February 16, 2017

House Health and Human Service Committee
Testimony In support of
HB 2206

Mr. Chairman and Members of the Committee:

I am testifying in favor of House Bill 2206, and to request two amendments. Vigilias Telehealth is a Wichita, Kansas-based multi-specialty medical practice providing care to rural areas via innovative and cost-effective telemedicine technology. We have one goal: Making high-quality care accessible to everyone, regardless of their location, age, or the time of day. Using telemedicine, we currently provide access to twenty-three different medical specialties **(Appendix A)** at 28 locations **(Appendices B and C)** across Kansas. We are the only rural telemedicine provider in Kansas, and among very few in the entire country, that offer a wide breadth of service without being subsidized by a large healthcare system or grant money. We are also the only rural telemedicine provider in Kansas that creates its own technology, and thus can control that cost.

Rural healthcare has long been plagued with provider shortages. Small communities spend large amounts to recruit and retain primary care providers, with variable success. Subspecialty care is often impossible to secure. Telemedicine – defined as the use of internet-based technology to securely interview and do a full physical examination on a remote patient – is an excellent solution to this problem. It enables tiny towns to have instant access to the full cognitive resources of a large medical center.

Until recently, the biggest hindrance to the spread of telemedicine was technology. It cost too much, did not work well, and often was not easily portable. These legacy systems are still widely marketed, and are usually installed after a community secures grant funding to pay for them. Ironically, the communities that most need telemedicine due to lack of financial resources or enough population to support a visiting specialist have traditionally also been those least likely to get it – they simply cannot afford it without grants. Our technology platform, which takes advantage of recent advances in multiple fields, has eliminated this obstacle **(Appendix D)**.

The second biggest hindrance to the spread of rural telemedicine is the cost of medical services. Until very recently, no insurance company would cover telemedicine despite it being equivalent to in-person care in the vast majority of use cases. As a result, physician services have often been funded by grants, charity, subsidies from large healthcare systems, or block payments from rural communities. As with the technology, this put access out of reach of many small towns. Roughly three years ago,

Medicare opened the door to reimbursement for rural telemedicine. KanCare also reimburses for telemedicine in some instances. This has made it possible for physicians providing care to rural areas to bill Medicare or KanCare, and not to have to charge up front, or depend as heavily on the other payment mechanisms outlined above. Unfortunately, private insurance payers have been much slower to adopt reimbursement for rural telemedicine.

When our group started, we approached Blue Cross Blue Shield of Kansas, United Healthcare, Aetna, and Humana about becoming in-network providers. In the case of United, Aetna, and Humana we were told they did not cover telemedicine at all, though in multiple cases, they covered it in surrounding states. Blue Cross Blue Shield, which publicly claims to cover some rural telemedicine, told us they would not contract with us because we were a telemedicine group. We approached these companies multiple times in an attempt to talk about what we were doing, how it helps rural communities, and how to address any concerns they had about telemedicine, but were consistently turned away **(Appendix E)**. That continues to the present.

As physicians, our commitment to patients supersedes questions of payment. This technology raises the standard of care in rural Kansas, so we have never turned away a patient because they have the "wrong" insurance. However this problem is hurting rural patients, rural hospitals **(Appendix F)**, and our efforts to serve them both in concrete ways. Patients have been harmed because they are unable to see a specialist in their own town, or are unable to be treated in their local hospital via telemedicine because their insurance will not pay for the care. In just the past few weeks, Blue Cross Blue Shield of Kansas alone has denied almost $5000 worth of claims for care delivered to their constituents. Other private payers denied roughly $2000. Total reimbursement on these claims across all private payers in Kansas during that block was $82. Other, larger healthcare entities that are in-network with Blue Cross Blue Shield and other private payers have also attested to receiving inconsistent payment of telemedicine claims, and these problems have increased reliance on grant funding, or reluctance to supply services to rural areas, since they may not be paid for. In short, in Kansas right now, privately insured rural patients may need to wait for months and drive hundreds of miles, or be emergently flown across the state, because their insurer refuses to pay for the same service to be delivered immediately, and in the patient's town, via telemedicine.

