Title: Staying Ahead of the Curve: Key Compliance and Risk Management Issues for Practitioners
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During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. Have a question for our presenters? Type them in using the Q&A box located on your webinar screen. A link to the presentation slides will be posted in the chat box of your webinar screen. If you miss it, don't worry. We will email the slides with the recording.

Now, let me introduce our panel. Today's moderator will be Connie Galietti. Connie is the Managing Director for State Engagement with the Office of State Advocacy at APA.

Our speakers are Allison Funicelli. Allison is the Assistant Vice President for Risk Management Group, AWAC Services Company, a member company of Allied World.

Cara H. Staus. Cara is the Assistant Vice President for Risk Management Group, AWAC Services Company, a member company of Allied World.

Alan Nessman. Alan is the Senior Special Counsel for the Legal and State Advocacy Practice Directorate at APA.

Deborah C. Baker. Deborah is the Director of Legal and Regulatory Policy with the Office of Legal and State Advocacy at APA.

Rachel T. Soule. Rachel is the Director of Business Regulations and Independent Practice with the Office of Legal and State Advocacy at APA. Welcome all.

Connie Galietti: Thank you, everyone, for joining us today. We're going to have our presenters give their talks, and then, we are going to end with a Q&A. We had asked everyone upon registration to include some questions, so I don't know if we're going to have time for live Q&A once that is done because we got a lot. We're looking forward to a really wonderful program. Let's get started, hopefully, with Rachel.

Rachel T. Soule: Hello, everyone. Please, bear with me. I do have a lot of information to cover, so I'm going to try to do this fairly quickly. To start, I want to talk about the recent amendment to the HIPAA privacy rules that was issued by the Department of Health and Human Services. This amendment was meant to strengthen protections for specifically reproductive health information.

If you recall the Dobbs decision that came out about two years ago, it reversed Roe v. Wade, and this created a new legal landscape for reproductive health care with each state having their own laws either permitting, severely restricting, or prohibiting abortion. This has impacted not only the relationship between certain providers and individuals of reproductive age considering or pursuing certain reproductive health care, but also the flow of health information across state lines and the risks associated with disclosing that information.

For example, a psychologist being asked to provide information about patients who have received reproductive health services. The changes to the HIPAA privacy rule aim to ensure that this information is protected and individuals feel comfortable seeking this type of care.

Some of the key changes that I want to talk about. Under HIPAA, there is an exception that permits disclosure of PHI without patient authorization when required by law, such as disclosure to law enforcement officials. The main change in this new amendment is the prohibition on using a patient's PHI for investigations or to impose liability on someone for seeking, obtaining, providing, or facilitating lawful reproductive health care. In other words, there are now limitations on PHI disclosure related to reproductive health care services.

Under the rule, a covered entity or provider, like a psychologist, who receives a request for information must make a good faith effort to determine if the care was lawful based on the state where it occurred. I do want to note that in the rule, there's a presumption that the reproductive health care provided was lawful. This includes when a resident of one state travels to another state to receive reproductive health care, such as an abortion, that is lawful in the state where such health care was provided.

For example, if you are in a state that bans abortion and you have a patient who traveled and received a lawful abortion in a state where such care is legal. Let's move on to the next slide.

There's also a new requirement that a written confirmation or attestation must be obtained when there is a request for disclosure from the requesting party to confirm that a PHI request is not for a prohibited purpose. Again, the prohibited purpose

being for any type of legal or administrative action against someone involved in lawful reproductive health care.

This requirement to obtain a signed attestation, it puts the person or entity making the request for this information on notice of the potential criminal penalties for those who knowingly are in violation of HIPAA obtain and use this PHI. It also generally will give the provider receiving such a request confidence that the request is being made for a lawful purpose.

Finally, the last requirement is in the new rule is that your notice of privacy practices that needs to be signed by your patients, they need to reflect these changes. These amendments become effective at the end of this month, but compliance isn't required until the end of the year, so December 22nd, 2024. This includes everything except for the revisions to the notice of privacy practices, which won't be required until 2026, the beginning of 2026. Let's move on to the next slide.

How did this impact psychologists? As psychologists, especially those who work with patients of reproductive age, you'll want to review your current procedures for handling requests for patient health information to ensure that these procedures comply with the new limitations on disclosing information related to reproductive health care.

