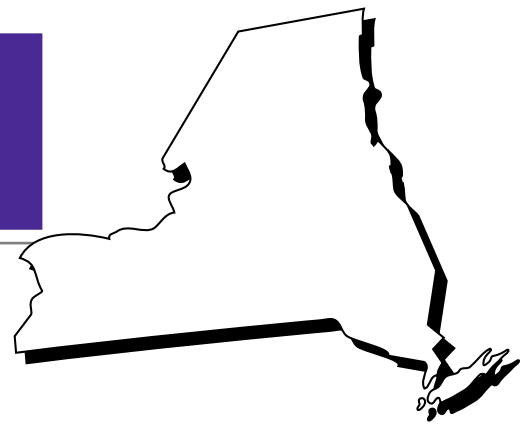


THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Fall 2010, Vol. 54, #3 • Bringing New York State Psychiatrists Together



President's Message

By Glenn Martin, M.D.

Health information technology (HIT) is in the news. It has probably been in the news for a decade now, but recently there has been more talk of implementation reaching a tipping 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; that is, the characteristics 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.



Glenn Martin, MD

The state recently awarded \$120 million to projects across the state to promote the medical home model and improve coordination of care to psychiatric patients through the adoption of technology, specifically EMR's and health information exchange. In many areas of the state EHR adoption is strongly subsidized, independently of the federal program, so a practitioner may receive many thousands of dollars of subsidies for purchasing a robust EMR with integrated practice management functions. During this same time it seems that many psychiatrists have voiced increasing concerns about the risks associated with these developments. Generally they come in three flavors, the inadequacy of current electronic medical

subsidized, independently of the federal program, so a practitioner may receive many thousands of dollars of subsidies for purchasing a robust EMR with integrated practice management functions. During this same time it seems that many psychiatrists have voiced increasing concerns about the risks associated with these developments. Generally they come in three flavors, the inadequacy of current electronic medical

[See **President's Message** on page 3]

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. HITECH, 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 corrections and other non-HITECH related changes aimed at improving the workability and effectiveness of the current HIPAA rules. This article will focus on 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 business associate has now been expanded to include health information exchanges (entities that oversee and govern the exchange of health-related information), e-prescribing gateways and vendors of personal health records, such as Google health.

PHI About Decedents

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 decedent 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 from 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 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 would be inconsistent with the 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 respect to disclosures 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 provisions sunset

[See **HIPAA** on page 3]

Albany Report

By Richard J. Gallo, Barry B. Perlman, MD and Jamie Papapetros

Since this Albany Report was prepared, the elections have taken place and the struggle for control of the State Senate, as reported below, is still uncertain but leaning toward the Republicans recapturing the majority in the upper house. As of this writing, Republicans have won 30 seats, Democrats have won 29 seats (32 constitutes a majority) and three seats are too close to call -- Senate Districts: 7 (Nassau County), 37 (Westchester County) and 60 (Niagara and Erie Counties). While most political pundits are speculating that the Republicans will emerge as victors in two of the contests, a final determination could be weeks away as the matter of what gets counted and what doesn't works its way through the courts.

In other news, we are pleased to report that on October 25, 2010, the State Insurance Department issued Circular Letter No. 17 clarifying that pursuant to §3224 of the Insurance Law insurers:

1. Must accept and initiate processing of all health care claims submitted by psychiatrists or other physicians pursuant to, and consistent with, the current version of the American Medical Association (AMA) current procedural terminology (CPT) codes, reporting guidelines and conventions, including Evaluation and Management (E/M) CPT codes; and
2. May not limit the types of CPT codes that it accepts from psychiatrists or other physicians to the codes specifically designated as "psychiatric" in the AMA's CPT codes, reporting guidelines and conventions.

This action on the part of the Insurance Department successfully concludes a two and a half year quest on the part of NYSPA to obtain this outcome. For a copy of the Circular Letter visit: http://www.ins.state.ny.us/circltr/2010/cl2010_17.htm

As of this writing we political observer types are anxiously awaiting the 2010 election results and listening to pundits opine as to what it all means from their decidedly partisan perspective.

The races for statewide office in New York State: Governor (Lieutenant Governor), Attorney General and Comptroller are interesting and at times entertaining but the real story in

[See **Albany Report** on page 5]

New Federal Programs Provide Financial Incentives for Providers Who Use Electronic Health Records

By Rachel A. Fernbach, Esq.