For these reasons, we support passage of HB 2206, but with the following amendments:

*New Section 1 (c): "No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical*

*service corporation contract, fraternal benefit society or health maintenance organization that provides coverage for telemedicine or the Kansas program for medical assistance shall:"*

5. ***exclude an otherwise-qualified healthcare service provider, or group of providers, from in-network participation solely because the services they provide are via telemedicine rather than in-person contact.***

6. ***exclude an otherwise-qualified healthcare provider, or group of providers, with valid Kansas medical licensure from in-network participation solely because the services they provide are via telemedicine rather than in-person contact.***

Kansas is one of the most rural states in the nation. Telemedicine is critical to our ability to supply high quality, affordable, reliably-accessible healthcare to our rural citizens for years to come. Kansas can and should be a leader in this area, yet we currently lag many surrounding states and most of the country, largely due to an unfavorable reimbursement situation. We feel HB 2206 is the first legislative step to improving things, and ask you to support it along with the requested amendments. Thank you for your consideration.

Sincerely,

Elisha Yaghmai, MD, MPH&TM

President

Vigilias Telehealth

eyaghmai@vigilias.com

800-924-8140, ext. 700

## Appendix A

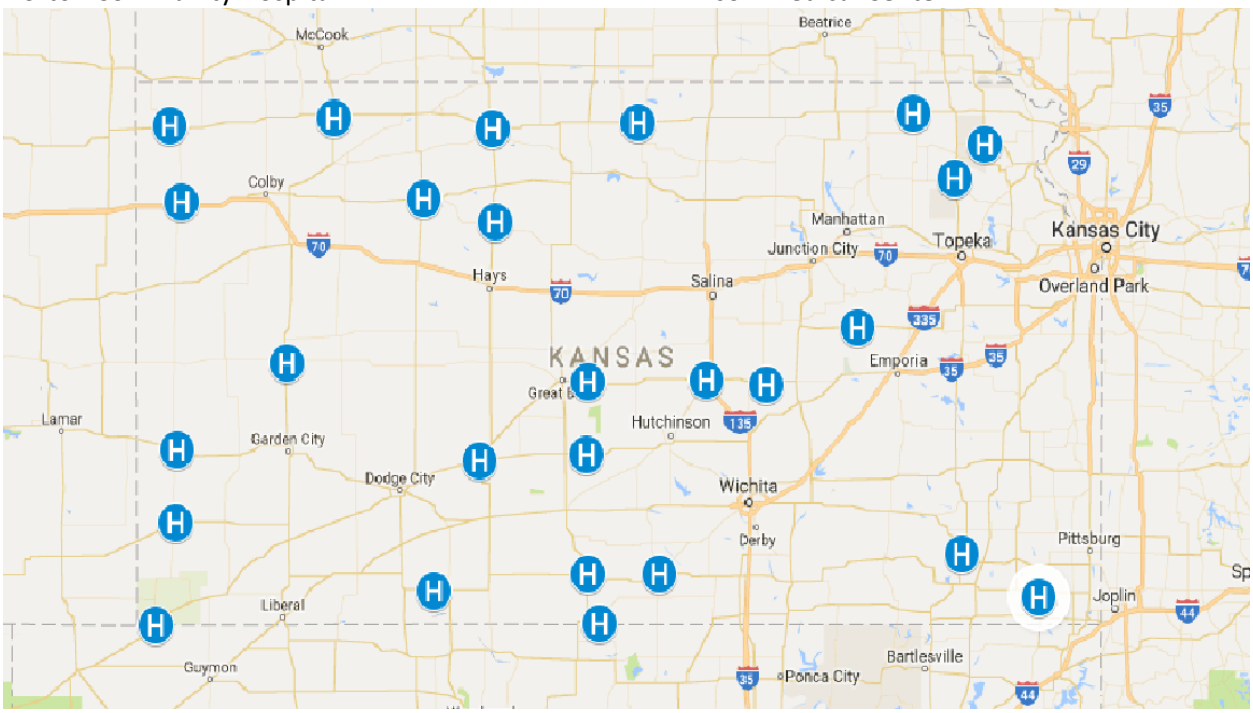
## Medical Specialties

- Allergy and Immunology
- Cardiology
- Complex Diabetes
- Dermatology
- Dietitian/Certified Diabetic Educator
- Emergency Medicine
- Endocrinology
- Family Medicine
- Hospitalist, including ICU
- Hospice and Palliative Care
- Infectious Disease
- Internal Medicine
- Mental Health
- Nephrology
- Neurology
- Non-Narcotic Pain Management
- Pediatrics
- Pediatric Hospitalist
- Pediatric Infectious Disease
- Pediatric ICU
- Physical Medicine and Rehabilitation
- Rheumatology
- Wound Care

# Appendix B

## Kansas Locations

Ashland Health Center
Bluestem Communities PACE (Program of All-Inclusive Care for the Elderly)
Cheyenne County Hospital
Community Health Center of Southeast Kansas
Decatur Health Systems
Edwards County Hospital and Healthcare Center
Ellinwood Hospital and Clinic
Goodland Regional Medical Center