If your practice requires obtaining attestations, you also want to set up and establish some type of procedures for doing so. Then you'll need to update your notice of privacy practices to reflect these recent changes. Again, this requirement won't be necessary until 2026. Overall, by following these steps, psychologists can ensure that they are protecting the privacy of their patients' reproductive health information.

I do want to note that HHS provides a number of resources and guidance to assist covered entities and generally providers with complying with these new amendments. They also plan on publishing model attestation language before the compliance date, which will be a valuable resource and make any type of compliance much easier. Near the end of this PowerPoint, there are a bunch of links to this guidance from HHS, but APA is also going to put out some guidance that can help you. All right. Let's move to the next slide.

Now we're going to talk about the recent FTC ruling. In April this year, the Federal Trade Commission issued a final rule that significantly restricts non-compete agreements. This ruling is significant because it restricts employers from enforcing non-compete clauses with most employees. We see a lot of these types of clauses in psychological practices and similar health entities. This rule is now a federal rule, so it applies across the country, meaning, states that once permitted these types of clauses will no longer be able to do so. Let's go into some of the key points.

The first key point is that the ruling bans employers from entering into any new non-compete agreements with employees, and this can include psychologists after the effective date.

The second point is that existing non-compete clauses with most employees will no longer be enforceable. There is a narrow exception to the unenforceability of existing non-compete clauses, which includes when these clauses are between the employer

and a senior-level employee, as defined by the rule. How they define a senior level employee is those meeting the salary threshold of around $151,000 a year and holding a policymaking position. You'd have to meet both of those prongs to fit within that exception.

In other words, for workers, other than senior executives, as defined by the rule, attempting to enforce an existing non-compete clause, entering into a new non-compete clause, or claiming that the worker is subject or employee is subject to a non-compete clause constitutes unfair competition under the rule. I do want to know a couple of exceptions to this rule, and that includes when these types of agreements are in connection with the sale of a business or, for most, but not all, nonprofit organizations. We can move on to the next slide.

How does this ruling impact psychologists and their practice? The impact of the FTC ruling will vary depending on your employment setting. Psychologists employed by hospitals or clinics or other types of entities will likely see existing non-compete clauses become unenforceable, with the exception, again, of senior psychologists meeting the exemption criteria discussed earlier. This means for those types of psychologists, it can increase job mobility for these employees.

Now, for psychologists running small practices, those who previously used non-compete agreements to prevent departing employees from setting up competing practices, for example, with non-compete agreements now largely unenforceable, these psychologists will need to consider alternative strategies to protect their patient base and their business interests.

Some alternatives that small practices can use include drafting and having employees sign other types of restricted covenants or agreements. This can include confidentiality agreements or carefully drafted non-solicitation agreements. These types of agreements can help protect not only your trade secrets. They can help protect client information. They can also limit how former employees can solicit your patient. Still, these agreements must be narrowly tailored to be enforceable under this new rule.

I also want to note that it's important to remember that some states may have stricter regulations around these restrictive covenants. It's always important to check with your state's regulation. Let's go to the next slide.

I also want to note that this rule will and is currently facing many lawsuits. As of the end of May, there have been at least three lawsuits filed in federal court to reverse this rule. If the rule survives these legal challenges, it will become effective as early as the end of the summer, beginning-- actually, September 4th is the compliance date. However, legal challenges could delay or even prevent any type of enforcement of this rule.

Again, there is resources at the end of the slide deck, but also, APA does plan on publishing guidance that goes into more detail about how this ruling may impact psychologists. You can go to the next slide.

Alan Nessman: Okay. Thank you, Rachel, for covering all that content so quickly. Good afternoon, everyone. I'm going to talk quickly about good faith estimates under

the No Surprises Act. What is the requirement? The requirement is that you give your patient a good faith estimate of costs for your health services going forward. When did it start? It started in January of 2020. We're concerned that despite the flurry of attention and articles on this issue back in early 2022, some practitioners may have forgotten about these requirements. We also have a lot of people who've gotten out and become licensed since then and may never have heard about these requirements.

Since we have very limited time, but ample resources, I mainly want to make sure everyone's aware of these requirements and also know where to go for information and tools. You can find almost all of them in the first GFE resource on Slide 22. These slides will become available to you. These resources should contain almost everything you need to start putting out GFEs or continue the process as hopefully many people are currently in compliance with this.

