New HIPAA Regulations Implement HITECH Act
By Rachel A. Fernbach, Esq.

Earlier this summer, the U.S. Department of Health and Human Services issued proposed regulations implementing the changes to HIPAA that were contained in HITECH, the Health Information Technology for Economic and Clinical Health Act. HIPAA, as a part of the 2009 economic stimulus bill, provided $19 billion in federal funding in support of health information technology initiatives. In addition to the HITECH requirements, HHS also used the rulemaking opportunity to make necessary technical correction and other changes aimed at improving the workability and effectiveness of the current HIPAA rules. The following represents some key aspects of the proposed regulations.

Business Associates
Perhaps the most significant changes included in the proposed regulations are global revisions that directly apply the requirements of the privacy and security rules to business associates. HITECH requires that business associates comply with all HIPAA rules and requirements previously imposed only upon covered entities. Also, in an attempt to exert some control over the flow of information downstream, subcontractors of business associate are now also subject to HIPAA, even if there is no business associate agreement in place between the business associate and the subcontractor. In addition, the definition of breach has been expanded to include health information exchanges (entities that oversee and govern the exchange of health-related information), prescribing gateways and vendors of personal health records, such as Google Health. HHS also pointed out that the HIPAA privacy requirements would apply to cloud computing arrangements, such as those in which health information is processed and maintained by a cloud computing service provider without the covered entity’s knowledge. HHS also proposed significant changes to the way personal health information (PHI) about deceased individuals is treated. Under the current privacy regulations, PHI about a deceased is generally treated the same as PHI about a living person, i.e., an authorization is required from the decedent’s personal representative for any uses or disclosures other than for treatment, payment or health care operations. However, HHS now proposes to exclude the definition of PHI information about a person who has been deceased for more than 50 years. If finalized, this would mean that PHI about a person deceased more than 50 years could be used or disclosed for any reason, without authorization. The regulations also propose to create a new permissive disclosure to friends and family members of decedents who were involved in the decedent’s care or payment for care prior to the decedent’s death, unless such disclosure is not consistent with the decedent’s prior expressed preference of the decedent (if known to the covered entity).

Minimum Necessary
Under the current HIPAA privacy regulations, covered entities are required to limit their uses and disclosures of PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request. In order to expand this rather vague definition, the HITECH Act called upon HHS to issue guidance on the minimum necessary standard. HHS has responded by calling for public comments to assist in the drafting of guidance on this important issue.

In the meantime, however, HITECH directed covered entities seeking to comply with the minimum necessary rule to use or disclose only a limited data set of information, creating a safe harbor of sorts. A limited data set is PHI that excludes certain direct identifiers, such as name, address, telephone number, social security number or account numbers. HITECH also provided that, with the prior disclosure of PHI, the covered entity or business associate making the disclosure shall determine what constitutes the minimum necessary. However, the leverage granted to providers in this situation is only temporary because the HITECH minimum necessary provision is set to expire in 2015.

President’s Message
By Glenn Martin, M.D.

Health information technology (HIT) is in the news. It has probably been in the news for at least a decade now, but recently there has been more talk of implementation, deployment or an inflection point. (Apparently the old “paradigm shift” is no longer operative!) This development has been catalyzed by the federal government finalizing its definition of meaningful use. While the criteria of an electronic medical record (EMR) must possess in order for the clinician to benefit from the substantial additional payments available to them beginning in 2011 through Medicare and Medicaid. In addition, at least in New York State, there has been a directed effort to expand HIT and data exchange for the treatment of psychiatric illnesses.

The state recently awarded $40 million to providers across the state to promote the medical home model and improve coordination of care for psychiatric patients through the adoption of electronic medical records, electronically EMRs and health information exchange. In many areas of the state, EHR adoption is strongly supported, independently of the federal program, so a practitioner may receive many of the dollars and dollars for purchasing a robust EMR with integrated practice management functions. During this same time it seems that Medicare and Medicaid have voiced concerns about the risks associated with these developments. Generally they come in three flavors, the inadequacy of current electronic medical records to meet the requirements of the privacy and security standards and non-HITECH related changes aimed at improving the workability and effectiveness of the current HIPAA rules.

Economically and Clinically Healthy Act

By Rachel A. Fernbach, Esq.

Glenn Martin, MD

In the meantime, however, HITECH would still focus on the requirement to use or disclose only a limited data set of information, creating a safe harbor of sorts. A limited data set is PHI that excludes certain direct identifiers, such as name, address, telephone number, social security number or account numbers. HITECH also provided that, with the prior disclosure of PHI, the covered entity or business associate making the disclosure shall determine what constitutes the minimum necessary. However, the leverage granted to providers in this situation is only temporary because the HITECH minimum necessary provision is set to expire in 2015.

