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New immunization requirement for 6th grade entry

Beginning with the 2010-2011 school year, a dose of Tdap vaccine is required for Alabama students age 11 years or older, entering the 6th grade.

This requirement increases by one successive grade each year for the following 8 years to include sixth through twelfth grades, through the fall of 2016.

For the school year 2013-2014, all students in grades 6-9 not previously receiving Tdap at age 11 years or older are required to have a Tdap vaccination.*

*For questions, please contact the Immunization Division at 1-800-469-4599.

ADPH.ORG
The Stethoscope of 2020

When Laennec invented the stethoscope in 1816 and physicians no longer had to put their ear to the patient’s breast, health care delivery changed. Asepsis, effective treatments for syphilis and other breakthroughs soon followed. By 1910, everyone was aware that medical training and practice needed updating. “Heroic” treatments (such as blistering, bleeding and purging) were known to cause harm to patients and were avoided. Patients had been exposed to newfangled technology such as antisepotic surgery, vaccinations and public sanitation. Most of the public understood the advantages of scientific medicine, though they didn’t know quite what it was. Almost all physicians now wanted to say they were practicing in a scientific manner, though, in truth, many were not.

Abe Flexner was hired to assess the state of medical education in 1910 and determine if the schools were up to providing practitioners for the scientific age. As a result of his report, the ideal of medical education and practice changed. The new leaders envisioned a system “in which physician scientists were trained in laboratory investigation as a prelude and foundation for clinical training and investigation in university hospitals. All physicians had a responsibility to generate new information and create progress in medical science, with assignment of this task to both laboratory and clinical scientists.” This system was created and was dominant for almost 100 years.

In 2007, the American Medical Association offered a critique of the care we Flexnerian physicians deliver. The good news: Doctors who train and practice in the Flexnerian model are knowledgeable and technically proficient in providing care for acute disease; they wish to do what is best for their patients; and patients respect them as credible sources of information.

The bad news? To paraphrase from the report, though many of us do try very hard, all of us are deficient to some degree in the following areas:

- Physicians are not prepared to evaluate the care they provide in their own practices and to use the results to improve patient safety and the quality of care provided, as well as participate in lifelong practice improvement.
- Physicians are generally not prepared to be advocates for patients on issues related to social justice (for example, elimination of health care disparities and access to care) and to be citizen-leaders inside and outside of the medical profession.
- Physicians often lose altruism and qualities of caring as they proceed through training and enter the practice environment.
- Because of their training, physicians find it difficult to deal with the inevitable uncertainty arising from incomplete or conflicting information. Additionally, they are not typically prepared to convey their uncertainty when interacting with patients and colleagues.
- Many physicians are not prepared to utilize information technology to assist in information acquisition and management.
- Physicians are trained to be autonomous. This can be a barrier to providing patient-centered care, where patient values and desires are an integral part of shared decision-making. The expectation of autonomy diminishes the ability of physicians to act as team players with other physicians and other health professionals.
- Physicians are not prepared to participate in ethical and political discussions about the allocation of health care resources, which are not limitless.
- Graduates do not acquire skills in cultural competence/awareness and to recognize that some patients may have health literacy issues.

In the future, we must perform consistently better. Partly as a response to the findings in this report, our Academy and others signed on to the joint principles that now form the basis for the patient-centered medical home (PCMH) model of primary care de-

Continued on page 13
Executive Summary
A comparison of the health status of Alabama’s citizens to nationally recognized health status indicators show that rural Alabamians do not compare well with the United States as a whole or even with Alabama’s urban population. Alabama’s rural residents have significantly poorer outcomes than urban residents. While there are multiple and diverse barriers to improving the health status of Alabama’s rural residents, the most significant and universal is their inability to access a primary care physician — and, more specifically, a family physician. Removing this barrier is dependent on having sufficient family physicians (availability) at appropriate locations throughout the state (accessibility) to meet the primary care demands of Alabama’s rural population. Global observation of the geographic location of Alabama’s rural hospitals and their associated communities indicates that they are spatially positioned in the state to serve as centers for primary care access.