A key question, and we just had a question from this recently from a member, "Which patients should get a good faith estimate or GFE?" It's for patients who don't have or don't intend to use their insurance. Eventually, CMS will propose regulations for the much more complex process of patients who do intend to use their insurance. In that case, the information is going to have to flow from the mental health practitioner to the insurance company.

Currently, that's nowhere on the horizon. An April release from CMS talked about how complex the process was, but had no estimate for even when the proposed regulations would come out. We're doing advocacy to try to make that process simple for practitioners.

Next question is how detailed does the GFE need to be? There are about 10 requirements for what needs to be in the GFE. Fortunately, those are all covered in the template that we have available in the resources. That's a template that's designed for a typical therapy practice to cover the types of certainty or uncertainty you might have around a therapy practice. Next slide, please.

These are the basic steps. All of these are covered in, again, in the resources on Slide 22, the Seven Steps resource. Step one is review the APA guidance. Again, that's at Slide 22. Number two, post a notice about GFEs for your patients. There's a sample notice from HHS that's contained in the Seven Steps document. Step three, determine if your patient should get a good faith estimate. Again, the test is does the patient have and intend to use their insurance? If the answer to both is no, they get a good-faith estimate. If the patient does get a GFE, you should give them one. This is the timing for appointments scheduled three to nine business days before the appointment. Provide a GFE within one business day after scheduling.

For appointments scheduled more than nine business days before the appointment, you have three days after scheduling to provide the GFE. Again, all this detail is covered in the Seven Steps document. Then you should update your GFE, especially when your actual costs of care exceed the estimate. We'll talk about that more in one of the questions coming up. That's it for now. We'll turn it over to, I believe, Deborah. Next slide, please.

Deborah Baker: Thanks, Alan. I'm going to talk to you for the next few minutes about telehealth with particular focus on-- well, some focus on HIPAA compliance, but also, interjurisdictional practice. When we're talking about telehealth, I think a lot of people think about it bifurcated between pre-COVID and post-COVID. Because of that, pre-COVID, there was a lot of policies in place supporting the use of telehealth, but it was really just a slow uptick among providers and in terms of payer policies. In response to the pandemic, obviously, that prompted a seismic shift in the use of telehealth by providers in terms of public health safety, as well as continuity of care.

As a result of the pandemic and the need for greater telehealth access, there have been a number of changes, both at the federal level and state level. For example, at the federal level, CMS had long been covering telehealth services for Medicare beneficiaries prior to the pandemic. In response to the pandemic, it increased or it either temporarily waived or eliminated a number of the restrictions that previously had been in place, now ensuring greater health access for telehealth or mental health, behavioral health telehealth services for Medicare beneficiaries.

One of those, for example, is the use of audio-only services, the ability to receive telehealth services in the home. Some services, such as psychological and neuropsychological testing are still temporarily allowed, but without a legislative fix or changes with the final rule, that isn't certain at the moment.

Also, at the state level, there were a number of waivers in place during the pandemic that allowed for a more robust use of telehealth. Since that time, states have eliminated those waivers, and so, some states have responded in terms of beefing up their telehealth policies to ensure that there's still a robust adoption or use of telehealth services within the state for those plans that are offered in the state.

Some states have taken a step back, so there's still a lot of variability, and it's important to really look at what your state requires in terms of, is there reimbursement parity? Are there any requirements on where the patient must be to receive services? Is audio-only covered?

Another issue that was happening at the federal level in response to the pandemic had to do with HIPAA compliance enforcement. As you may recall, HHS had temporarily suspended its enforcement of HIPAA compliance for providers who were delivering telehealth services in good faith while using non-compliant platforms.

However, once the federal public health emergency period ended, which was May 12th of 2023, HHS advised that all providers would be expected to transition to using HIPAA-compliant platforms as HHS would be resuming its enforcement efforts. Next slide, please.

What does this mean? Well, HHS does provide guidance, and there's the link at the bottom of the slide, which you'll have later in the next week or two, that outlines what constitutes a HIPAA-compliant platform. Not only should the platform purport to be HIPAA-compliant and say so on its website and its marketing materials, but it also should be offering a business associate agreement outlining its obligations to the covered entity, to you, the provider, on how it would protect against unauthorized disclosure of any PHI that it might access as a result of providing services to you as being a third-party vendor.

It's also important to keep in mind that this isn't just limited to video conferencing platforms, but should be thinking about HIPAA compliance for any technology that is used in your healthcare practice. That could be practice management software. It could be an electronic health record system, payment processing system. It's something to think about across the board. Next slide, please.