New Federal Program: Provide Financial Incentives for Providers Who Use Electronic Health Records
By Rachel A. Fernbach, Esq.

Starting in 2011, Medicare and Medicaid providers who adopt an electronic health record (“EHR”) technology in their practices will be eligible to receive significant financial incentives. The EHR incentives program was created under Title IV of the American Recovery and Reinvestment Act (“ARRA”) and is aimed at encouraging the adoption and use of certified EHR technology, apply only to providers who participate in either Medicare or Medicaid. Under ARRA, both hospitals and non-hospital based care providers are eligible to receive payments; however, this article will focus only on incentives for individual providers.

The U.S. Department of Health and Human Services issued final regulations on the incentive programs this past July. In order to be eligible for the incentives, a provider must refer to the minimum necessary rule to accomplish the intended purpose of the use, disclosure or request. In order to expand this rather vague definition, the HITECH Act called upon HHS to issue guidance on the minimum necessary standard. HHS has responded by calling for public comments to assist in the drafting of guidance on this important issue.

In the meantime, however, HITECH directed covered entities seeking to comply with the minimum necessary rule to use or disclose only a limited data set of information, creating a safe harbor of sorts. A limited data set is PHI that excludes certain direct identifiers, such as name, address, telephone number, social security number or account numbers. HITECH also provided that, with the prior disclosure of PHI, the covered entity or business associate making the disclosure shall determine what constitutes the minimum necessary. However, the leverage granted to providers in this situation is only temporary because the HITECH minimum necessary provision is set to expire in 2015.

Financial Incentives for Providers

Starting in calendar year 2011, Medicare providers who are meaning- ful users of EHR are eligible to receive an annual payment add-on for a total of five years, as follows:— $15,000 in the first payment year (or $8,000 if the first payment year is 2011 or 2012, rewarding those who act quickly to implement EHR);— $12,000 in the 2nd payment year;— $8,000 in the 3rd payment year;— $4,000 in the 4th payment year; and— $2,000 in the 5th and final payment year.

In order to be eligible for the five-year payment add-on, an eligible professional must adopt EHR technology no later than calendar year 2014. If a provider fails to adopt and use EHR technology by the end of 2014, the individual will be subject to a reduction in Medicare fee schedule, as follows:— 1% reduction in 2015;— 2% reduction in 2016; and— 3% in 2017 and each subsequent year.

Starting in 2018 and later, HHS is permitted to increase the penalty amount by 1% per year, but not to exceed more than a 5% reduction. Physicians practicing in a rural area with limited Internet access may take advantage of a significant hardship exception which allows them to avoid penalties for a period of up to five years.

Medicaid Payment Incentives

By Rachel A. Fernbach, Esq.

The Medicaid incentive program provides

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his past year, as part of a continuing effort to increase efficiency of funding, simplify structure and reduce costs, the APA decided to make some corporate changes regarding its three affiliated entities: The American Psychiatric Association, Research and Education (APRIE), American Psychiatric Foundation (APF), and American Psychiatric Institute, Inc. (APPI). APPI was merged into the APA while APRIE and APF were merged into a new charity. The APA, under its own roof, will conduct fundraising, research and public education. The reasons for the reorganization and what the result should simplify the APA’s tax, audit and regulatory compliance requirements. The changes were also designed to make more efficient provision of services, as separate entities, including the APA Foundation, which will provide assistance with licensure and certification, advocacy with third party payers and development, to provide greater clarity and accountability. The APA also noted that it could allow for more efficient provision of services, including the APA Foundation, which will provide assistance with licensure and certification, advocacy with third party payers and development.

Information for Contributors
The Bulletin welcomes articles and letters that NYSAPA members will find timely, relevant and compelling. Articles should be between 750 and 1500 words (three to five double-spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

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his edition of the Bulletin includes a summary of electronic medical records, including the President’s Report and an article that reviews new Medicare and Medicaid programs that provide financial incentives. We also have a summary of the new HIPPAA Regulations related to health information technology.

The Area II Trustee’s Report provides an overview of APA initiatives on the national level. The Area II Report summarizes key legislative issues in New York State. Finally, we have a list of 2010 contributors to the NYSAPA Political Action Committee. One way to have an impact on behalf of all our patients and profession, is to contribute to the PAC.

Finally, I want to encourage people to register with APA. If you have an email address so you can receive timely updates via our Bulletin.

FROM THE EDITOR’S DESK...

Jeffrey Borenstein, M.D.

Area II Trustee's Report: The “New” American Psychiatric Foundation, Update on DSM-V, Practice Guidelines, Scope of Practice, Election Disclosure

James Ninninger, M.D.

