October 19, 2021

Vicki Schmidt, Kansas Insurance Commissioner
Kansas Insurance Department
1300 SW Arrowhead Road
Topeka, KS 66604

Dear Commissioner Schmidt:

On behalf of the Kansas Hospital Association, we are writing to keep you informed on persistent insurance matters that do not align with patient safety and access to care in Kansas.

- Sepsis 3 audit denials
- White bagging safety
- Prior authorization delays and denials
- Credentialing delays

Below we have outlined each of these concerns by providing a summary, risk, and action breakdown.

**Sepsis 3 Audit Denials**

**Summary**
The Kansas Hospital Association has received complaints from hospitals saying that some health insurers recently changed their definition of ‘sepsis’ from Sepsis-2 to a new definition introduced in 2016 by “The Third International Consensus Definitions for Sepsis and Septic Shock,” referred to as Sepsis-3. The Sepsis-3 definition is narrower than the Sepsis-2 definition.

Sepsis is a severe reaction of the body due to an infection, and is one of the most deadly diagnoses in the United States. There is consensus early identification and treatment dictates patient outcomes. Sepsis rapidly develops from an issue as innocuous as a scratch. Health care providers have implemented bundled interventions to standardize response every time sepsis is suspected. There is a high risk of death when potential sepsis cases are not treated seriously.

**Risk**
Some of the largest private health insurance companies operating in the state – and nationally – are following UnitedHealthcare’s lead in implementing new payment audit policies that do not support early sepsis detection and intervention. This puts patients at great risk and is a prime example of policies at odds with good health care practice.

After a hospital provides care to a patient and sends the claim to the insurer, clinical claims reviewers only recognize sepsis was present and treatment was appropriate when it meets the Sepsis 3
definition. Sepsis 3 is defined as life-threatening organ dysfunction accompanied by septic shock, which increase the risk of mortality more than the sepsis alone. The definition of Sepsis 3 has yet to be accepted by the Centers of Medicare and Medicaid Services, the largest payer in the United States. Sepsis 3 criteria was created as a tool for judging potential mortality, not for diagnosis purposes.

CMS uses the Sepsis-2 definition for diagnosis and as a best practice for clinical treatment. The inherent goal of using the Sepsis-2 definition is to capture and prevent patient death in as broad a patient population as possible. A great deal of investment has been made by systems and others to respond appropriately to these guidelines. As a community, we are working diligently to achieve success. We are now being presented with new rules from private payers. They are using their influence to supplant the physician and define what sepsis is, forcing the medical experts to think two different ways about the same patient. This presents several problems and provides a great disservice to patients with sepsis.

Action
The entire health care system is shifting towards value-based care and population health. These concepts focus on keeping people healthy and intervening before a medical issue requires intensive resources. Only allowing payment when there is an indication of organ failure unfairly targets the financial resources of the patient.

We are all sensitive to bending the cost curve in health care, but unilateral policy decisions that delay what is most beneficial for patients – puts lives at risk and contradicts best practices and the tenets of healthcare. It is a step in the wrong direction.

White Bagging

Summary
Imagine a restaurant where everyone with a reservation has sent ingredients from numerous vendors for the restaurant’s staff to prepare and cook instead of trusting the restaurant to procure and prepare the ingredients themselves. This is similar to what clinics and hospitals face when payers implement white bagging policies for prescription medications.

Over the past 16 months, three of the nation’s largest commercial payers – UnitedHealthcare, Anthem BCBS, and CIGNA – have instituted new policies affecting how and whether they will pay for high-cost drugs, such as chemotherapy, administered in hospital outpatient infusion centers and outpatient sites. These new payer policies require hospitals administering certain high-cost medications in an outpatient setting to receive those medications from third parties contracted with the health plan, instead of providing those medications directly from the hospital pharmacy. This is known as white bagging.

Each of those commercial payers have identified a specific list of drugs to which the policy applies. However, one payer has already expanded its initial list of drugs subject to white bagging. As more payers initiate these policies and add new drugs to their list hospital reimbursement decreases and payers increase their bottom line.

Risk
There is more at the issue than an entity increasing their bottom line. Concerns received from Kansas hospitals include delays in medication administration and supply chain integrity. White
bagging bypasses health system formularies, safety checks such as drug interactions and dose weight checking, and care planning processes. Hospitals are having significant issues with inventory management and timely deliveries from the payers’ contract pharmacies. One Kansas hospital specifically mentioned the inability to adjust dosages in response to emergent laboratory results or clinical findings during examination.

Lawrence Memorial Hospital reports wasting over $90,000 in medications in one quarter, because drugs arrive unsecured and below the recommended temperature. Patients must be rescheduled. This may be life-threatening to chemotherapy patients that are on a scheduled regiment.

Action
At a time when patient-centered care and patient choice is a concern for clinicians, requiring patients to use the white bagging system is a step backward. White bagging serves zero purpose other than enriching insurance payers through their PBMs and pharmacy business lines. Bottom line, it risks patient safety.

