

Red Flag Rules – Yet Another Reprieve on the Enforcement Date

by Tricia Hoffman-Simanek

We have been talking about Red Flag Rules for years now (it was enacted in 2003). Once again (for a fifth time), at the request of several member of Congress, the deadline has been extended through **December 31, 2010** (from June 1, 2010).

As noted in previous newsletters, the Federal Trade Commission's current position is that the Red Flag Rules do **apply** to many participants in the healthcare industry. If you have concerns about whether the Rule is applicable to your organization, contact Tricia at phs@shuttleworthlaw.com.

During the extension period, Congress is considering legislation that would affect the scope of entities covered by the Rule. It should be noted that the enforcement delay does **not** extend to the rule that applies to users of consumer reports when an address discrepancy is found. ■

Case Law Update

by Nancy Penner

Several recent cases of interest to the health care world are summarized below.

New protocol for releasing a victim's mental health records in a criminal proceeding

In a July 2, 2010 opinion, the Iowa Supreme Court addressed a criminal defendant's right to a victim's mental health records. In *Iowa v. Cashen*, 2010 WL 2629827 (Iowa 2010), the Court established a "protocol" for the attorneys and the district court to use to strike "the proper balance between a victim's right to privacy in his or her mental health records and a defendant's right to produce evidence that is relevant to his or her innocence." *Cashen* involved a charge of domestic abuse assault.

Many providers already have excellent procedures in place

concerning if, and when, records are produced in response to a subpoena (as opposed to an authorization signed by the patient). And, in general, providers understand that subpoenas *alone* are usually not sufficient to authorize the production of records. The *Cashen* case adds steps in the process before a crime victim's mental health records can be produced.

Here are the steps established by the Iowa Supreme Court (steps 1-3 are relevant to providers):

1. The criminal defendant's attorney must file a motion with the district court, demonstrating why the records are relevant. *The defendant's attorney "shall not subpoena a victim's privileged records without a court order."*
2. The county attorney notifies the victim that the records have been requested. If the victim consents to disclosure, *the*

district court will issue a subpoena for the records to be produced under seal to the district court. If the victim objects to disclosure, the district court will hold a hearing and issue a subpoena only if there is a reasonable probability the records are relevant. Again, records are only produced under seal to the district court.

3. If the district court orders the records to be produced, the attorneys may inspect the records *at the courthouse*. The records cannot be copied for the attorneys and the information cannot be disseminated by the attorneys.

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4. If the defendant believes some records are relevant to the defense, he or she will notify the district court of those records.

5. The district court will hold a hearing to determine if the records are relevant and can be actually copied and produced.

In summary, providers should no longer be receiving subpoenas from attorneys for a victim's mental health records in a criminal matter. These subpoenas should only come from the district court. Further, such records are only to be produced to the district court at the courthouse and under seal. Compliance with the above should satisfy responsibilities under HIPAA. If you have any uncertainty as to whether the proper procedures are being followed, you should contact either the county attorney involved in the matter (hopefully identified on any subpoena you receive) or your own legal counsel.

Paramedics not included in the physician-patient privilege

Iowa Code §622.10 provides that a person's confidential communications to certain professionals are protected by a "privilege"—in other words the communications are protected against forced disclosure. The list of professionals includes attorneys, counselors, physicians, PAs, ARNPs, nurses, social workers, mental health professionals, and clergy. In *Iowa v. Gates*, 2010 WL 2598334 (Iowa Ct. App. 2010), the Iowa Court of Appeals held that communications to a paramedic are not protected by this privilege because the statute does

not expressly include paramedics. This means that a paramedic may testify about what a patient told the paramedic, even if the patient does not consent to that disclosure.

Physician disciplined for unauthorized access to medical records

In an action that again demonstrates the legal consequences of confidentiality breaches, in June 2010, the Iowa Board of Medicine published a Statement of Charges and Settlement Agreement concerning a physician who "inappropriately accessed the medical records of a patient who was not under her care, in violation of patient privacy standards." The physician (who had been terminated from a residency program), received a citation and warning from the Board of Medicine, was assessed a \$2,500 civil penalty, and was ordered to complete an ethical educational program.

Most unusual "donee" under the Anatomical Gift Act trumps the family

In a case involving rather unusual facts, a cryonic suspension company prevailed over the family of a deceased man. *Alcor Life Extension Foundation v. Richardson*, 2010 WL 1875687 (Iowa Ct. App. 2010) involved Orville Richardson's 2004 authorization for Alcor Life Extension Foundation to take possession of his remains upon his death and cryopreserve his head and cremate the rest of his body. Alcor's business was based upon "the hope that future medical

development will allow the restoration of life and health." Orville paid Alcor a lump sum of over \$50,000. Orville later developed dementia and family members were appointed as guardian and conservator. When Orville died in 2009, his family did not notify Alcor and had Orville buried. When the family requested a refund of the \$50,000, Alcor demanded Orville's remains.

