KAMU strength unity advocacy
THE PRIMARY CARE ASSOCIATION OF KANSAS

House Bill No. 2512
Neutral Testimony
House Health and Human Services Committee
February 1, 2018

Chairman Hawkins and Members of the Committee, thank you for the opportunity to present neutral testimony for HB 2512, establishing coverage parity between in-person and telemedicine-delivered healthcare services and providers. I am Denise Cyzman and have the honor to serve as the Executive Director of the Kansas Association for the Medically Underserved (KAMU). As the Primary Care Association of Kansas, KAMU serves 44 primary care clinics that provide care to all - regardless of who they are, where they live, how much they make, or if they have health insurance. In 2017, KAMU member clinics served more than 306,000 patients through 882,000 visits.[1]

Many of these clinics have adopted, or are working to adopt, real-time technology linked services for serving patients within their medical home. According to a recent survey of KAMU members, seven clinics responded that they currently provide telemedicine services and three plan to offer services within the next 12 months. Of those who currently provide these services, they provide general and specialist telemedicine, and telepsychiatry. Most clinics bear the financial burden for the cost of the technology and professional services provided for the telemedicine visit.

Access to distant providers via technology is a solution to providing prevention, treatment, management and ongoing health care to patients served by KAMU member clinics. This is especially true for rural and frontier communities where access to specialty providers is problematic. It also provides services in home communities and establishes a reasonable mechanism of opening access to needed care. Imagine having to drive 180 miles to see a specialist and having transportation problems or needing to take time off work. Faced with these barriers, your choice may be to delay care. You may not even seek care until you are sicker and require more complex and costly services.

This leads us to our first concern with HB2512. The bill defines healthcare provider as “licensed mental healthcare professional or a physician.” We recommend the definition include advanced practitioners such as Physician Assistants (PAs) and Advanced Practice Registered Nurses (APRNs). These healthcare providers are valuable and critical members of the health care team, especially in rural and underserved areas. In KAMU member clinics, 68% of the medical providers (116) are PAs or APRNs, as compared to 37% (68) physicians. Eliminating these essential providers from the bill would drastically reduce the ability of Kansans living in rural and underserved areas to benefit from telemedicine services.

Similarly, we recommend that dentists are included in the definition of healthcare provider. KAMU member clinics employ more than 40 dentists, serving 93,000 patients. Kansas is currently struggling to identify

[1]KAMU Quality Reporting System, State Grantee Preliminary Data, 2017. Accessed on 1.25.18

strategies to address the dental workforce and oral health care services shortages. Including dentists in the list of healthcare providers would be one solution worth considering.

To illustrate our next concern – payment or reimbursement parity - I would like to start with an example of a federally qualified health center (FQHC) in rural Kansas. In 2015, they initiated telemedicine services to bridge the community gap from a psychiatrist shortage, and to reduce extremely long wait times for patients seen by existing providers. They contract with a telepsychiatry firm that maintains qualified and credentialed psychiatrists to provide these services.[2] The demand has grown and the health center has increased its telemedicine services from two hours to four hours per week. Telepsychiatry has become a standard component of care in the health center's integrated health care delivery system.

As a federally qualified health center, they bill at the originating site rate, a rate that is much lower than the cost of care provided by the health center. Over the two-year period in which the health center provided telepsychiatry services, the cost to the agency was $37,125. The amount collected through insurance payments was $6,800. For every dollar that the FQHC expended on the telepsychiatry service, they collected 18 cents. This is not a sustainable way to deliver health care. While this example focuses on telepsychiatry, KAMU member clinics also provide general and specialist telemedicine services.

Coverage parity will help offset some of the loss they experience, as not all health insurers currently cover this service. Yet, the difference between the originating site payment and the payment for a medical visit is substantial. In order to cover the costs of providing telemedicine services, reimbursement for the telemedicine visit should be the same amount as in-person care. Additionally, payment parity will support the growth of telemedicine by encouraging more health care providers – and in our case, KAMU member clinics – to incorporate it as an effective and efficient tool to provide health care.

Kansas should be a state where all individuals have access to comprehensive, affordable, and quality health care. Telemedicine is the future of health care and an important solution to the healthcare provider shortage, particularly in rural and underserved Kansas. Yet, telemedicine is not sustainable without a compensation mechanism to cover clinic, provider and technical costs. The primary care system made up of KAMU members will continue to gain experience and grow their services with real-time technology. They will serve more people. They will improve health.

We appreciate this committee dedicating time to this type of service and urge you to consider our recommendations to expand the definition of healthcare provider to include advanced practitioners and include payment/reimbursement parity.

[2] The psychiatrist is credentialed under the FQHC and licensed to practice in the State of Kansas.