To confirm that rural hospitals are, in fact, the appropriate service points for Alabama’s rural population and to determine the number of family physicians needed at each of these locations, this study used geographic information systems (GIS) technology and spatial analysis to create a spatial accessibility model unique for each of 99 general hospital locations in Alabama. This model used the known health care assets (family physicians), the population demographics and driving-time impedance, along with the practice variables panel size and office visits to make demand a function of local census-derived population data. Spatial analysis was then used to create area/provider ratios, which, in turn, were used to create bands of accessible populations at these locations. GIS software was then used to analyze the bands of influence and characteristics that fall within and outside of those bands to determine the family physician need at each of these 99 locations.

Findings
An extensive review of the health outcomes literature relative to primary care services, primary care access and primary care providers finds that patients of primary care physicians had better health outcomes regardless of the geographic area, year or outcome measured. Traditionally derived physician/population ratios using the 2012 medical licensure database and the 2010 Alabama census data finds that the supply of primary care physicians in rural Alabama is inadequate to meet the current rural population demand, thus making access to a primary care physician a major barrier to improving the health status of Alabama’s rural citizens. Literature review also finds that the primary care physician with the most extensive impact on population health outcomes is the family physician.

A geographical survey of medical facilities and primary care providers in rural Alabama found that the most appropriate medical facility to serve as a center for rural accessibility is the rural hospital. The rural hospital is also the community resource that historically and currently is the major recruiter of family physicians to rural communities. Review of the 2010 medical licensure database finds that the most available primary care physician practicing in communities where rural hospitals are located are family physicians.

Applying spatial accessibility analysis to the location of Alabama’s general admission hospitals and using the family physicians located within a 20-minute driving time of each hospital as their primary care assets finds that Alabama’s rural hospitals are geographically located and spatially distributed within the state to allow Alabama’s rural population physical access to a family physician. To meet the population demand for family physicians, this study shows that Alabama currently needs an additional 76 family physicians in 25 locations throughout the state. Of the 25 locations where family physicians are needed, 23 are in rural Alabama. Mapping of coverage bands for metropolitan hospitals shows that metropolitan coverage bands have no significant effect on rural populations.

Conclusions
Community-oriented access to primary care through a relationship with a family physician is the most functional and practical way to improve the health status of Alabama’s rural population. The communities in which Alabama’s rural hospitals are located are spatially distributed throughout rural Alabama in a manner that allows Alabama’s rural residents physical access to a family physician.

Rural hospitals are the most essential resource for recruiting, retaining and supporting the rural family physician. In this model, rural hospitals are the geographic locations for primary care access, and family physicians managing 2,650-person panels are the availability assets at each of these sites. A rural health plan based on a family physician/rural hospital model for access to primary care as described in this presentation is realistic and achievable. It directs Alabama’s current rural physician pipeline activities and sets the stage for the expansion and addition of activities to recruit and educate a cohort of rural students to be family physicians while identifying and designating the rural communities where state and federal resources can be utilized with local resources to maximize recruitment and retention of family physicians.

In short, this model provides a foundation for expanding our current primary care coverage in general and to pursue more in-depth analysis of workforce issues and barriers to primary care access based on the micropopulations at individual rural sites. It identifies local strengths and needs and gives focus for developing public and private partnerships, rural public policy, legislative support, pilot projects and rural outcomes research. It gives direction to rural educational programs.

For more information and to read the entire report, please visit: www.uab.edu/medicine/home/rural-medicine.
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ALABAMA PROVIDERS USING MEDISYS COLLECT OVER $3 MILLION IN INCENTIVES
During the first month of the 2013 Alabama Legislative Regular Session, two bills in the organized-medicine-backed “drug-diversion package” passed the House Health Committee. Those bills, HB 150 and HB 152, refine and update the PDMP database (prescription-drug monitoring program) for controlled substances and combat “doctor-shopping” by patients seeking controlled-drug prescriptions from multiple providers within a concurrent period of time.

HB 150 (“PDMP bill”) would:
• Allow physicians needed access to the database for better monitoring their own prescriptions and the prescriptions of those authorized to do so under their supervision
• Allow physicians to designate two employees under their supervision to access the database on the physicians’ behalf, saving physicians valuable time
• Allow the Medicaid Agency to access the database for inquiries concerning prescription abuse by Medicaid patients
• Allow interoperability between Alabama’s database, the Department of Justice and other states and allow law-enforcement officials access to the database in certain circumstances in order to help them combat prescription-drug abuse

HB 152 (“doctor-shopping bill”) would:
• Allow law enforcement to effectively prosecute “doctor-shoppers,” those patients going from one physician to another obtaining the same or similar controlled drug prescriptions at the same time
• Protect the physician-patient relationship by clarifying that an individual would have to attempt to “deceptively” obtain the multiple controlled-drug prescriptions during the “concurrent time period” to violate the act
• Provide that initial convictions for “doctor-shoppers” would be Class-A misdemeanors with a fourth conviction in a five-year period constituting a Class-C felony

HB 150 and HB 152 work in concert with the third piece of legislation in the “drug-diversion” package: HB 151, a bill regulating pain management in the state.