Another issue that was looked at as a result of the pandemic and the significant shift to the use of telehealth was the interstate/interjurisdictional practice issues. Excuse me. In May of 2020, CMS confirmed that practice authority through a multistate licensing compact, such as the Psychology Interjurisdictional Compact or PSYPACT, would be treated as a valid full license for the purpose of meeting CMS federal license requirements. That means MACs are required to accept CMS provider enrollment applications from providers reporting an interstate license compact credential. You can see more information in this particular bulletin that was issued by CMS. Next slide, please.

The main way we talked about multistate licensing compact in the previous slide. For psychology, it is the Psychology Interjurisdictional Compact or PSYPACT is the acronym. What that does is it sets up two ways in which a psychologist can practice across state lines. One of which is by obtaining an e-passport, a psychologist whose declared home state is in a PSYPACT state can provide telepsychological services to patients in any other PSYPACT state without any kind of time limitation.

The other credential is the Interjurisdictional Practice Certificate. For that, that is to allow for temporary in-person practice. For example, if you are having to cross state lines to testify, to conduct an evaluation, but you're not licensed in that other state, that credential would allow for that. Under the temporary in-person practice credential, there is a limit of 30 days a calendar year. That's important to keep in mind.

At this point, there are 40 states that have adopted or actively involved in PSYPACT. There are 42 total. South Dakota and Vermont just adopted the enacting legislation. Those states won't join the compact until July 1st. As of the end of the summer, then there will be 42 states participating in the compact, as you can see. Those are highlighted in the light blue. The darker blue are those states that are participating already in the compact. The three states that are in black, Massachusetts, New York, and California, is where there is legislation pending. We will see where things go. My guess is that, at least for New York and Massachusetts, they'll have to carry over until next year. Some sessions may be winding down soon. Next slide, please.

PSYPACT is not the only methodology by which a psychologist could possibly provide telehealth services into another state. Some states are looking at other options for providing services across state lines. One model is called the Telehealth Registry, which allows for out-of-state providers to provide telehealth services into a state.

Arizona is one state that has adopted this model. The statute requires a healthcare provider who is not licensed in Arizona to register with the appropriate Arizona licensing board before being able to provide services to patients in Arizona. This does not constitute a full license to practice in Arizona.

Similarly, in Florida, Florida also has a registry that allows out-of-state providers to deliver telehealth services to patients in Florida. Keep in mind, the requirements typically involve a current valid unrestricted license from another state, not subject to any past or current disciplinary proceedings, appropriate evidence of professional liability coverage. No. You cannot open or offer in-person treatment within the state. There's usually an annual registration and accompanying fee to participate in the registry.

The other model is there are other temporary practice or telehealth provisions. One example is in Utah that allows out-of-state licensed healthcare providers in good standing to provide temporary transitional therapy to a client in Utah. What that contemplates is if you have a patient that you've been seeing in your state and they are in the process of moving to Utah where you are not licensed, Utah would allow you to continue providing short-term transitional services up to 45 days beginning from when the client relocates to Utah. The provider would need to contact the Utah board to allow them to understand that you are providing services under this provision, but that is in place.

Then, also, Washington State just enacted legislation that is adopting what's called the Uniform Law Commission's Telehealth Provision. Basically, what this bill does is it allows an out-of-state healthcare provider to provide telehealth services to a patient in Washington State under certain circumstances. One is if you're providing consultation to a Washington licensed healthcare provider, or you are conducting a specialty assessment diagnosis or recommendation for treatment, but you are not actually implementing treatment, or you're providing continuity of care because the patient is temporarily located in Washington. Because this law was just passed, it will still need to go to the rulemaking process so that the state can better ascertain what is considering temporarily located, for example, and what the rules of the road would be for an out-of-state provider to deliver services in Washington State under this provision. Okay. I will now turn it over to my colleagues.

Connie: Thank you, Deborah. The next few slides are just the references, resources that have been mentioned earlier. Again, they posted the slides in the chat, and you will also receive them in the next couple of weeks. I will breeze through these and let's have our colleagues, Allison and Cara, take it from here.