The issues before the Court included whether the arrangement with Alcor fell under Iowa's Uniform Anatomical Gift Act ("Gift Act") and who had the right to control the disposition of Orville's remains—Alcor or the family. The Court held that Alcor met the definition of a proper donee under the Gift Act as it was "an appropriate person for research." The Court also addressed the fact that Orville's arrangement with Alcor was not one aimed at saving or improving the lives of others (a stated purpose of the Gift Act) and that Orville paid Alcor (and the Gift Act prohibits the sale of body parts). While the Court had "some concerns" with Orville's transaction with Alcor, those concerns were not sufficient to place the transaction outside the scope of the Gift Act.

As to who had the right to control Orville's remains, the Court held the Gift Act trumped another Iowa statute—the Final Disposition Act. Essentially, the rights of the donee under a valid anatomical gift were superior to next-of-kin. The Court also ordered that the family allow disinterment of Orville's remains so that they could be provided to Alcor. ■

Health Care Reform and Providers

by Jennifer Hennessy**

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (PPACA), which was later amended by the Health Care Education and Reconciliation Act. These two pieces of legislation constitute the current efforts at health-care reform.

The following is an overview of many of the PPACA provisions that more directly affect health care providers. Future newsletters will cover additional topics, such as fraud and abuse and Accountable Care Organizations.

While there are many sites with summaries and commentary devoted to health care reform, the federal government recently launched healthcare.gov. While aimed at the consumer, the site summarizes provisions that impact providers as well.

Provisions impacting individual providers

PPACA enacts several provisions designed to increase the number of primary care providers and general surgeons. These provisions generally increase reimbursements for these health care providers and adjust medical education requirements to provide incentives for individuals entering the health-care profession to practice in primary care specialties.

Incentives to Strengthen Primary Care Workforce

- *Grants to Training Hospitals:* The Secretary of Health and Human Services (hereinafter, the Secretary) is authorized to award grants to training hospitals to plan, develop, or operate accredited training programs in family medicine, general internal medicine, and general pediatrics (§5301), and to establish and expand primary care residencies. §5508. Additionally, the Secretary is required to award grants to medical schools to recruit and train students likely to practice medicine in underserved rural communities. §10501
- *Medicare Bonus Payment:* Physicians and other healthcare providers engaged in select evaluation and management activities are eligible for a 10% Medicare bonus payment beginning on January 1, 2011. General surgeons practicing in health professional shortage areas are also provided with a 10% payment bonus for certain major surgical procedures. §5501.
- *Medicaid Reimbursement:* Medicaid payment rates to primary care physicians for furnishing primary care

services must not be less than 100% of Medicare payment rates in 2013 and 2014. §1202.

Changes to Medical Education

- *Time Spent in Non-Provider Setting:* Time spent by interns or residents in patient care activities in a non-provider setting will be counted toward hospital direct graduate medical education and indirect graduate medical education if the hospital covers the costs of the stipends and any benefits, beginning on July 1, 2010. §5504
- *Non-Patient Activities:* Time spent by interns and residents in a non-provider environment, in non-patient care activities (such as conferences and seminars, but not research) shall be counted toward full-time equivalency for direct graduate medical education. §5505
- *Redistribution of Residency Slots:* Allows for redistribution of unused residency slots to encourage training of primary care physicians and general surgeons beginning July 1, 2011. The Secretary will compare the resident limit for each hospital with a residency program to the highest resident level that hospital has had in the prior three years for which a cost report has been submitted. If the hospital has fewer residents than its limit would allow, its resident limit will be reduced by 65% of the unused slots. The slots will be redistributed to hospitals that apply to increase their resident limits. §5503
- *Additional Funding for National Health Service Corp (NHSC):* PPACA provides \$1.5 billion in additional funding for the NHSC between 2011 and 2015. The NHSC provides scholarships and student loan repayments for health care providers. §5207.
- *Student Loan Refunds:* Prior to the passage of PPACA, medical students receiving a Primary Care Loan (PCL) had to practice in a primary care specialty until the loan was repaid. Now, the physician must practice in a primary care specialty until the loan is repaid or ten years, whichever occurs first. If the physician fails to fulfill this obligation, the loan accrues interest at a rate 2% higher than the initial rate per year (versus the 18% rate that was triggered upon default prior to the PPACA). §5201. Additionally, PPACA establishes a loan repayment program for physicians agreeing to work for at least two years in a pediatric medical specialty in a medically underserved area. §5203.

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– *Nursing Student Loan Program*: PPACA increases the maximum amount of loan funds a nursing student can receive. §5202. Additionally, PPACA provides funding for nurse retention and promotion programs. §5309

Medicaid/Medicare Expansion

– *Reduce State-by-State Variation*: Medicaid will cover individuals up to 133% of the federal poverty level to help reduce state-by-state variation in eligibility for Medicaid. The federal government will pay the entire cost of coverage for newly-eligible individuals from 2014 to 2016. In 2017, the federal government will pay 95% of the cost of coverage; 94% in 2018, 93% in 2019, and 90% in 2020 and subsequent years. §2001.

– *Medicare Coverage of Wellness/Prevention Activities*: Medicare will cover the cost of annual wellness visits and personalized prevention plan, with no copayment or deductible. §4103.

