says. "If someone is signing up for assistance, we ensure that every dependent in the household is approved for aid. We look

at it from the perspective of the whole family."

When financial counselors receive an account that appears to be self-pay, they check hospital and physician databases to determine if the patient has visited any of CHOA's facilities before, and if there was past insurance coverage, she says. "If so, we run that through our insurance verification system and see if the insurance is still valid."

If counselors find a Medicaid account that has been closed, they call the parent to find out what happened and, if they can't reach the parent, they take the account number to the DFCS workers and ask them to research it.

"A lot of times a relative [other than the parent] brings in the child, and our system has a lot of entry points," Gilkey notes. "Just because you're registered as a self-pay, that doesn't mean you are a self-pay. We leave no stone unturned."

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Scripting popular with ED and customer service

Could it be said better?

Are you as aware as you could be of how your access employees speak to the customers? Hospitals are increasingly taking note of not only what is said, but the dramatic impact it can have on patients' perception of the care they receive, as well as on the organization's bottom line.

With that in mind, the practice of "scripting" suggested remarks — whether to fine-tune a registrar's cash collection technique or to gather information in the emergency department (ED) more quickly and efficiently — appears to grow.

While much of the attention is on helping employees gain the confidence and assertiveness they need to ask patients for point-of-service payment, there are many occasions where a well-turned phrase can diffuse a volatile situation or streamline operations, suggests **Beth Fries**, education and training specialist for the patient access department at The Ohio State University (OSU) Medical Center in Columbus.

Even the most well-meaning registrar — faced with a patient who is complaining about wait time — might be prone to say something like, "Don't feel bad — yesterday, somebody had to wait six hours."

And despite the usual focus on accuracy, when a patient proclaims that he's been waiting two hours, it's probably not the best idea for the registrar to respond, "Oh, no, it was only one hour."

At OSU Medical Center, scripting was added to the training repertoire about1½ years ago, says Fries, at the behest of access managers.

Their complaint, she says, was that while employees were well schooled in processes and filling in fields, "nobody talks about how to actually talk to patients."

When the time allocated for training was expanded, Fries adds, she put scripting, role playing and dealing with real patients on the schedule.

"As part of our training with all new registrars, there are at least two sessions of role playing," she explains. "The trainers are always the patient, and the trainee is in front of the group, asking the questions, so [the class] can review at the end [and ask], 'Could we have said it better?'

While the new registrars access most of their training materials on-line, Fries notes, a copy of the suggested scripts is given to the employees to take with them. **(See excerpt from script, p. 139.)**

In some cases, she says, the emphasis is on what one doesn't say. "When they give out the notice of privacy practices, we teach them to say, 'Here's your notice of privacy practices. Would you sign here that you received it?'"

The registrars are told not to get into a long discussion about the notice unless they're asked, Fries adds. If they are asked, she says, they are to respond, "It's how medical records are used here at OSU."

Fries says she learned long ago — and shares her experience with the new hires — not to begin a conversation with ED patients with, "How are you?" If you do, she points out, "you hear more than you want."

Instead, Fries notes, the ED registrar would do better to begin with, "Hello, I'm Mary. I need to get some information from you. Have you ever been a patient at OSU?"

During her own time in the ED, she adds, "all of that was out of my mouth before the person made it to the chair." Insurance cards should be requested immediately, as well, Fries points out. "Sometimes, it takes forever for them to get it out."

In some exchanges with patients, it's particularly important to think about what you're actually saying, she explains. "When you ask, 'May we release your religious information?' be sure to add, '. . . to a member of your faith' or 'to our

(Continued on page 140)

Excerpt from

How to ask & How to say it

"KISS" method (*Keep it Simple, Sweetie*)

Introduction

- If you working in an area where you bring the patient to your desk (main admitting) or your enter the patient's room (such as ED) introduce yourself and explain what you will be doing.

"Hello, I am --------. I need to get some information from you before you go to surgery"

"Hi, I am _____. I need to get some demographic information from you today before you see the doctor. Have you ever been a patient at OSU? Do you have your insurance cards with you?"

- If you work at a "walk up" registration area & you do not call the patient to your work station:

"Hello. I need to get some demographic and insurance information before your admission next week. Do you have your insurance cards with you?"

(Don't say: "How are you today?" People are coming to the hospital because they do not feel well)

Release of religious preference?

"May we release this information to a representative of your faith?"

Ethnicity & Race

"Are you Hispanic or Latino?"

- If yes, hand the list to the patient to select which group under Hispanic and them ask them to select their race.
- If no, hand the list to the patient and ask the following:

"Would you identify your race from this list"

- Why do we need this (for ethnicity & race)?