HB 151 (“pain management bill”), by Rep. Weaver, would:
• Define “pain management” and allow the Board of Medical Examiners (BME) to promulgate rules
• Would require annual registration with the BME
• Would allow unannounced inspections
• Would allow for license suspension in the case of a public health danger and allow for disciplinary actions

Together, the three bills comprehensively tackle the complex issue of drug diversion in Alabama. The AAFP appreciates the sponsors of the three bills; Rep. Jim McClendon of Springville, chairman of the House Health Committee; and Rep. April Weaver of Alabama for their diligence on the issue and their leadership during the committee hearing in which the bills were voted upon favorably.

While some objections to the bill to license and regulate pain clinics in Alabama have been voiced by some nonphysicians and entities that may own or manage pain clinics, the legislation is designed to help solve the drug-diversion epidemic in Alabama. The AAFP is working with Rep. Weaver, who sponsors the pain management bill, to move it through the committee process with a favorable vote. Once this bill is approved by the House Health Committee, the three-bill package can move to the floor as a group, where the full House of Representatives can approve it, which will be a significant step toward combating prescription-drug abuse in Alabama.

The three-bill package in the House has a companion package in the Senate, where Sen. Cam Ward of Abbeville is the sponsor. The bills are assigned to the Judiciary Committee, which Sen. Ward chairs, but have not yet been scheduled for a hearing.

“Ban the Tan” Bill Would Keep Minors Out of Tanning Salons
House Bill 179 by Rep. Ron Johnson of Sylacauga would regulate tanning facilities and prohibit minors from patronizing these businesses. Figures indicate that up to one-third of U.S. teenagers use tanning beds, with 40 percent of those doing so regularly. Shockingly, Birmingham has one of the highest rates of per capita tanning bed use in the country. While Alabama has no state law preventing children from using tanning devices, similar legislation has already passed in surrounding states to protect children and provide oversight of the indoor tanning industry.
For more information on the “Ban the Tan” legislation, visit the UAB Department of Dermatology website, www.uab.edu/medicine/dermatology.

Members, our best offense and defense when lobbying our Legislature are making personal constituent contact with your legislators when a piece of legislation is in the Senate and/or House health committees. Below you will find contact information for both chambers.

The Academy will continue to keep you apprised of legislative developments as they occur, but we need your help getting our message to these legislators. Together, we can continue to protect the practice of family medicine.

**Senate Health Committee**
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Sen. Gerald Dial
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Sen. Harri Anne Smith
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Sen. Cam Ward
124 Newgate Road
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Sen. Jabo Waggoner
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Sen. Tom Whatley
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Rep. John Knight
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Gadsden, AL 35904
256-546-1378

Rep. James Patterson
P.O. Box 286
Meridianville, AL 35759
256-985-7990

Rep. Allen Treadaway
P.O. Box 126
Morris, AL 35116
205-566-6835

Rep. April Weaver
P.O. Box 1349
Alabaster, AL 35007
334-242-7731
The Alabama Medicaid Agency should end its current fee-for-service model in favor of locally led managed-care networks that eventually can assume the responsibility and the risk for improving patients’ health outcomes, according to a report submitted to Gov. Robert Bentley on January 31 by the Alabama Medicaid Advisory Commission. Gov. Bentley created the 33-member commission by executive order in October, tasking the group with evaluating the financial structure of the Alabama Medicaid Agency and identifying ways to increase efficiency while also helping ensure the long-term sustainability of the agency.

State Health Officer Dr. Don Williamson, who served as commission chair, emphasized that both patients and taxpayers will benefit from such a change. “For the patient, it could mean they are going to have more encompassing care. For the agency, this will be the biggest fundamental change in Medicaid since its inception,” he said.