Graham County Hospital
Hamilton County Health
Harper Hospital District #5
Hillsboro Community Hospital
Holton Community Hospital
Horton Community Hospital
Jewell County Hospital
Kiowa District Healthcare
Medicine Lodge Memorial Hospital and Physicians Clinic
Morris County Hospital
Morton County Health Systems
Nemaha Valley Community Hospital
Oswego Community Hospital
Phillips County Health Systems
Rooks County Health Center
Scott County Hospital
Stafford County Hospital
Stanton County Hospital
St. Luke Hospital and Living Center
Wilson Medical Center



## Appendix C

## Sample of Services Supplied in December/January, and In-Person Alternatives to Receive Same Service

| Specialty | Patient Home | Closest town with Specialist | Wait For In-Person visit |
|---|---|---|---|
| Endocrinology | Medicine Lodge | Wichita - 1.5 hrs. | April |
| Endocrinology | Agra, KS | Wichita - > 3 hrs. | April |
| Endocrinology | Kiowa, KS | Wichita - 1.5 hrs. | July |
| Endocrinology | Woodston, KS | Wichita - > 3 hrs. | April |
| Dermatology | Hazelton, KS | Wichita – 1.5 hrs. | Late February |
| Dermatology | Macksville, KS | Great Bend - 50 min. | Mid-March |
| Hospitalist | Neodesha, KS | Wichita – 1.75 hrs. | 4 hrs. + ambulance; instead treated in minutes |
| Nephrology | Kiowa, KS | Wichita - 1.5 hrs. | Late March |
| Neurology | Medicine Lodge | Wichita – 1.5 hrs. | Mid-April |
| Neurology | Logan, KS | Hays KS - > 1 hr. | Late March |
| Neurology | Chanute, KS | Independence - 47 min. | Mid-April |
| Rheumatology | Neodesha, KS | Girard - 1 hr. | Mid-March |
| Rheumatology | Tyro, KS | Girard – 1.5 hrs. | Mid-March |

## Appendix D

## Telemedicine Technology

**Video of technology in action:**

**http://www.bizjournals.com/wichita/video/FkdXdwNjE6hRV006G2Y08WYfIqFCkoQs?autoplay=1**

**MITEE ("Mighty") 2.0**

**The Smartphone-based Telemedicine Cart**

**Powerful**

- 1080p-capable, 8-megapixel video camera
- Handheld exam tool enables incredible zoom, easy examination of any body part
- Omnidirectional microphones with noise and echo reduction
- 17” screen in base model

**Reliable**

- Connects via WIFI, cellular, or satellite
- 6-12 hour active-use battery life
- 7-day standby battery life, and optional solar charging

**Comprehensive**

- **Full examination of heart, lungs, ears, eyes, nose, throat, and skin**
- Included stethoscope/otoscope peripherals