Prior Authorization Delays

Summary
There has been an ‘explosion’ in prior-authorization requirements and it is extremely frustrating to patients and providers. The prior authorization process gives health insurance companies an opportunity to review how necessary a certain treatment or test may be in addressing a medical condition. Although intended to help control costs for unnecessary or over-utilized procedures, it is now being exploited as a delaying tactic designed to make patients and doctors jump through hoops before critical procedures or treatments are approved. A hospital or provider cannot possibly keep up with insurance plans constantly changing list of prior approvals. Payers purposefully make it challenging to understand ever-changing policies and keep information under lock and key with their private portals. This lack of transparency creates roadblocks for providers when payers deny prior authorizations for unknown reasons.

An example given by a Kansas physician (provider) who details how automatic prior authorization request denials waste time and delay care. Recently, a physician’s nurse was denied a prior authorization request. The next morning, the physician himself gave the exact same information the nurse delivered to the insurance company. His request was immediately approved. This wasted 30 minutes of the physician’s time when it appeared a predetermined decision was already made to deny the prior authorization request when first requested by the nurse. This process added to the delay in care when the patient was sent home due to the initial denial and then had to schedule a second appointment to finish the treatment.

Risk
The prior authorization process can be quite lengthy, resulting in delays in treatment or care. In a 2020 survey released by the American Medical Association, 94 percent of providers report care delays due to insurance company’s prior authorization requirements. Thirty percent of the delays led to serious adverse events for the patients. On average, physician offices complete forty prior authorizations per week, and paperwork can take up to 16 hours to complete. The time spent by providers carefully filling out forms to ensure insurance companies approve treatment is a substantial loss in patient care. Other examples include:
Kearny County Hospital, Lakin, KS

- Physician ordered an emergent colonoscopy for the patient that required a prior authorization. In an initial call, a nurse was on hold for over an hour, unable to complete the request and had to move onto other patients. Delay in process equaled one lost day of treatment. A second call was placed the next day. The nurse was placed on hold for 30 minutes and then the call was dropped. The nurse received no return call. Later, the nurse called back and was placed on hold for an additional 30 minutes. The total delay in the care process was two days.

Community Memorial Healthcare, Marysville, KS

- Young adults passing through the area from out of state stopped for emergency appendectomy. The hospital tried to reach insurance for prior authorization and after significant delay performed surgery without authorization. Later, the insurance company refused to retro-authorize the procedure, so hospital charges were irrecoverable.

Gove County Medical Center, Quinter, KS

- Patient came in for MRI of foot. A prior authorization was given, however, during the exam the provider determined further contrast was needed to get a better look at injury. The provider was not able to immediately administer contrast and continue with MRI because prior authorization was needed to add contrast to scan. The patient was discharged and a new prior authorization was received three days later. The patient had to come in for second exam delaying proper care for the serious injury.
- All out of state insurances require prior authorizations. With location of Gove County Medical to the Interstate highway, they receive frequent out-of-state visits per month. It is impossible to perform any kind of imaging or testing unless the patient agrees to be seen through the emergency room. Oftentimes, the only solution to exams is to either have the patient present through the ER or require the patient to sign an Advance Beneficiary Notice agreeing to pay charges not accepted by insurance.

AdventHealth, Shawnee Mission, KS

- The hospital reports that Medicare Advantage plans deny 75-90 percent of initial prior authorizations for placement of inpatients into post-acute care settings. Upon appeal, 100 percent are approved. While providers are happy to win these appeals, the process takes 4-6 days, which leads to a loss of patient referral and delay in care.

Memorial Hospital, Abilene, KS

- A community member suffered a major back injury leading to multiple physician visits and treatments. Several physicians sought authorization from the insurance company to proceed with surgery. After six months and numerous hours of physician testimony, the authorization was approved. The employee suffered permanent disability due to delay in surgical care.

Action

Serious reform is needed to the prior authorization process, including further automation and transparency. Insurance companies should be required to reduce the number of services and medications requiring prior authorizations. The net effect benefits patients, who would receive prescriptions and services on time, and providers who could provide more patient care. Eliminating prior authorization requirements is the best alternative, however, regulating the insurance companies to ensure the process is standardized, transparent and immediate would be a step in the right direction.
Credentialing Delays

Summary
Starting a new job as a physician should be an exciting time, but this exciting new endeavor can quickly turn into a nightmare for a physician and a hospital fighting credentialing approvals. On a small practice, every patient matters to the bottom line, so when insurance companies take several months to approve a credentialing application from a physician, the physician payment for medical services may be delayed and even denied.

The experience is frustrating and health plans have been largely unhelpful in their attempts to complete the credentialing process in a timely manner. The biggest health plans – UHC, Aetna, and Anthem BCBS tend to take the longest and average three to four months.

Action
Insurers may purposefully drag their feet during the credentialing process to keep physicians out of network for longer periods of time. This delay benefits the health insurance plans financially. Standardization in the credentialing process is needed and encouraged.

Conclusion
Additional examples presented by Kansas hospitals can be presented at any time.

Thank you for taking the time to review this report. We would be happy to discuss in more detail at your convenience. If you have any questions, please contact Shannan Flach email at sflach@kha.net.org or by phone at 785-276-3132.

Sincerely,

Shannan Flach
Vice President, Healthcare Finance and Reimbursement