1 February 2018

House Health and Human Services Committee
Testimony Neutral on House Bill 2512

Chairman and Members of the Committee,

Thank you for the opportunity to provide testimony. I am Stuart Little, President of the Behavioral Health Association of Kansas (BHAK) the state's trade association dedicated solely to substance use disorders treatment and prevention providers seeking integrated behavioral health care. BHAK believes that true integrated behavioral health means access and funding for mental illness and substance use disorder treatment without regard to where a consumer seeks services. Our stakeholders large and small and geographically diverse adhere to the core beliefs of expanding capacity and access, and providing consumer choice in the publicly funded behavioral health system.

We are neutral on House Bill 2512 for a couple of reasons. First, we support payment parity as well as coverage parity. Despite some occurrences when cost of business rates vary, in general all factors considered suggest that payment parity is not significantly out of line between in-person and electronic services for the staff intensive behavioral health services. Economies of scale and technology in behavioral health are less likely to result in cost savings. The second and more specific reason for our neutrality is that the bill specifically notes in:

> *Sec. 3 (a) The same requirements for patient privacy and confidentiality under the health insurance portability and accountability act of 1996 that apply to healthcare services delivered via in-person visits shall also apply to healthcare services delivered via telemedicine.*

In the substance use disorder treatment field the confidentiality requirements of 42 CFR (Code of Federal Regulations) replace HIPPA. These special privacy provisions are not new and all funders and providers in the field work with 42 CFR requirements daily. See the attached brief summary on page two. If House Bill 2512 is advanced, when you work the bill we believe the bill should include language that adds 42 CFR to section 3 (a) so that SUD treatment participation is not excluded from participation in telemedicine. We have suggested language to ensure 42 CFR is included.

I am happy to answer questions at the appropriate time.

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American Society of Addiction Medicine Summary of the federal government's Substance Abuse and Mental Health Services Administration FAQs as to 42 CFR.

- 42 CFR Part 2 applies to any individual or entity that is federally assisted and holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment (42 CFR § 2.11). Most drug and alcohol treatment programs are federally assisted. For-profit programs and private practitioners that do not receive federal assistance of any kind would not be subject to the requirements of 42 CFR Part 2 unless the State licensing or certification agency requires them to comply. However, any clinician who uses a controlled substance for detoxification or maintenance treatment of a substance use disorder requires a federal DEA registration and becomes subject to the regulations through the DEA license.
- The regulations restrict the disclosure and use of alcohol and drug patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program (42 CFR § 2.3(a)). The restrictions apply to any information disclosed by a covered program that "would identify a patient as an alcohol or drug abuser …" (42 CFR §2.12(a) (1)). In laymen's terms, the information protected by 42 CFR Part 2 is any information disclosed by a covered program that identifies an individual directly or indirectly as having a current or past drug or alcohol problem, or as a participant in a covered program.
- With limited exceptions, 42 CFR Part 2 requires patient consent for disclosures of protected health information even for the purposes of treatment, payment, or health care operations. Consent for disclosure must be in writing.