"It helps us better understand the patients who receive care here"

pastoral care department?'"

Overhearing registrars ask the Medicare Secondary Payer (MSP) questions, Fries says, she notices a tendency some have to put an unnatural separation in the flow of conversation. "I tell them, 'Don't even give an introduction [to the MPS topic]. You already know [from previous questions] if the person is employed, so [go directly to], "Is your wife working?"

Word the questions "so it won't sound like you're reading them," Fries advises registrars.

One thing she always emphasizes, Fries says, is the importance of asking patients before the registration is completed whether Medicare — or whatever — is their only insurance. Experience has taught her, she notes, that patients often don't mention such pertinent facts as that they also are covered under a spouse's insurance, or that there might be two insurance plans for outpatient care and only one for inpatient care.

At Swedish Covenant Hospital in Chicago, employees throughout the facility are encouraged to use "key phrases at key times" as part of the organization's service recovery process, says **Gillian Cappiello**, CHAM, senior director for access services and chief privacy officer.

"There are key components to a greeting," she adds. "You always say 'Good morning' or 'Good afternoon' and 'How may I help you?'" Closing phrases, Cappiello notes, include "Thank you" and "Is there anything else I can do for you?"

"If someone has a concern, you always start out by saying, 'I'm sorry you had a problem with that," she adds. "There are certain phrases that evoke the kind of interaction you want to have."

Such scripting helps reduce instances of employees not knowing what to say in a given situation, Cappiello explains. Having a key phrase ready also "allows a little time to think about what you want to say next."

"The purpose is not to tell people exactly what they should be saying, but the idea is that the message should be consistent," she says. "There is always intended to be flexibility, and always circumstances that will [call for] unique responses, too."

Carolinas HealthCare System in Charlotte, NC, is among a growing number of providers that prepares scripts for staff involved in upfront collections, says **Katie Davis**, CAM, assistant vice president of patient registration. Employees making pre-service calls are given the following script, she notes, to help avoid the potential awkwardness that comes with asking patients for payment:

> *"I have verified your insurance benefits and the estimated cost of the procedure, and your coinsurance/deductible for this visit will be $____. I can take care of that for you today so you don't have to be concerned about handling it the day of your procedure. We accept cash, checks, MasterCard, and Visa."*

If the patient does not pay in advance, Davis notes, the hospital sets the expectation for payment on the date of service by having the employee use this script:

> *"You may pay your copay/deductible on the date of service. The registrar at (name of the area) will be happy to assist you with your payment on (specific date of service). We accept cash, checks, MasterCard, and Visa."*

However, Davis points out, "At no time do we push the patient for payment or in any manner indicate that payment has to be received before services are rendered."

In teaching registrars at OSU Medical Center about asking for money, Fries notes, she always tells them to wait for several moments for the patient to answer. "The inclination is to fill in that silence by adding something like, ". . . or we can bill you.'"

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Adventist manual aids registrar, manager

Directions are concise and consistent

A new best practice registration manual, jointly written by an eight-member team at Adventist Health, has been "very useful" for both new registration hires and admitting managers throughout the hospital system, says **Ken Mitchell**, MM, CHFP, director of patient financial services at Adventist Medical Center in Portland, OR.

The project was initiated by corporate admitting manager Susan Baxley after she visited the organization's 20 member hospitals, which are spread across Washington, Oregon, California, and Hawaii.

"She saw a need for a document that would provide concise and consistent direction for registration personnel, so she gathered a group

Best Practice Registration Manual
Assessment Tool (excerpt)

	Financial Utilization Review	Yes	No	Comments
37	Does the hospital have a financial UR coordinator that acts as the liaison between facility and third party payers, case management functions to resolve certification and stay issues, disputes, etc.?			
38	Does the hospital formally track and report unauthorized days and/or denials?			
	Inpatients? Outpatients? Emergency?			
39	Do you receive a denial log from your CBO or business office?			
40	Does case management document notes directly into the computer system? If not, how does information get to registration or PFS regarding concurrent review?			
41	Does the Registration Manager monitor registration-related denials?			
	Quality Assurance Process	**Yes**	**No**	**Comments**
42	Are you using any QA software?			
43	Do you have a Quality Control Analyst?			
44	If so, how many QC FTEs and how many accounts are they reviewing?			
45	What are they reviewing (entire checklist or shortened version)?			
46	Does the QC Analyst correct mistakes found by employees?			
47	Are statistics maintained, reviewed and distributed?			
48	Do you provide feedback to your employees regarding their error ratio?			