Finally, I want to encourage people to register with APA. If you have an email address so you can receive timely updates via our Bulletin.

The Office of Professional Practice Services, on behalf of the APA Board of Trustees, is educating legislators about a proposal to introduce legislation to permit psychologists to prescribe in the state. The Office of Professional Practice Services, on behalf of the APA Board of Trustees, is educating legislators about a proposal to introduce legislation to permit psychologists to prescribe in the state. The Office of Professional Practice Services, on behalf of the APA Board of Trustees, is educating legislators about a proposal to introduce legislation to permit psychologists to prescribe in the state.
President’s Message

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upon the issuance of final guidance. It still remains to be seen exactly how HIPAA will address the privacy provisions in its guidance document.

Right to Request Privacy Protections for Your Medical Information

Under current law, individuals are entitled to request restrictions on uses and disclosures of their health information for treatment, payment and health care operations, but the covered entity is not necessarily required to agree to a requested restriction. However, under HITECH, a covered entity must comply with a patient’s request to restrict information if the information is to be sent to a health plan for payment of health care operations purposes and the patient paid out-of-pocket in full for the health care service involved (assuming the disclosure is not otherwise required by law).

In the preamble to the proposed rule, HHS acknowledges the intent of the legislature in permitting patients to pay out-of-pocket for certain services in order to restrict the disclosure of their health information to health plans. Taking it one step further, the proposed rule clarifies that patients may also be prohibited from requiring patients to pay out-of-pocket for all services in order to have any requested restriction honored. By way of example, the pre-amble states: “an individual who regularly

is the same provider for the treatment of both asthma and diabetes must be able to restrict the use or disclosure of information on asthma-related care in addition to other mental health treatment. The provider cannot require that the individual apply the restriction to all care given by the provider and, as result, cannot require the individual to pay out-of-pocket for both the diabetes and asthma-related care in order to have the restriction on the diabetes care honored.”

A similar situation might arise in the case of a primary care provider who provides treatment for both mental health in addition to treatment for other medical conditions. Under HHS’ interpretation, such a patient would be prohibited from requiring the patient to pay out-of-pocket for all services in order to restrict disclosures of only mental health related information, as long as the patient pays out-of-pocket for the mental health treatment. Needless to say, this issue is rather complex and may be further complicated when prescription medications and pharmacies are involved. As a result, HHS specifically solicited public comment on situations where this particular provision might prove excessively difficult or confusing to patients.

Notice of Privacy Practices

The proposed regulations set forth new requirements for the contents of the Notice of Privacy Practices, the document distributed to patients that describes in detail how a provider will use and disclose an individual’s PHI. HHS proposes to require that the Notice contain a specific list of the types of uses and disclosures that require a patient authorization, as well as use of psychotherapy notes and in connection with marketing and fundraising activities. In addition, in an attempt to alleviate any confusion about the use or disclosure of psychotherapy notes, covered entities would be required to explicitly state in the Notice that uses and disclosures of psychotherapy notes require an authorization.

NPSA Comments

In response to the proposed regulations, NPSA prepared and submitted comments that focused on the issue of psychotherapy notes. NPSA argued that HHS should provide additional guidance on the definition of the term psychotherapy notes and the exact interpretation of the phrase ‘separate from the rest of the medical record.’ Under the current privacy rules, it is unclear whether the term separately means on a separate sheet of paper in a paper chart, in a separate file in an electronic medical record, or maybe even on the same page as other non-psychotherapy note material, but in a clearly labeled, separate section.

NPSA pointed out that if a provider chooses not to separate psychotherapy notes from the rest of the clinical record, then psychotherapy notes do not exist for the purposes of HIPAA and therefore special protections would apply. In that case, there would be no reason to specifically state in a Notice of Privacy Practices that psychotherapy notes may be used or disclosed only upon patient authorization since that provider does not maintain any psychotherapy notes in the first place.