Starting in 2011, Medicare and Medicaid providers who adopt electronic health record ("EHR") technology in their practices will be eligible to receive significant financial incentives. The incentive programs, created under Title IV of the American Recovery and Reinvestment Act ("ARRA") and 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 health care providers are eligible to receive payment incentives; 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, referred to in the regulations as an eligible professional, must become a meaningful user of EHR technology. For calendar year 2011, an eligible professional is considered to be a "meaningful user" of EHR technology if the professional: (i) uses EHR technology in a meaningful manner, including electronic prescribing; (ii) exchanges health information electronically to improve quality of care; and (iii) uses EHR technology to report clinical quality and other measures. The definition of meaningful use may be revised by future regulation.

Medicare Payment Incentives

Starting in calendar year 2011, Medicare providers who are meaningful 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 \$18,000 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, they forever forfeit the right to receive the EHR payment incentive.

At the same time, if an eligible professional is not a meaningful user of EHR 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 never 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

The Medicaid incentive program pro-

[See **EHR Incentives** on page 6]

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The Bulletin welcomes articles and letters that NYSPA 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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The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. *The Bulletin* is received by members of the American Psychiatric Association who belong to a district branch in New York State. *The Bulletin* is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. *The Bulletin* is published quarterly. Both classified advertisements and display advertisements are available. Please contact the editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

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FROM THE EDITOR'S DESK... By Jeffrey Borenstein, MD

This edition of the *Bulletin* includes a focus on 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 HIPAA



Jeffrey Borenstein, MD

Regulations related to health information technology.

The Area II Trustee's Report provides an overview of APA initiatives on the national level. The Albany Report summarizes key legislative issues in New York. Finally, we have a list of

2010 contributors to the NYSPA Political Action Committee. One way to have your voice heard, on behalf of our patients and profession, is to contribute to the PAC.

Finally, I want to encourage people to make sure that NYSPA has your email address so you can receive timely updates via our E-Bulletin. ■

Area II Trustee's Report: The "New" American Psychiatric Foundation, Update on DSM-V, Practice Guidelines, Scope of Practice, Election Disclosure By James Nininger, M.D.

This past year, as part of a continuing effort to increase efficiency of functions, simplify structure and reduce costs, the APA decided to make some corporate governance changes regarding its three affiliated entities: The American Psychiatric Institute for Research and Education (APIRE), American Psychiatric Foundation (APF), and American Psychiatric Publishing Inc. (APPI). APPI was merged into the APA while APIRE and APF were merged into a new charitable 501(c)(3) entity that will oversee fundraising, research and public education. The reasons for the reorganization are complex, but the result should simplify the APA's tax, audit and regulatory compliance requirements. The changes will also allow for more efficient provision of member services, including assistance with licensure and certification, advocacy with third party payers and development of clinical updates of the DSM and Practice Guidelines.

The newly formed board of the new fundraising entity is comprised of several individuals from each of the three prior boards: Dr. Jack Barchas, Dr. Grayson Norquist and Dr. Jeffrey Lieberman from APIRE; Dr. Richard Harding, Dr. James Nininger and Judge Steven Leifman from APF; and Dr. Laura Roberts, Dr. Donna Norris, and Dr. Amy Ursano from APPI. Dr. John Oldham, APA President-Elect, Dr. David Fassler, APA Treasurer, and Dr. Alan Schatzberg, APA Immediate Past President, will serve as ex officio members and Dr. Scully will serve as Chair.

Programs conducted under the original American Psychiatric Foundation will continue. The *Typical or Troubled?* program has educated over 35,000 teachers and school personnel. The *Helping Hands* grant program has supported 22 schools with approximately \$32,000 to help medical students cultivate an interest in psychiatry. The Minority Mental Health Awards have provided needed support to underserved populations. The Partnership for Workplace Mental Health's network now includes over 4,000 businesses and other stakeholders and is a recognized national resource for employers committed to advancing effective approaches to mental health. Our partnership with *Give an Hour* has helped to grow the volunteer network to more than 5,000 members willing to donate time to treat our veterans and their families. A nationally distributed PBS television show on mental health, hosted by Dr. Jeffrey Borenstein, is now available to over 60% of US television households. Additionally, consistent support for APIRE research and APA programs will continue to be provided through the new foundation.