Cara Staus: Thanks, Connie. In the interest of time, I will go through this relatively quickly so that we can get to the important Q&A. Talking about patient records management, retention, destruction, and release of information, we're looking at who typically can consent to release records. The patient, obviously, is primary. Then parents of treating minors, looking specifically, if they're married, divorced, legally separated, you'll want to make sure that you have a custody agreement that designates who is the legal responsible person over those minor children.

If there's any legal guardians, guardian ad litem, conservators, or medical power of attorney, again, documents are going to be required in all of these situations to validate appropriate consent. Minors, depending upon what state you may be practicing in, minors may have the ability to consent. Again, some states are as young as 12, so be aware of your state statute when it comes to minor consent. If there's power of attorney in effect or also any executor or administrator of the state

upon the death of an individual, they may also request and be entitled to the records as if they were the patient.

Oftentimes, you're going to see releases of information to third parties. This is a common question that we often get. Regulators, licensing boards, Department of Children and Families, Department of Public Health, law enforcement. I know, I believe, it was Rachel early on was mentioning there are exceptions under HIPAA. Be aware of the HIPAA guidelines in terms of law enforcement exceptions where you can release information also with the medical examiners.

The Health and Human Services website has a great tool, the HIPAA FAQ for professionals that does give information about when it is appropriate to release. Health insurers may request information. Again, if you are under contract with certain healthcare providers under the payment and treatment and operations in HIPAA and right to access, health insurers could have a right to access certain components of a record. Employers, interestingly enough, again, all of these releases of information to third parties, it should be noted, appropriate consent would be required prior to releasing anything.

These are third-party requests that we typically see. Schools, if you're involved with any type of school system for evaluations, and then, medical providers and other consultants. Again, there's that collaborative approach to care. You may need to communicate with other providers involving the patients that you're treating. Next slide, please.

Maintaining medical records. The retention of records is important, and there are state-specific statutes. Please, be aware of your state statutes in terms of medical record retention. There are certain guidelines that you need to follow. It also depends on how they define it. Again, state statute. If you are also receiving funds, Medicare does also have a record retention. Be aware of the Centers for Medicare and Medicaid in any record documentation request. I believe it's at 10 years.

Again, being familiar with those federal and state statutes as it pertains to retention of records is important. I will highlight that medical record retention does also occur after death as well, so you would need to keep those retention of records in accordance with state statutes.

The last one for the medical practice statute of limitations, if you have any case that's involved in a board complaint or any other matter, you would want to keep that record throughout the opening of the case or the malpractice statute in your particular state.

For appropriately destructing records, there's HIPAA, again, under the HHS has information regarding how to properly destroy records, utilizing outside vendors with the appropriate business associate agreements, and also, requiring a destruction log record. Keeping track of the records that you are destroying, the date in which you destroyed them. There is guidance under the HHS website, again, that HIPAA FAQ to provide you with tools and resources when it comes to destroying medical records and how to properly ensure the destruction. Thank you.

Connie: Thank you all so much. Now we're getting into the audience question and answer. We had asked everyone to submit questions in advance. We received close to 150. We tried to consolidate them as well as we could by topic, and we will do our best to get through what we can.

Question number one, Cara/Allison, I think you guys can take the first two. What additional insurance do I need to carry if I am now on PSYPACT? What are the insurance considerations when practicing telehealth under PSYPACT?

Allison Funicelli: I'll take that question. Thank you, Connie. The first thing is if you are going to practice through PSYPACT, you want to notify your medical malpractice insurance carrier of which state you plan to see patients Because when you fill out an insurance application, it asks you not just what state you might be licensed in, but you also want to notify your insurer as to what state you might be seeing patients because you don't want to have a situation where you are deficient in insurance if your carrier is not aware of what states you're practicing in, because it does have an underwriting difference based on the state that you practice in, or sometimes the counties within a state that you practice within.

Then, as far as insurance considerations besides the malpractice insurance, your malpractice insurance limits the amount or a type of coverage you may get, usually to like HIPAA-type violations when you're providing telehealth. There's a whole slew of types of allegations that can occur when you're practicing telehealth that you really should consider buying cyber insurance. It's relatively cheap and it provides a much more in-depth policy to protect you if you get a ransomware attack, if you are hacked, et cetera. We really do recommend that you carry cyber insurance, that you notify your insurance carrier or your broker of what types of practice and where you're practicing so that this way, you are amply covered.

Connie: Thank you, Allison. This would also go to you and Cara. What are some of the key risk considerations when practicing telehealth and/or under PSYPACT?