Source: Adventist Health.

of individuals from several hospitals to write he manual," Mitchell adds. "Over a period of months, that's what we did."

Team members met once a month, sometimes more, to develop ideas and agree on content, he explains. "Different individuals took different chapters and did the original draft. As a group, we would work through the draft and update it."

His role, Mitchell says, "was as the typist who, in the meetings, did the word crafting" while the revisions were being done.

"It was a smooth process, the group worked very well together, and we had lots of fun at the same time we worked on it," he adds.

While functions needing particular attention varied from hospital to hospital, Mitchell notes, "one consistent issue in registration is turnover, so there is always a great need for training."

New registration employees sometimes don't receive adequate training, he points out, "because the person they're replacing is not there anymore. Some of the facilities are small, so it's challenging to have enough individuals to provide ongoing training. We needed some documentation that was other than word of mouth."

With the registration manual, Mitchell says, "[employees] get the benefit of having somebody provide the [relevant] documents. We make sure they read it, then we have someone do hands-on training."

While much of the information in the manual is applicable to any hospital, much of it is geared to Adventist facilities, he notes. "We did include very specific things that are requirements for our hospitals — our expectations, things that are supposed to be recorded and tracked."

Chapter 1 is the manual's introduction, Mitchell says, and Chapter 2 deals with "return on investment" from a registration perspective.

"It isn't a technical chapter and doesn't define a return on investment model," he explains. "The focus was analyzing what the effect would be of having proper policies and procedures that were consistent across the organization. It gives registrars some financial information that shows the value of doing it right."

The rest of the chapters deal primarily with various aspects of registration, Mitchell adds, briefly outlining them as follows:

- **Chapter 3:** Registration standards, and

expectations for quality performance.

- **Chapter 4:** Job descriptions, including sample job descriptions for 14 different positions within the department, from registrar to financial counselor to scheduler to admission manager.
- **Chapter 5:** Emphasizes the value of a strong training program. Provides a great list of items that should be included in training. Subjects include systems, customer service, compliance, primary registration functions, etc. Suggests web sites that may be helpful.
- **Chapter 6:** Account workflow — the process that an account follows from the point of preregistration to the billing department "so a new person gets the idea of what happens to their work. A lot of times [registrars] just see what they do and have no idea how it affects somebody else."
- **Chapter 7:** Briefly discusses theories of motivation in the context of providing incentives for employees. It talks about money as an incentive, and then describes other possible financial and nonfinancial ways to reward and motivate employees.
- **Chapter 8:** Denials — "Organizationally, we log denials, keep track of them, so this chapter provides information about how we do that, how statistics are reported and outlines some of the cost of having denials and why we want to prevent them."
- **Chapter 9:** A summary of the preceding chapters.
- **Chapter 10:** An appendix with some documentation requirements, Internet resources, more on incentive plans, and an assessment tool for registration departments "that's useful if you're a new manager and want to assess how well the department is meeting objectives." **(See excerpt from the Best Practice Registration Manual's assessment tool, p. 141.)**

Such resources make the manual effective at both helping managers and educating employees, Mitchell points out. "It's a reference — a guidebook that says, 'Here's the standard.' Managers should review it once in a while to make sure they stay focused on their goals."

Upon completion, the manual was presented to the top leadership at Adventist, approved, and then rolled out at a corporate meeting of patient financial services directors and admitting managers from all the hospitals, he says.

"Each site got copies," Mitchell adds, "and the information is also on the web site within our intranet for use electronically by all of our 20 hospitals and numerous clinics throughout the system."

(Editor's note: Ken Mitchell can be reached at mitcheke@ah.org.) ■

HIPAA privacy requirements considered 'burdensome'

First year smoother than expected

Providers and health plan representatives say two provisions of the HIPAA privacy rule — the requirement to account for certain information disclosures and the requirement to develop agreements with business associates that extend privacy protections "downstream" — are unnecessarily burdensome, according to a recent report from the Government Accountability Office (GAO).

While the report found that implementation of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule went more smoothly than expected during the first year after most entities were required to be compliant, a variety of issues that continue to be problematic were raised.

The GAO has recommended that the Department of Health and Human Services (HHS) modify the privacy rule to exempt public health disclosures from the accounting of disclosures requirements.

"This requirement is seen by many to have created a costly and unnecessary demand on providers and health plans, and a drag on the flow of information for purposes considered to be in the public interest," the GAO said.

"Public health entities noted that some states have had to take concerted action to ensure that providers' concerns about complying with the privacy rule do not impede the flow of important information to state health departments and disease registries," the report stated. "Some consumer

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advocacy groups told us that patients' families, friends, and other representatives have experienced unnecessary difficulty in assisting patients.