The commission’s recommendations included: (1) Alabama should be divided into regions, and a community-led network in each region should coordinate the health care services of the Medicaid patients in that region. (2) Regional care networks should formally engage consumer input and oversight at all levels of governance and operation. (3) The expanded regional patient care networks should become risk-bearing organizations. (4) Regions may choose to contract with a commercial managed-care organization to provide care, risk management or other services in the region; (5) The Legislature, where appropriate, and Medicaid, where administratively possible, shall authorize regional care networks throughout the state and establish an implementation timeline. Specific benchmarks shall be set that must be met by the networks. Failure to meet the benchmarks shall authorize state intervention. (6) The Alabama Medicaid Agency should seek an 1115 waiver from CMS to implement the transformation to managed care. And (7) Legislation should be developed to create a Medicaid cap, provided that the legislation ensures adequate flexibility for the Alabama Medicaid Agency to address federal mandates, rules and regulations; economic uncertainty; catastrophic health events; and provider rates.

Since the commission’s first meeting on November 1, 2012, members met several times to hear presentations from other state Medicaid programs, commercial managed-care organizations and Alabama Medicaid’s Patient Care Networks and to review cost and other data. Commission members include health care providers, legislative leaders, state health and human service agency officials, consumers and insurers appointed by the governor. Information on the Commission, including the final report, meeting minutes, presentations and membership, is available on the Medicaid website at www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.2.1_Med_Adv_Commission.aspx.

Provider Payment Accuracy Is Focus of State-Based RAC Program

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. Goold Health Systems (GHS), a Maine-based firm, has been selected to be Alabama Medicaid’s contractor for a two-year period that began January 1, 2013.

The RAC program is designed to improve payment accuracy by identifying underpayments and overpayments in Medicaid. The Medicaid RAC program is a separate program from the Medicare RAC, which is overseen by the Centers for Medicare and Medicaid Services.

Reviews will be conducted by the GHS staff to include full-time medical directors, pharmacists, certified professional coders and experienced clinicians. Audits will be conducted by GHS using a “top-down” approach where data analysis, through data mining, is applied against the universe of paid claims to identify patterns of utilization or billing that look atypical based on Alabama Medicaid and/or national standards. Following the high-level claims analysis, GHS may expand its review by requesting clinical records and/or other documents in accordance with state and federal regulations.

“Our goal throughout this process is to ensure that providers are paid accurately and that taxpayer dollars are spent as intended based on state and federal rules and regulations,” Program Integrity Director Jacqueline Thomas said.
Project Designed to Prevent Preterm Births in at-Risk Recipients

When babies are born too early, they are more likely to have serious health problems or to die. To combat this problem, the Alabama Medicaid Agency is teaming up with the state’s maternity care providers to reduce the number of premature, or preterm, births among Medicaid-eligible women.

The two-year project, which began February 1, is based on the American College of Obstetricians and Gynecologists’ recommendation that all pregnant women with a prior history of a spontaneous preterm birth at 37 or fewer weeks’ gestation be counseled on the benefits of taking 17-alpha hydroxyprogesterone caproate, or 17P, to prevent a second preterm birth.

“Preterm birth is associated with long-term problems such as neurologic handicaps, blindness, deafness and chronic respiratory disease, among others, especially in births before 30 weeks’ gestation,” Medicaid Medical Director Dr. Robert Moon said. He noted that conditions related to short gestation and low birth weight are the leading cause of infant death, based on a 2009 study conducted by the Alabama Perinatal Program.

In fiscal year 2011, the Alabama Medicaid Agency financed more than 50 percent of all deliveries in the state. Of the 31,028 Medicaid deliveries, 3,538 babies — 11 percent — received care in a neonatal intensive care unit at a cost of $57.8 million, or an average cost of $16,345 per baby.

According to Dr. Moon, the project has two goals. One is to help identify and refer maternity patients at risk for preterm births, and the second is to determine the use of 17P and the pregnancy outcomes in this population.

The first phase of the project will take place between February 1, 2013, and September 30, 2013. During this phase, maternity care coordinators will be trained to screen, educate and refer maternity patients at risk of having a preterm birth. If a patient is at risk of a preterm birth, a copy of the screening tool used will be provided to the patient’s medical provider for follow-up. After the screening and education process, data will be collected to determine how many patients were screened, how many recipients received educational materials and how many were referred to their delivering health care provider.