Allison: You're going to practice the same way, whether you're under PSYPACT or even practicing within your home state. You practice the same way as you do when you see patients in person, plus some extra stuff. One is you want to make sure you have an informed consent that does cover telehealth, that it talks about some of the limitations when there's emergencies, some of the limitations regarding-- for technology, if your technology fails. You want to make sure you have a plan in place when tech fails, emergencies, that type of stuff. Your patient should understand and be signing an informed consent. They would have your standard informed consent and then a telehealth informed consent. Your malpractice carrier should be able to help you with some templates in producing those types of documents.

Connie: Thank you, Allison. [crosstalk] want to [crosstalk]

Deborah: I'd like to jump on that if I could as well.

Connie: Oh, sure. Go ahead, Deborah.

Deborah: In thinking about practicing across state lines, particularly under PSYPACT, the laws generally of where the patient is, is going to control the

therapeutic relationship. It's going to be very important that you understand what that state's policies are particularly when it comes to exceptions to patient confidentiality, abuse reporting, duty to warn, duty to protect. It's really important to know what those are, the mature minor doctrine, if that exists in the state where your patient is. Those are other things to think about as well.

Allison: One other thing is when you document, when you have a telehealth patient, is you should always be documenting where your patient is located. Just ask them where they're located at the time of the visit, because the licensing follows where the patient is physically located at the time of that visit. Again, just document that it's a telehealth visit. It's always a good idea to document, what type of technology you're using, if there was any technology failures, and again, where they're located. Is there anything you'd like to add, Cara?

Connie: Okay. Thank you. Next question. That one I think I can take is what is my obligation regarding talking to lawyers who send a subpoena, and do I have to divulge all of my notes, not psychotherapy notes?

Your obligation is to respond to a subpoena, and how you respond to it really makes a difference. If you do not have a written authorization or a court order that accompanies the subpoena, then you shouldn't be divulging protected health information until you get that permission. Sometimes, the response is simply, "I don't have the proper authorization or court order to release the information."

If you do have the authorization or court order, what you divulge really is dictated by what's in that order or the authorization. Also, keep in mind that psychotherapy notes, those authorizations have to be separate. It can't just be one request. You have to have one for the regular record and one for psychotherapy notes.

We did an entire webinar with Allison and Cara on how to respond when an attorney calls. I believe that's going to be put in the chat if you want to take a look at that webinar.

Next one, Rachel, I think this one's going to be for you. Is there a new HIPAA authorization form that needs to be signed for disclosure of PHI based on the new HIPAA rule regarding reproductive health information? Rachel? Are you there?

Rachel: Sorry. I was trying to get my video turned on. Oh, there we go. No. There is not a new HIPAA authorization form required for reproductive healthcare under the recent rule change. Under HIPAA, there's been an exception and there still exists an exception where you need an authorization form or a PHI can be used or disclosed without an individual signed authorization. This includes for law enforcement purposes.

The new HIPAA rule essentially prohibits this type of use of disclosure to law enforcement for the prohibited purposes discussed earlier, so for some type of investigation or to impose liability for this reproductive healthcare services. I know someone asked in the chat earlier a question about giving an example.

Say, for example, you have a patient and during a visit, that patient expresses anxiety about a possible unplanned pregnancy and mentions she might consider

abortion in a state where it's legal. That type of information would be protected if you get some kind of record request that is specific to an investigation to impose liability on this type of patient. Otherwise, no, there's no new HIPAA authorization form that is required. If you get such a form, then you are permitted to disclose information to others outside of your practice.

Connie: Thank you. Alan, this next question's for you. Which privacy law takes precedence, the federal HIPAA privacy rule or state law?

Alan: Okay. The simple answer on this is for real privacy laws, it's whichever is most stringent. In other words, whichever best protects the patient's privacy from third parties. When you look at laws about patient's access to records or their control over the records, then it's whichever law gives the patient greater access to or control over their records. That's the short answer. We could talk longer about that, but let's get some more questions.

Connie: Awesome. Thank you, Alan. Deborah, this question's for you. If I offer an online course that is psychoeducational in nature, can I offer it outside of the state where I am licensed?

Deborah: No one's going to like my answer. It's going to be it depends. It really depends. Is it purely psychoeducational in nature where it is a one-way relaying of information? Is it more of an interactive where you are using it, perhaps, it starts to skew towards the line of providing psychological services?