**Ultraportable**

- Full unit weighs 3-4 pounds
- Handheld exam tool weighs a few ounces

**Easy to Use**

- No keyboard or mouse required
- Touch screen functionality

# Appendix E

## Sample Interaction With Private Insurance

**Nicole.Ramer@bcbsks.com 9/2/15**
to me, Robyne.Goates, Prof.Relations, Brian.Thurbon

Good afternoon Dr. Yaghmai. At this time we will not be scheduling a face to face meeting. Per your previous conversation with our management in May, 2015, BCBSKS will not be offering a contract agreement to Vigilias. Any licensed physicians in Kansas interested in contracting with us independently should contact us to discuss their eligibility as a tele-medicine provider in Kansas.

Nicole Ramer, CPC
Provider Network Services
Blue Cross and Blue Shield of Kansas
PO Box 239
Topeka, KS 66601
Phone - 1-800-432-3587 or 785-291-4135
Fax - 785-290-0734
E-mail - Prof.Relations@bcbsks.com

ICD-10 implementation is coming. For more information, click on the Website link below.
http://www.bcbsks.com/CustomerService/Providers/icd-10

----- Forwarded by Nicole Ramer/bcbsks on 09/02/2015 05:01 PM -----

From: Brian Thurbon/bcbsks
To: Prof.Relations
Date: 09/02/2015 03:05 PM
Subject: Vigilias / Dr. Yaghmai

Dr. Elisha Yaghmai (pronounced YOG-my) stopped in at 2:45 today to meet with a provider relations representative regarding setting up his group Vigilias Telemedicine as contracting providers with BCBSKS. His telephone

number is 972-561-0067. I told him to expect a call within 48 hours. He said that would be acceptable, but that he would still like to schedule a time to meet in person before finalizing any agreement.



**Elisha Yaghmai** **eyaghmai@vigilias.com** **9/2/15**

to Nicole.Ramer, Robyne.Goates, Prof.Relations, Brian.Thurbon

Dear Ms. Ramer,

I apologize if my visit caused consternation. I was just passing through, and stopped in because other attempts to reach out have gone unanswered. The spring conversation you reference was brief, and to date we have never had the opportunity to speak with anyone in provider relations about who we really are, what we are doing, or what your concerns are, which was my only intention today.

At this point you may be inclined just to delete and have done with it, but I would appreciate any patience you have to review a few thoughts:

1. We are a Kansas practice. Though conceived in Seattle, where I was living while my wife completed fellowship, we started in, and were originally intended for Kansas, where we both did residency, and now live again.

2. We are not Teladoc, AmWell, or any of the other telemedicine companies monetizing iPhone visits to treat the sniffles in the worried well. We are not about induced demand. We want to treat serious medical problems that truly require a doctor.

3. We are a multispecialty group of docs that care about rural health, and believe telemedicine, done well, represents an excellent way to help.

4. Our technology is portable, cheap, and works beautifully, and are currently deploying it to serve rural communities in both the inpatient and ambulatory setting.

5. When rural hospitals transfer patients to urban centers, many of our docs are on the receiving end. Some of those transfers could have been avoided if a provider with more comfort with the disease process in question had been available to consult. Many ED visits and hospitalizations could also have been prevented entirely had patients not faced long waits and long drives to get follow up. While a no-show costs Blue Cross nothing, I'd guess that avoiding one preventable hospitalization for CHF is worth several clinic visits.

6. We are open to considering capitated reimbursement based on the quality, not quantity, of care we provide.

Here's a typical scenario I've seen many times: Patient in a rural hospital develops renal failure, and is immediately transferred to a large center to see Nephrology. On arrival the patient does not see the Nephrologist - they see the hospitalist. The hospitalist initiates evaluation and therapy, and in some cases that is the end. In others, Nephrology input is needed, but this consists of review of labs, imaging, history, and a basic physical exam, all of which are easily done via telemedicine. In this context, only a few problems make immediate transfer, or any transfer, imperative, yet early transfer is a common decision.