In the second phase of the project, the Agency will determine how many recipients who were referred actually received the medication and if the number of preterm births among at-risk patients improved while receiving the drug. This phase is scheduled to begin December 1, 2013, and continue through July 13, 2014.

Medicaid, ADPH Collaborate to Build New Enrollment System

Building on the past successes between the two agencies’ programs, the Alabama Medicaid Agency and the Alabama Department of Public Health are collaborating to build a new eligibility and enrollment system using current technology while saving millions of dollars for the state.

The new system will replace the existing architecture and structure of the current Medicaid system, which is more than 30 years old and suffers from inefficiencies common to older, outdated systems. By using departmental employees, the two expect to save $20 million in state and federal funds by building the system in-house.

During the project’s development, design and implementation phases, Medicaid and CHIP will complete the requirements for the Affordable Care Act (ACA) by January 2014 while creating a system that automates application processing. According to Lee Rawlinson, Medicaid deputy commissioner for beneficiary services, this will result in quicker and more accurate eligibility determinations for pregnant women, parents, ALL Kids and Medicaid children, and Plan First women.

“By using an agile development process and user-centered design principles, we will move the state through the design and implementation phases quickly to create a system that not only meets federal requirements but also the needs of the end-user,” Rawlinson said.

Once the first phase is completed, the next step will be to add the state’s elderly and disabled programs to the system by the end of 2015. The state also plans to investigate the feasibility of adding Department of Human Resources programs such as TANF, SNAP and Child Care. If approved by the Centers for Medicare and Medicaid Services, these programs could be integrated into the new system by December 2015.

A recent study by the Kaiser Commission on Medicaid and the Uninsured found that nearly all states are making changes to develop faster, streamlined Medicaid enrollment systems as required under the Affordable Care Act, whether or not they intend to expand Medicaid coverage under the law.
The U.S. Department of Health and Human Services published in the Federal Registrar on January 25, 2013, the HIPAA/HITECH Act Omnibus Final Rule. The Final Rule, effective March 26, 2013, modifies the requirements of the HITECH Act Breach Notification Rule and the HIPAA Privacy, Security and Enforcement Rules. Covered entities will be required to comply with most provisions by September 23, 2013. For covered entities and business associates, they will have an additional year to restructure their business associate agreements to comply with the Final Rule. Below, we have summarized the key provisions of the Final Rule.

I. Breach Notification Rule
The Final Rule revises the definition of a “breach” and the standard for determining whether patient notification is required. Previously, a covered entity or business associate was not required to notify patients of a breach of unsecured protected health information (PHI) if it determined, in good faith, that the breach would not result in a significant risk of harm to the patient. The Final Rule replaces the “harm” threshold with a “probability of PHI being compromised” threshold. The Final Rule states that any use or disclosure of unsecured PHI not permitted under the HIPAA Privacy Rule is presumed to be a breach requiring patient notification unless the covered entity or business associate demonstrates that there is a “low probability that the protected health information has been compromised.”

When determining whether there is a low probability that the PHI has been compromised, covered entities must take into account the following four factors: (a) the nature and extent of the PHI involved; (b) the unauthorized person who used the PHI or to whom the PHI was disclosed; (c) whether the PHI was actually acquired or viewed; and (d) the extent to which the risk to the PHI has been mitigated.

In addition, the Final Rule revises the definition of a “breach” to remove the exception for limited data sets that do not contain ZIP codes and dates of birth. Under the revised definition, an impermissible use or disclosure of such limited data sets is presumed to constitute a breach unless the covered entity or business associate is able to demonstrate there is a low probability that PHI has been compromised.

II. Business Associates and Contractors
Under the Final Rule, business associates and contractors are now required to comply with the HIPAA Security Rule. The Final Rule provides a transition period of an additional year for business associate agreements that are currently in existence to come into compliance with the Rule. For example, business associate agreements that existed prior to January 25, 2013, and that are not renewed or modified during the period from March 26, 2013, to September 23, 2013, should be revised to comply with the Final Rule by the earlier of two dates: (1) the date on which the agreement is renewed or modified; or (2) September 22, 2014. Business associate agreements that contain automatic renewal provisions without any additional change in terms do not trigger the earlier deadline.