The development of DSM-V is proceeding and is scheduled to be published in



James Nininger, MD

May, 2013. Proposed diagnostic criteria were posted this past February on the website and more than 8,600 comments were received over a two month period and reviewed by the thirteen DSM-V work groups.

Field trials to assess the current diagnostic criteria will occur at eleven academic sites (seven adult and four pediatric). Fourteen hundred psychiatrists will be involved, including those specializing in geriatric and addictive disorders, picked randomly from the AMA database, and 500 each of social workers, nurse practitioners, and psychologists will also be involved. Attempts are being made to focus on age, gender, cultural variables, risk and protective factors, and associated laboratory findings for each disorder. ICD-10, which does not specify diagnostic criteria, is scheduled to be adopted October 1, 2013, and efforts are being made to determine DSM-V chapter headings and diagnostic terms by October 2011 for their inclusion and coordination with ICD-10.

The third edition of APA's Practice Guideline for the Treatment of Patients with Major Depressive Disorder has been published on PsychiatryOnline.com and as a supplement to the October American Journal of Psychiatry. The document has had a complicated history of development, in part due to the 2008 Institute of Medicine report calling for clear boundaries between industry funding and educational activities. In June 2009, the APA Board of Trustees established a new policy that chairs and vice chairs of practice-guideline work groups should not receive more than \$10,000 a year from direct services to industry, including speaking and consulting, as had been established for those involved in the development of DSM-V. Because some members of the workgroup who wrote the original document, which was approved by the Assembly in May 2009, had had some industry ties to the pharmaceutical industry, the APA under then-President Alan Schatzberg, M.D., together with the new chair of APA's Steering Committee on Practice Guidelines, Joel Yager, M.D., appointed an independent panel to review the guideline before its approval by the APA Board of Trustees. The panel, chaired by Victor Reus, M.D., consisted of experts in depression treatment without current ties to industry. The panel determined the guideline was free of bias and the Board then approved it for publication this past March.

While the publication has been significantly delayed, the panel process and the planned minimization of industry ties in work group leaders and members drafting future guidelines will serve to reinforce the integrity of the guidelines

and help avoid perceptions of bias. APA's guideline development process is being revised to conform to principles issued by the Council on Medical Specialty Societies (CMSS) recommending that chairs of work groups and the majority of work group members that develop practice guidelines not have significant conflicts of interest. For future APA Guidelines, recommendations will be separately rated according to strength of evidence and strength of recommendation, and expert opinion will be determined through formal surveys of research and clinical experts who are identified by a blind nomination method.

Regarding Scope of Practice activities, in the State of Oregon, Governor Ted Kulongoski vetoed legislation that would have put in motion a psychologist prescribing program. The Oregon Psychiatric Association coordinated efforts with the Oregon Medical Association, the APA, patients and other advocates. To ensure the Governor's veto, the coalition of individuals and organizations collaborated with Psychologists Opposed to Prescribing by Psychologists and with county NAMI chapters to formally oppose prescribing legislation. Other bills were defeated in Arizona, Hawaii, Illinois, Mississippi, Utah and the U.S. Virgin Islands. Since 1995, bills to grant prescribing privileges to psychologists have been considered 106 times, in 25 different States and the U.S. Virgin Islands and defeated 104 times. As you know, psychologists won prescribing privileges in New Mexico in 2002 and in Louisiana in 2004.

Our Department of Government Relations distributes its annual "Advocacy Readiness Assessment" to all District Branches and State Associations to alert them to the various components necessary for solid advocacy efforts. The Ohio Psychiatric Physician Association is educating legislators about a proposal to introduce legislation to permit psychologists to prescribe in the state prison system. Since 2001, the Committee on Advocacy and Litigation Funding has issued advocacy grants to twenty-six DB/SAs. The Fund to Defeat Psychologist Prescribing Legislation, made up solely of member donations, has provided more than \$3 million to DBs and SAs. APA continues to be a key member of the Scope of Practice Partnership (SOPP) working with the AMA, other national medical specialties and the state medical societies on scope of practice legislation. A rough estimate allocated to scope of practice issues since 2001 by APA (grant, staff, other) is more than \$5 million.