Performance Measures

PPACA requires the development of quality measures and then links payment to performance in regards to those measures.

– *Pay For Performance*: Acute care hospitals have been required to report information regarding certain quality measures to the Secretary for several years. Prior to the passage of PPACA, failure to report led to payment reductions. Beginning with discharges occurring on or after October 1, 2012, the amount of Medicare payment an acute care hospital actually receives will be linked to the hospital's performance on certain quality measures. The Secretary will develop incentive payments for common and high-cost conditions, including acute myocardial infarction, heart failure, pneumonia, surgeries, and healthcare associated infections. The Secretary will announce performance standards at least 60 days prior to the beginning of a performance period. Hospitals that meet or exceed the performance standards will receive incentive payments. If the hospital does not meet a performance standard, the base operating DRG payment amount is decreased for the fiscal year following the performance period. §3001. Additionally, physicians who report quality data will continue to receive incentive payments through 2014. Beginning in 2015, physicians

that do not submit quality data will see their Medicare payments reduced. §3002.

– *Quality Reporting Measures*: PPACA requires the Secretary to implement quality reporting measures for a variety of health care providers. The Secretary must publish such measures for long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric hospitals, and hospice programs by October 1, 2012. Long-term care hospitals and inpatient psychiatric hospitals must begin submitting quality data by July 1, 2003, and inpatient rehabilitation hospitals must begin doing so by October 1, 2013. Providers that fail to submit such quality data will face a two-percent reduction in Medicare payment updates. §3004

– *Preventable Readmissions*: Effective October 1, 2012, a hospital's readmission rate for certain conditions (initially heart attacks, heart failures, and pneumonia) will be compared to its expected readmission rate and hospitals with high rates of preventable readmissions will see their Medicare payments reduced. The Secretary will determine what counts as a "readmission." §3025.

***The federal
government recently
launched a website
devoted to the Act:
healthcare.gov.***

– *Disproportionate Share Hospital (DSH)*

Payments: Beginning on October 1, 2013, payments to disproportionate share hospitals (DSH) will initially be reduced by 75%. Thereafter, increases in payments will be based on the percentage of the population that is uninsured and the amount of uncompensated care provided. The reasoning is that most individuals should have insurance coverage by 2014 due to the individual coverage mandate. PPACA also eliminates any judicial or administrative review for factors used to calculate the DSH payment. §3133

– *Hospital-Acquired Conditions*: To incentivize hospitals to improve their infection control programs, PPACA requires the Secretary to identify hospitals in the top quartile of all hospitals nationally for hospital-acquired conditions, and reduce Medicare payments to those hospitals by one percent, effective October 1, 2014. The meaning of "condition" remains unclear, as PPACA allows the Secretary to determine what "conditions" are appropriate to be included here. A report on the infection rates will be available to the public. §3008

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– *Medicare Payments Adjusted for Quality/Cost of Care*: The Secretary will develop a payment system that will adjust Medicare physician payments based on the quality and cost of care the physician delivers. The payment system will be phase in over a two-year period beginning in 2015. §3007

Initiatives, research, pilots, and programs

PPACA creates several programs and initiatives designed to study ways to improve the overall quality of health care, as well as reduce costs.

– *Independent Payment Advisory Board*: PPACA establishes a fifteen-member Independent Payment Advisory Board that is responsible for submitting annual recommendations on how to reduce costs and improve quality to the President, Congress, and private entities. In years when Medicare growth is below the targeted growth rate, the Board's recommendations are not binding on Congress. However, in years where Medicare costs are above the targeted growth rate, the Board's proposals will take effect unless Congress passes an alternative that will result in the same level of savings as the Board's recommendation. §3403

– *Center for Medicare and Medicaid Innovation (CMI)*: PPACA establishes the CMI within the Centers for Medicaid and Medicare Services (CMS). The purpose of the CMI is to test innovative payment and service delivery models to reduce costs and enhance the quality of care. The CMI should be functioning by January 1, 2011, and

has a \$10 million budget through 2019. §3021

– *Demonstration Project*: PPACA establishes a five-year demonstration project to study bundled payments under Medicaid for hospital and physician services, beginning on January 1, 2012. Participating hospitals must have, or establish, robust discharge planning programs for placing patients in post-acute care settings.

– *Pilot Program on Payment Bundling*: PPACA establishes a five-year Medicare voluntary pilot program for integrating care across hospitals, physicians, and post-acute care providers during an "episode of care" for certain medical conditions, beginning on January 1, 2013. The hope is that payment bundling will result in Medicare savings. PPACA allows for expansion of the program beginning January 1, 2016 if the pilot is successful. §3023

– *Trauma Center Development*: PPACA establishes a new trauma center program to strengthen emergency department and trauma center capacity. PPACA provides funding for research on emergency medicine and develops demonstration programs to evaluate innovative models for emergency care systems. §3505

– *Publication of Charges*: All hospitals operating in the U.S. must create a list of the hospital's standard charges for items and services, and make the list available to the public. The effective date for this provision is unclear. §2718 ■

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