"These groups perceived that while providers and plans are allowed, in certain cases, to disclose health information without written patient authorization, they are reluctant to do so," the report continued.

Patients do not understand privacy rules

There also is indication that the general public is not well informed about their rights under the privacy rule. According to consumer and provider representatives, the report said, patients may not understand the privacy notices they receive, or do not focus their attention on privacy issues when the notices are presented to them.

"Some evidence of patients' lack of understanding is reflected in the 5,648 complaints filed with the Office for Civil Rights (OCR) in the first year after the privacy rule took effect," the report said. "Of the roughly 2,700 complaint cases OCR closed as of April 13, 2004, nearly two-thirds were found to fall outside the scope of the privacy rule because they either involved accusations of actions that were not prohibited by the regulation, involved entities that were not 'covered entities' as defined by the privacy rule, or involved actions that occurred before covered entities were required to be compliant."

Of those that were germane to the rule, the report continues, OCR determined that about half represented cases in which no violation had occurred.

The report, which can be found at www.gao.gov, recommended that HHS conduct a public information campaign to improve patients' rights under the rule. ■

EMTALA specialist expounds upon transfers

Expert says CMS is unclear on issue

An Emergency Medical Treatment and Labor Act (EMTALA) requirement regarding the responsibilities of hospitals when a patient is transferred to another facility was clarified recently by **Stephen Frew**, JD, a risk management consultant and EMTALA expert.

In a recent "EMTALA E-Bulletin," Frew included a Sept. 15, 2004 e-mail comment from the Boston Regional Office of the Centers for Medicare & Medicaid Services (CMS) that read as follows:

> "There is no EMTALA requirement for the sending hospital to identify who is the attending physician who will care for the patient at the receiving hospital. There is a requirement that the sending hospital show it has obtained agreement from the receiving hospital to take the patient. This is [stated] in 489.24(d)(ii)(B).
> "To show compliance with section 489.24(d)(ii)(B), it would be wise for the sending hospital to document who they spoke to at the receiving hospital. But the [regulations] don't say that only a physician can accept an incoming patient, or that the sending hospital has to have the identity of the attending at the receiving hospital — neither of these [things] is required by EMTALA."

Frew, who is the publisher of the web site www.medlaw.com, says that, while the CMS statement is technically correct — and does not represent a change in position by CMS — it is "not quite all the answer" and is not

automatically applicable to every reader.

"First, it is up to each hospital to determine the manner in which acceptances are to be made," Frew points out. "It can be by clerical staff, administration, physicians, or even housekeeping, as long as it [happens] promptly and the hospital *facilitates* the transfer. That means they must follow their policies, make those policies known to callers, and help get prompt acceptance."

Hospitals that rely on on-call specialists to make the acceptances may do so, but put themselves at risk of the physician turning down a transfer without their knowledge, he explains. Case law says hospitals can be fined even if they did not know about the wrongful denial, Frew adds.

"The new guidelines also suggest that CMS will give consideration to hospitals that manage to arrange other physician coverage when an on-call [physician] fails or refuses to respond — and that logically would include the denial of transfer," he says. "The big issue here is that the hospital cannot cover for a violation it knows nothing about."

Secondly, Frew notes, some states require physician acceptance as part of state transfer laws, and if that is the case, EMTALA requires the hospital to comply with those laws or also be found in violation of EMTALA.

"Third, many hospitals have been cited on transfer acceptance issues where they have failed to document the time of acceptance, by whom acceptance was given, and who obtained the acceptance for the transferring hospital," he says.

"While this note [from CMS] indicates [this action] is desirable," Frew adds, "it should be worded more strongly than that to accurately reflect CMS citation practices." ■

Immigration status report not required, CMS says

Hospitals will not be required to report a patient's immigration status to receive funding for uncompensated emergency care provided to undocumented immigrants, the Centers for Medicare and Medicaid Services has said in a letter to the American Hospital Association (AHA).

The Medicare Modernization Act included $250 million for each of the next four years to offset the costs of providing care to undocumented immigrants. But to qualify for that funding, CMS' proposed implementation plan, posted in July 2004, would have required hospitals to obtain direct evidence of emergency patients' immigration status.

Hospitals and patient advocates expressed concern that the requirement would deter patients from seeking needed emergency care.

But in an Oct. 1, 2004 letter to AHA, as reported in the on-line news service "AHA News Now," CMS administrator **Mark McClellan** said "providers will not be asked — and should not ask — about a patient's citizenship status in order to receive payment under this program." ■

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