At the recent Board of Trustees meeting in September, 2010, I raised the issue of what disclosures are appropriate for those running for national APA office. An Action Paper passed by the Assembly

[See **Trustee's Report** on page 6]

President's Message continued from page 1

records, the potential loss of privacy and confidentiality for our patients, and the intrusiveness of the government reporting mandates which implement and expand pay for performance plans. As is frequent in our profession many views are based on the individual's experience, practice location and type. Psychiatrists in large hospitals and the VA system have used parts of an EMR for years. While they will complain about the poor human interface and unintuitive nature of many of the products they recognize the advantages of being able to access a legible more or less complete record, of having built in decision support at least for med-med interactions and allergies, and the marked decrease in having to re-order tests and procedures because of missing results, etc. For those in a paper based private practice, where there are not intensive care coordination needs or complicated medical management, there is little familiarity with the EMR and little if any perceived need to obtain one.

Data exchange is clearly an area of concern. On one hand it is well established that the life expectancy of the severely mentally ill is shortened. Medical co-morbidities are frequent, and with recognition of obesity, diabetes and cardio-vascular problems as expected side effects of many of our treatments this is only increasing. No one can argue that tighter communication between a patient's psychiatrist, primary care provider and associated specialists would not be to the patient's benefit. However, health information exchanges are designed to facilitate the exchange of information, thus the process is primarily automated. There is little or no human oversight to filter out "juicy" but non-crucial information. Breaches of privacy are most likely only noted after the fact by audits or complaints. Unlike a banking error, a mistake is not easily corrected by the

infusion and/or transfer of funds. Once a medical secret is revealed the damage to reputation, social standing, etc. cannot be undone. New York State does allow information to be loaded into an exchange prior to obtaining a patient's consent, but does not allow access to the identifiable information without a patient's permission except in emergencies. Since tight control over individual pieces of data is currently impossible or impractical, patients are informed that if they grant permission to access their medical information they are doing so for all available information, however, it is limited only to providers or organizations they know about and approve. It is outside the scope of a short column to explain the immense difficulties around tagging certain information as sensitive and treating it differently. A valproate level ordered by an internist may be just as revealing of a diagnosis as one ordered by a psychiatrist but the computer wouldn't know which one is sensitive. The system may be programmed to block certain medications from being shared, but this may be worse than nothing as it gives an incomplete picture to other prescribers who try to prescribe safely. Additionally, even with an effort to filter at the level of the EMR, it is likely things will slip through as different providers cover for another, or as data sources change, e.g. from the pharmacy to the benefit manager to the MD's EMR.

And while we debate these issues of patients' control of information and a desire to minimize confidentiality losses it is still important to realize the quantity of information that is already shared on the non-clinical billing and benefits side of the equation. Express-scripts and Medco, Medicaid and Medicare, and the large commercial insurers already have tons of revelatory claims data. The question is how to

have information that needs to be shared to improve a physician's ability to help a patient be handled in a way that doesn't unduly increase risk. To reframe the question, given that society has already assumed a great deal of risk to privacy to facilitate insurance coverage and payment, what are the acceptable incremental risks to achieve direct patient care benefits?

As for those who are shocked by the sorts of data that the government has listed as needing to be reported to attain meaningful use and thus be eligible to receive heightened reimbursement, I would suggest that once again it is location, location, location. Most hospital based psychiatrists are used to robust QA programs that look at process and clinical outcomes. Were weights done and labs drawn and AIMS performed on patients on anti-psychotics? Were blood sugars and BPs under control, etc? As long as they are reported in the aggregate without identifiers, many have accepted this as either a necessary evil to increase reimbursement (pay for performance), or a rational effort to improve care by monitoring outcomes and giving feedback to providers and patients. For the moment at least no one is obligated to report on these measures from a private office, unless they are interested in the pay for performance perks, or to get a heavily subsidized EMR. (I will ignore for now the fact that many if not all Hg A1C are being reported from the labs directly to the NYC Department of Health, without many clinicians, and certainly virtually no patient any the wiser).

I believe a few principles can be taken from the debate:

- No one should be forced to participate in a health information exchange.
- NYS should issue regulations that will govern these exchanges and psychiatrist and patient advocates


should be at the table while they are being debated. The legislature recently gave the commissioner of health the ability to do this.