III. Revised Privacy Notices
HHS has revised the Privacy Notices section of the Privacy Rule to require providers to include additional information. The Privacy Notices must now grant the recipient the right to receive the breach notification. The revised notices must also restrict health plans from using genetic information for underwriting purposes. In addition, covered entities must also obtain patient authorization before using PHI for marketing purposes and before selling PHI.

The revised privacy notices instituted under the Final Rule are considered to be material changes by OCR. Thus, covered entities will need to provide a revised Notice of Privacy Practices to individuals. Health plans may provide the revised Notice of Privacy Practices by prominently posting the revised notice in its office or on its website prior to September 23, 2013 (compliance deadline for the Final Rule), and by providing a copy of the revised notice in its next annual mailing.

IV. Penalties
The Final Rule increases the maximum penalty for a violation up to $1.5 million per violation.

V. Sale of PHI
Also included within the Final Rule is a prohibition on the sale of private health information without prior patient consent.

VI. Marketing
The Final Rule has created dramatic changes to the marketing and fundraising requirements. The rule requires that covered entities must obtain authorization before sending patients treatment or health care operations communications related to a company or product that the covered entity receives compensation.

VII. Disclosures to Health Plans
The Final Rule modifies the previous Genetic Information Nondiscrimination Act, which prohibits health plans from disclosing genetic information for underwriting purposes. It allows patients to pay cash for a visit, for treatment or for a procedure. If the patient does this, he or she may instruct the covered entity not to share the information with the patient’s health plan.

VIII. Conclusion
This new rule issued by HHS will work to strengthen the privacy and security protection for health information. It also has significant revisions to forms that health care providers use on a daily basis, however, and should be addressed very soon in order to meet the deadline of September 23, 2013.

Rich Sanders is president of the Sanders Law Firm, P.C. with offices in Atlanta, Birmingham, Montgomery and Jacksonville. The firm provides high-quality, affordable legal services to health care providers and can assist with compliance under the Final Rule. Rich can be reached at rsanders@southernhealthlawyers.com.
livery. Medicare, Medicaid and now private insurers such as Blue Cross of Alabama are rapidly moving to reward this type of care.

Medical schools have been forced to respond to the challenges outlined in this report. Both of the allopathic schools in Alabama have retooled their entire curriculum as a result, reducing the hours dedicated to “basic science” instruction. They introduced team-based learning, early patient experiences and lifelong learning techniques. The emphasis of the curriculum at both schools is on developing the skills necessary to practice medicine in the future.

Family medicine residencies have been at the forefront of providing instruction in the skills necessary to practice in the PCMH. Our Alabama residencies are leaders in the introduction of information technology into their setting, providing training in a team-based environment and in implementing practice-improvement initiatives. Our training programs are rapidly moving toward becoming PCMH-certified.

It is now time for our Academy to step up to the plate. Physicians currently in practice, who perhaps trained in the previous, dated system but intend to be in practice through 2020, will need skills in practice-based improvement. She or he will need to leverage technology to provide the best patient care possible. He or she will need to practice in an environment where the culture of the patient is honored. All will need to deal with uncertainty and constraints on resource utilization. In short, we will need to be able to lead the PCMH. Change will not be easy, but it is inevitable.

To offer support to this young physician group, the Academy is going to offer learning opportunities to develop skills to lead the PCMH. Beginning in June in conjunction with the summer meeting, we are going to provide a vehicle for ongoing instruction to those who feel that they want to practice using the precepts of the patient-centered medical home but who are lacking the training or experience to do so. Whether you are young or merely young at heart, I encourage you to take advantage of these opportunities. Once you use a stethoscope, there is no going back.

References

Classified

BIRMINGHAM:
The Alabama Disability Determination Service (DDS) invites letters of interest from family physicians wanting to work part-time as a medical consultant. The work is reviewing disability claims. An Alabama Medical License is required. The DDS is committed to maintaining a diverse workforce; and therefore, we encourage minority applications. If interested, please contact the Medical Staff Supervisor, DDS, Post Office Box 830300, Birmingham, Alabama 35283-0300.

Congratulations to Matthew Caldwell, MD, for being the 2012 Stan Brasfield, MD, Scholarship recipient for resident members. Dr. Caldwell is a past president of the ALAFP Student Chapter and is currently a first-year resident at the UAB Huntsville Family Medicine Residency Program in Huntsville, Alabama.
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