In the alternative, NPSA suggested that HHS eliminate the “maintained separately” requirement and instead require providers to redact psychotherapy note material from records prior to disclosure for treatment, payment or health care operations purposes. Records containing psychotherapy notes that are not redacted could be used or disclosed only upon written authorization from the patient. This approach would permit all patients to secure the privacy protections afforded by the psychotherapy notes exception regardless of the documentation approach of the provider. The legislative text of the Privacy Rule and its special treatment of psychotherapy notes.
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vides for payments to individual states to non-hospital based Medicaid providers. Under Medicaid, the pay- ment is in the form of a reimbursement for costs associated with EHR technology including purchase and initial implementation or upgrade training, maintenance and day-to-day operation. Although participation in the Medicaid incentive program is voluntary for states, CMS personnel have indicated that they expect all 50 states to participate at this time. In order to be eligible for the Medicaid incentive program, Medicaid patients must represent at least 30% of the provider’s patient volume. To calculate Medicaid patient volume using the patient encounter method, the regulations propose the following formula: Medicaid encounters in any 90 day period in the preceding calendar year divided by total encounters in the same 90 day period. Medicaid providers who are meaningful users of EHR are eligible to receive an annual payment incentive for a maximum of six years of no more than $21,250 in the first payment year and no more than $8,500 in five subsequent payment years. There is an important exception for eligible professionals applying for incentives under the Medicaid program – if the provider has adopted, implemented or upgraded EHR technology in the first payment year, the provider does not have to demonstrate actual meaningful use until the next reporting year. Medicare vs. Medicaid

Providers who participate with both Medicare and Medicaid may receive incentive payments from only one program. In order to be eligible for the Medicare incentive program, the provider must waive the right to any incentive payments made under the Medicare program. However, the regulations do permit providers to switch between the programs after receiving at least one payment, but they are permitted to switch only once and only for payment years prior to 2015.

Assigning Payments to an Employer or Other Entity

Eligible professionals are permitted to assign their incentive payments to an employer or other entity they have entered into a contract with whereby the employer or entity bills and receives payments for the provider’s covered services. Each eligible professional may reassign their incentive payment to only one employer or entity per reporting period. However, assignment designations may be changed each reporting period, as necessary, if the provider changes employment or engages with a new entity.

Further, an entity is permitted to receive assignments from multiple eligible professionals during one reporting period. For example, if an entity employs 10 eligible professionals (including part-time employees) during a reporting period, all 10 providers are permitted to assign their payments to that entity (e.g., under the Medicaid program, $21,250 per payment year, multiplied by 10). However, for eligible professionals who work at multiple sites, in order to be considered a meaningful user of EHR, at least 50% of the professional’s patient encounters during the reporting period must occur at a location or locations that are equipped with the EHR technology.

Trustee’s Report continued from page 2

had raised concerns about this in the past. The Board agreed with the policy that those running for office continue to provide the same disclosure forms as those serving on components of the APA, and that general disclosure of percent of income derived from pharmaceutical or medical device industries be made available and published in Psych News. However, specific information regarding candidates’ stock holdings and investments will not be required. Candidates may, of course, be asked by members for more details during the campaign.

Classifieds

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from one party or the other arrive in Albany in January they are all likely to find the normally inhospitable winter weather considerably less chilling than the economic forecast for the state. The projected state budget deficit for FY 2011-2012 stands at $8.2 billion and growing.

A Quick Look Back on the 2010 Session

The status of several scope of practice bills and other bills of interest to NYSPA members has changed since the last Albany Report (see page 4, Summer Bulletin 2010, Vol. 54, #2).

The updates are noted as follows:

• A.179-A – The Governor vetoed the bill, which would have allowed a nurse practitioner to issue an order to not resuscitate.

• A.179 – The Governor vetoed the bill, which would have required a hospital’s governing body to consider a psychologist’s application for staff membership or professional privileges.

• A.817-B – The Governor signed the bill, which eliminates the requirement that a midwife practice with a written collaborative agreement with a physician.

• S.623-C – The Governor signed the bill known as Ian’s Law, which prohibits insurers from discriminating against an entire class or group of policies as a pretext or with the intent of dropping a high-cost individual’s insurance policy.

• A.5602 – The Governor vetoed the bill, which would have required the Department of Health to research and study the “violent side effects” of medications prescribed for attention deficit disorders and attention hyperactivity disorders to school-aged children.

• A.30/301 – The Governor signed the bill, which provides a five year extension of New York’s Assisted Outpatient Law, Kendra’s Law, thereby extending it to June 30, 205.

• S.8088 – The Governor signed the bill, which requires insurers to get prior approval from the Superintendent of Insurance before raising health insurance premiums for individuals and small businesses (50 or fewer employees) and raises the medical loss ratio for these two markets from 75 percent to 82 percent.

This year, during the “regular” session of the New York State Legislature (January-June) physicians in this state came closer than ever to no losing a number of major battles on scope of practice issues. A confluence of factors too convoluted to do justice to in a few words enabled organized medicine, psychiatry included, to capture several victories from the opposition. Nevertheless it was alarming that a number of these bills could not be stopped in the Legislature, indicating a shift in sentiment on the part of committee chairs and leadership in one or both houses. The experience has alerted us to wonder about methods and messages going forward. Several meetings are and will be taking place with MSSNY and a broad spectrum of specialty societies on the subject of strategic planning for the 2011 legislative session and beyond.