- Physicians should not be forced to adopt an EMR or participate in a data exchange, though carrots and sticks will continue to be used to influence our decisions.
- Technology has to improve to allow for a better usability by physicians, staff and patients, and the ability to identify, segment and granularly control data sharing has to be improved. Government, purchasers and professional societies should all work to those goals.

The rational dispassionate evaluation of risks v. benefits and the voluntary decision to opt in or out should be the fundamental principles governing physicians' and patients' participation in this electronic transformation of healthcare.

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HIPAA continued from page 1

upon the issuance of final guidance. It still remains to be seen exactly how HHS will interpret these provisions in its guidance document.

Right to Request Privacy Protections for PHI

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 or 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 that health information to health plans. Taking it one step further, the proposed rule clarifies that covered entities are 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 preamble states: "an individual who regular-

ly visits the same provider for the treatment of both asthma and diabetes must be able to request, and have the provider honor, a restriction on the disclosure of diabetes-related treatment to the health plan as long as the individual pays out of pocket for this care. 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 mental health in addition to treatment for other medical conditions. Under HHS' interpretation, the primary care provider would be prohibited from requiring the patient to pay out-of-pocket for all services in order to restrict disclosures of only the mental health records, 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 enforce.

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 details how a provider will use and disclose an individual's PHI. HHS proposes to require that the Notice now contain a specific list of the types of uses and disclosures that require a patient authorization, such as use or disclosure 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 most uses and disclosures of psychotherapy notes require an authorization.

NYSPA Comments

In response to the proposed regulations, NYSPA prepared and submitted comments that focused on the issue of psychotherapy notes. NYSPA suggested that HHS 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 separate simply 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.

NYSPA 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 no 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, NYSPA suggested that HHS eliminate the "maintained separately" requirement and instead require providers to redact psychotherapy note material from records prior to disclosures for treatment, payment or health care operations. Likewise, medical 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 while still promoting the full intent of the Privacy Rule and its special treatment of psychotherapy notes. ■

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this election is which political party wins control of the State Senate for the next two years and by how many seats. The outcome of the Senate races is important because one of the most challenging and important responsibilities of the incoming Legislature will be

to reconfigure the geographic boundaries for the New York State Congressional districts as well as their own Senate and Assembly districts, all of which will stand unchanged for the next ten years. The process, which coincides with the United States Census

data compiled at the beginning of each decade, is controlled by the majority in both houses and has been historically the key opportunity for securing long-term electoral advantages for the parties in power. Hence, the election is seen as a "do or die" situation for Senate

Republicans. Of course, this is not a matter of concern in the Assembly where the Democrats enjoy a 107-43 member majority over their Republican colleagues.

Regardless of how many individuals
[\[See Albany Report on page 6\]](#)

EHR Incentives continued from page 1

vides for payments by individual states to non-hospital based Medicaid providers. Under Medicaid, the payment 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 second payment year.

Medicare vs. Medicaid

Providers who participate with both Medicare and Medicaid may receive incentive payments from only one pro-

gram. In order to be eligible for the Medicaid 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 receive 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 designa-

tions 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 in the first 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.

Please feel free to contact me at nininger@bestweb.net with any comments, questions, etc., or issues you would like me to address in future columns. ■

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Albany Report continued from page 5

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*).

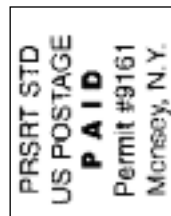
The updates are noted as follows:

- A.1719-A – The Governor vetoed the bill, which would have allowed a nurse practitioner to issue an order to not resuscitate.
- A.1729 – 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.8117-B – The Governor signed the bill, which eliminates the requirement that a midwife practice with a written collaborative agreement with a physician.
- S.6263-C – The Governor signed the bill known as Ian's Law, which prohibits insurers from discontinuing 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.10790 – 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, 2015.
- 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.

CORRECTION: The chart printed in NYSPA Summer 2010 Bulletin should have reported that NYSPA supports legislation that would allow collective negotiation by physicians (A.4301-B/S.5204A) and medical liability reform (A.6184/S.6799).

This year, during the "regular" session of the New York State Legislature (January-June) physicians in this state came closer than ever to 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. ■



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