Another I have seen: Child comes to rural ED with a rash. Local provider is concerned about Stevens-Johnson, a serious disease that they have unfortunately never actually seen. The child is transferred. At the larger center, it is immediately clear that the rash is not Stevens-Johnson, and is actually benign. The child is discharged.

In both these cases, the inefficiency and waste are obvious, yet these scenarios are not uncommon. Here's an alternative:

In scenario one, the patient is seen by a hospitalist or nephrologist who helps guide inpatient care locally via telemedicine until the patient improves, or shows a true indication for transfer. Blue Cross still pays the consultant, but in many cases does not pay for a transfer, or the reduplicated labs or imaging which often accompany those events.

In scenario two, the child is seen immediately via telemedicine, then discharged home. Blue Cross pays the consultant once, but does not pay for transfer, or hospital admission.

And none of this takes into account the acute care visits prevented by simply having more readily available primary and subspecialty ambulatory care.

The technology to support these efficiencies already exists, and the safety has been established in a variety of studies, some recently published by the Mayo Clinic.

Blue Cross' current telemedicine policy has, from our perspective, a few limitations:

1. **No contracts with groups.** To date we have never had an opportunity to speak with anyone long enough to understand why this policy is in place, or what Blue Cross would need to see to consider changing it.

2. **Only cover ambulatory care.** ED and inpatient care can be provided safely and cost-effectively, and we would be happy to do a demonstration to prove it.

3. **Only cover specialties not already present in a community.** Two difficulties: 1. If a Cardiologist goes to a community once a month, does that represent a specialty truly present in a community? 2. If a single family physician serves an entire town, why is it a bad idea to provide backup supplied by another family physician via telemedicine? Provider burnout from endless call is a serious problem for rural health. If we can keep a good doctor in a community long term with telemedicine support, why is that a poor decision?

4. **Only contract with physicians located in Kansas.** Some Kansas communities have to wait six months for an appointment with a Kansas-based Dermatologist or Rheumatologist. Telemedicine alone does not fix the fact that those specialties are rare in the state, and already heavily subscribed. However we have access to great docs in other states that have time and interest to help rural Kansas, but they currently can not be reimbursed for treating Blue Cross patients because they don't live here. If we can bring people excellent, timely care from a doc in another state, why not support it?

If you've actually made it this far, I appreciate your time and consideration. All we want is a conversation to help us better understand your concerns, and what, if anything, we can do to demonstrate that we are trying very, very hard to be part of the solution, not another problem. If we're missing something in this equation, please tell us.

Elisha

**Elisha Yaghmai, MD, MPH&TM**

President

Vigilias LLC

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Web: www.vigilias.com

LinkedIn Facebook Twitter

**There was no reply to the above e-mail.**

**Elisha Yaghmai** **eyaghmai@vigilias.com** **2/17/16**
to Robyne.Goates

Hi Robyne,

I just left you a voicemail as well, but wanted to check in to learn about the results of the meeting I was told you would be having a few weeks ago. No one got back to us, and we need to know how to plan moving forward.

We offer a variety of specialties that are not present in most communities in Western Kansas, and just need to know if we should plan to move forward in partnership with Blue Cross, or on our own. At this point we are serving 16 communities in Kansas.

We also need to know if those of us who live in Kansas are able to be credentialed with you to see patients in person in the same way any appropriately-certified group of physicians would be typically be allowed to do. We would greatly prefer not to have to create a separate entity to accomplish this given that we have not had to do so for other payers.

Please let me know one way or another, and thanks!

Elisha

**Elisha Yaghmai, MD, MPH&TM**

President

Vigilias LLC

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LinkedIn Facebook Twitter

**Robyne.Goates@bcbsks.com 2/18/16**
to me

Elisha,
As communicated several times, BCBSKS' stance has not changed regarding

telemedicine. As Nicole Ramer outlined in her Septemember 2015 e-mail to you, if you are a licensed Kansas provider, located in Kansas and wanting to provide covered services to our BCBSKS members, we would be happy to send contract information to the group/providers for consideration.