Psychoeducation does fall under the very broad definition of practice of psychology in most state practice acts. I think you're really going to have to look at it narrowly defined and in very specific contexts, but so long as it's educational in nature, and it's a one-way transmission of information, it won't be more likely that you're not engaging in psychological practice that requires licensure.

Connie: Thank you, Deborah. The next question is how can I recognize when a subpoena for records is mandatory? I can take this. Again, you'll see a subpoena is typically either issued by a court or by an attorney. Every once in a while, it might be signed by a judge. Again, if it doesn't come with a release of information, that authorization form, your response would be, like I said before.

If you're really questioning whether a subpoena has been properly served or if it's properly filled out, your best bet is to call a local attorney that's familiar with the procedures in your state or in that jurisdiction, or give us a call and we can help you talk through it.

How frequently do we need to redo good faith estimates? Alan, this looks like a you question.

Alan: It is a me question. The most important reason to update your GFE is if your actual cost of services is exceeding your last estimate. In particular, you want to make sure that your actual services don't get more than $400 over your last estimate, because at that point, it could trigger a patient's right to put you into dispute resolution. That's something we don't recommend anyone get into. We haven't heard complaints about people being put into dispute resolution. I think partly all the stuff is

so complicated that patients may not be fully aware of their rights on that, but you definitely want to avoid that.

The second most important reason to update your GFE is if you've gone beyond the time period of the GFE. In the resources, there's information on your flexibility for continuing therapy services to set the timeframe out as one month, three months, up to a year. That's the other important reason. Technically, you're supposed to update a GFE if there's any change to the scope of a GFE, but it's not clear what negative consequences there would be if you aren't updating it for those less important reasons. Thanks.

Connie: Great. Okay. The next two, Deborah, can take. Are there any additional processes that should be included as standard in the intake process for out-of-state therapy clients? Then, the next one is, what are the most important considerations for psychologists living in other states and primarily serving clients in other states?

Deborah: I love technology, except when it doesn't work. [chuckles] I think these questions are very similar and kind of have the same answer. It really is needing to understand what the policies are in the state where the patient is, particularly when it comes to exceptions to patient confidentiality, so that you can clearly spell out for the patient what those exceptions are, where you might, in what situations, where would you be obligated or allowed to disclose patient information without necessarily requiring patient consent.

The other aspect is understanding their insurance coverage. It may be are they in a state that has more robust telehealth coverage requirements in their state? That's another issue. It's just really understanding what the other state may or may not require. That may be consulting with the state psychological association in the other state looking for resources, looking at the psychology licensing board website for information about policies related to psychological practice in that state, but mapping out those things early on and understanding where the resources are for your patient in the other state. For example, where's the nearest hospital? What are some other emergency resources in the case of emergent circumstances?

Connie: Thank you, Deborah. What are some issues associated with releasing records of minors to their guardians and the associated HIPAA rules? I believe, Cara, you touched on this already during your presentation. I don't need to embellish that much more, just making sure you have proof that this person is a guardian because HIPAA typically allows them to stand in the shoes of the patient, which allows them to inspect or copy or have access to those records. If you have questions about a particular issue, though, that's a good question for your risk management folks. Thirteen, this is for Cara and Allison. Who controls the release of medical records once a minor turns 18?

Cara: I'll take this one. As we talked, when they turn 18, they're now an adult, so they are going to control their records. The age of majority in most states, however, if there are states that have consent that is younger than 18, again, being aware of your state statutes.

As you all know, it's helpful to have those conversations during the onset of care so that you're addressing that really with the child and parent or guardian there so that

there's no issues going on. We do recommend, obviously, when they turn 18 to obtain an appropriate consent so that if a parent is involved or looking for information, you get permission from the now adult child because often, parents still have a financial responsibility, so there is a lot of questions that come into play.

Again, be mindful of the age, get appropriate authorization so that you're not chasing it down as that child turns 18, and now, you're at a crossroads of what to do. Allison, anything to add?

Connie: Okay. Thank you.

Allison: No, Cara.

Connie: All right. Question 14. Rachel, I think this is for you. How do we document sessions related to pregnancy when discussing with patients' decisions regarding abortion?

Rachel: As with other situations where a patient may be put at risk by a psychologist putting certain details in their records, you should consider the potential impact on patients of your describing in the record discussions with them about reproductive health issues. It's always important to consider confidentiality and patient safety.