For a better understanding of our current telemedicine guides, see article on page 2 of the linked Newsletter below.

http://www.bcbsks.com/CustomerService/Providers/Publications/professional/newsletters/2013/S-7-13.pdf

Robyne Goates, CPC
Manager, Provider Relations
Blue Cross Blue Shield of Kansas
Phone: (785) 291-8206
FAX: (785) 290-0734
Robyne.Goates@bcbsks.com

From: Elisha Yaghmai <eyaghmai@vigilias.com>
To: Robyne.Goates@bcbsks.com
Date: 02/17/2016 01:42 PM
Subject: Check in



**Elisha Yaghmai** **eyaghmai@vigilias.com** **2/18/16**
to Robyne.Goates

Hi Robyne,

I know this is irritating for you, but we aren't getting consistent answers from anyone we've spoken to. When we spoke by phone, my understanding was that our group of physicians physically located in Kansas could apply for BCBS credentialing under our group tax ID. After our call, I asked our credentialing company to proceed with this. Kathie, our credentialing rep, was then told that BCBS now wasn't sure that would be allowed under the Vigilias tax ID, and that someone would get back to us after another meeting. One of your reps, possibly Nicole, but my memory on the name may be incorrect, also confirmed this to me over the phone. We then never heard anything again, from anyone. So from our perspective, the question is very simple: Can we apply

under our current tax ID, or not? We've been told no, yes, and maybe, depending on who we speak with. I'd love to stop bothering you, but I need an answer.

Thanks!
Elisha

**Robyne.Goates@bcbsks.com 2/18/16**
to me

1. A group of physicians CAN apply for credentialling/contract. A telehealth group CANNOT.
2. Vigilias is listed as a telehealth provider and therefore, would not be considered for contract.

I am sorry for any confusion. You are not irritating me : - ) all part of my job.

Robyne Goates, CPC
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From: Elisha Yaghmai <eyaghmai@vigilias.com>
To: Robyne.Goates@bcbsks.com
Date: 02/18/2016 12:06 PM
Subject: Re: Check in

**Elisha Yaghmai eyaghmai@vigilias.com 2/18/16**
to Robyne.Goates

Thanks!

Last question then. Multiple groups in Kansas that have long-standing in-person operations are actively considering working with us to bring care to rural Kansas, and have been told they can do telemedicine by their BCBS reps (within the limits of your policy, of course). We obviously came in first via telemedicine because of our rural emphasis, but have physicians in our group, myself included, that will ALSO be offering in-person services in Kansas. For example if a patient I am seeing needs to be transferred to an urban medical center, I want to be able to continue the care there. I also want the freedom to drive out to a partner hospital to help in person if needed. Similarly, we have, for example, a Pain Management provider that may see patients on video, but ultimately may also need to see them in person to do an injection. Given that telemedicine codes carry distinct modifiers or G-designations that clearly differentiate them from in-person work, is it feasible to have our group be treated the same as any other group in Kansas doing both things? And if there is any concern about people billing an in-person code for a telemedicine interaction, if you don't trust us to be honest with what we do, which is fine given that you don't know us, you can crosscheck our claims against the technical fee our partner hospitals will also submit for visits.

We are based in Wichita, and several of us do in-person work in South-Central Kansas. It would be nice not to have to create an entirely separate entity just to be allowed to do what other in-person Kansas providers are already being allowed to do under a single tax ID.

Does that make sense? We aren't Teladoc or American Well, nor are we trying to emulate their model. We are trying to build something rather different, which continues to evolve as we gain a deeper understanding of the many ways the healthcare system is failing patients. We are a Kansas-based practice, and only ask to be treated the same as others, even if we are a bit more technologically inclined than the average.

**Robyne.Goates@bcbsks.com 3/4/16**

to me

Again, due to the nature of your entity, BCBSKS is declining contract
offering at this time. Thank you for your continued interest. If something changes in the future, we will be in touch.

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## Appendix F

## Letters of Support from Rural Hospitals