While anti-abortion laws exist, the new HIPAA rule just adds another layer of protection for reproductive health information, but exceptions always exist. The legal landscape in this space is still evolving.

That being said, you should always just consider using, or you should consider using more neutral language in your documents. For example, you might simply note that you discussed family issues or healthcare decisions with the patient just to be safe.

Connie: Thank you, Rachel. Next question is a PSYPACT question, so that'd be for Deborah. When licensed in two states and on PSYPACT, can you declare both states as home states?

Deborah: Thanks, Connie. You cannot. You will have to make a determination as to one state being your home state. I believe there is a mechanism that, for example, if you split your time between two different states, both of which are licensed, one six months out of the year, the other six months, you can notify the Commission to let them know that you're changing your declared home state, but you can't have more than one as your declared home state.

The way PSYPACT works, you're generally only allowed to provide services through PSYPACT from your home state. It's not like you can travel around to other PSYPACT states and then provide services back into your home state or others. The idea is a hub and spoke model. You're licensed and credentialed in your home state, which is a PSYPACT state providing services out to patients in other home states.

I do want to respond to a question I saw in the chat. Somebody asked, "Why would you necessarily do a registry if it's a state that also has PSYPACT or if you're already practicing through PSYPACT?" It may be that, A, you're a psychologist in a non-PSYPACT state, and, therefore, the registry does offer another avenue for interstate practice.

The other thing is, for some reason, you may not be eligible to practice under PSYPACT because one of the criteria, which was not set by APA, it was set by the Commission, is that coming from an APA-accredited program. Not all psychologists have come from an APA-accredited program and therefore, they may not be eligible to practice through PSYPACT. That might be another consideration.

Connie: Thank you, Deborah. Allison and Cara, I believe you addressed this a little bit, but how long do I need to retain medical records?

Allison: You're required to retain records-- we always recommend by whatever is the longest statute. Each state has a statute that tells you how long you have to retain records. We always recommend you look at the medical malpractice statute of limitations. Remember, it's usually different for minors as it is adults. CMS has requirements and HIPAA has requirements. We always say look at the different requirements and keep them for whichever one is the longest. This way, we don't have spoliation of potential evidence in the event of a claim or a complaint filed.

Connie: Thank you, Allison. We only have a couple minutes left. Luckily, we only have a couple of questions left. We should be able to get through these. Alan, this is for you. What can be done about the fact that the No Surprises Act's good faith estimate requirement can be difficult for forensic psychologists because they often do not know how to estimate costs accurately prior to the initial visit?

Alan: I can answer this one quickly. We might go get onto one more question. The thing is forensic psychologists don't need to worry about this because the No Surprises Act applies to medical and healthcare costs. Forensic services are not healthcare services, so forensic services fall outside of that. That's something, if you look through the guidance, it's all about surprise medical bills and providing estimates of healthcare costs. That's the quick answer on that. Let's see if we can squeeze in one more.

Connie: One more, Deborah. Oh, you can answer this one quickly, huh? How do the privacy laws impact telehealth? [chuckles]

Deborah: Well, a lot of it's going to have to do with security rule compliance. There is the privacy aspect. You're still going to have to adhere with the privacy laws. You're going to need to look at HIPAA. You're also going to need to look at any relevant state patient privacy laws, as Alan alluded to earlier. If it's more protective of patient privacy, then that's what's going to prevail.

A lot of times with telehealth, it's going to be the security rule requirements. How is the data being protected? How are you storing, receiving, transmitting electronic patient health data? How are you providing access to your patients? Unfortunately, this is a really big question. We're not going to be able to answer it in any great detail here this time.

Connie: Thank you so much. I believe that concludes our event. Thank you to our presenters. I'm going to now turn it over to Allison for a quick announcement.

Allison: Thank you everyone for attending. If anybody listening is insured through the American Psychological Association Partnership Program with American

Professional Agency, when you receive your certificate of attendance, please, send that to the underwriting department at American Professional Agency because this presentation will count towards one of your three required risk management credits to get your discount upon your insurance renewal. Thanks.

Host: Thank you so much to our presenters. Thank you to all of our listeners for your participation. We'd also like to thank the American Professional Agency for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slide. As soon as the webinar has ended, a short survey will appear on your screen. Please, take the survey and give us your feedback. We thank you for your attention and hope you have a great day.