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Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care

Majority Staff Report Senator Richard Blumenthal

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EXECUTIVE SUMMARY

Every day, doctors evaluate thousands of seniors recovering from falls, strokes, and other ailments, and enter a recommended course of treatment into an online portal, or in some cases feed it into a fax machine. But whether the requested service is determined to be medically necessary is a decision that belongs to people at the other end of the line. This is prior authorization. And for beneficiaries of Medicare Advantage, the alternative to Traditional Medicare in which private companies contract with the government to administer health plans, it has become not just a bureaucratic maze, but a potential threat to their health.

On May 17, 2023, the Permanent Subcommittee on Investigations ("PSI" or "the Subcommittee") launched an inquiry into the barriers facing seniors enrolled in Medicare Advantage in accessing care. PSI sought documents and information from the three largest Medicare Advantage insurers: UnitedHealthcare, Humana, and CVS, who together cover nearly 60 percent of all Medicare Advantage enrollees. This report presents new findings based on the more than 280,000 pages of documents obtained from these three companies to date.

The magnitude and scope of prior authorization requests and denials for particular types of care has been undisclosed before now. This Majority staff report reveals how Medicare Advantage insurers are intentionally using prior authorization to boost profits by targeting costly yet critical stays in post-acute care facilities. Insurer denials at these facilities, which help people recover from injuries and illnesses, can force seniors to make difficult choices about their health and finances in the vulnerable days after exiting a hospital.

Among the Subcommittee's new findings:

- Between 2019 and 2022, UnitedHealthcare, Humana, and CVS each denied prior authorization requests for post-acute care at far higher rates than they did for other types of care, resulting in diminished access to post-acute care for Medicare Advantage beneficiaries.
    - In 2022, both UnitedHealthcare and CVS denied prior authorization requests for post-acute care at rates that were approximately three times higher than the companies' overall denial rates for prior authorization requests. In that same year, Humana's prior authorization denial rate for post-acute care was over 16 times higher than its overall rate of denial.

PSI also obtained internal documents that provide insight into each company's use of the prior authorization, including the role of automation and predictive technologies.

PSI found that:

- UnitedHealthcare's prior authorization denial rate for post-acute care surged from 10.9 percent in 2020, to 16.3 percent in 2021, to 22.7 percent in 2022. During this time, it was implementing multiple initiatives to automate the process.

- In April 2021, an internal UnitedHealthcare committee voted to approve the use of "Machine Assisted Prior Authorization" in the company's utilization management efforts. They were told that the doctor or nurse reviewing the case still had to "verif[y] that the primary evidence is acceptable," but also that testing of the technology had reduced the average time needed to review a request by six to ten minutes.

- In early 2021, UnitedHealthcare tested a "HCE [Healthcare Economics] Auto Authorization Model." Minutes from a meeting of an internal committee reviewing the model noted that initial testing had produced "faster handle times" for cases as well as "an increase in adverse determination rate," which the meeting minutes attributed to "finding contraindicated evidence missed in the original review." The committee voted to tentatively approve the model at a meeting the following month.

- UnitedHealthcare's denial rates for skilled nursing facilities experienced particularly dramatic growth during the period covered by this report. The denial rate in 2019 was nine times lower than it was in 2022. UnitedHealthcare also processed far more home health service authorizations for Medicare Advantage members during this period, underscoring concerns about insurers rejecting placements in post-acute care facilities in favor of less costly alternatives.

- A January 2022 presentation about naviHealth included a sample patient journey in which a "naviHealth Care Coordinator completes nH Predict"—an algorithm linked in media reports[1] to denials of care—"to determine optimal [post-acute care] placement" while the patient was hospitalized. In April 2022, naviHealth issued instructions for the employees handling phone calls with providers about their requests, "IMPORTANT: Do NOT guide providers or give providers answers to the questions" used to collect information UnitedHealthcare used to make prior authorization decisions.

- In December 2022, a UnitedHealthcare working group met to explore how to use AI and "machine learning" to predict which denials of post-acute care cases were likely to be appealed, and which of those appeals were likely to be overturned.

- CVS's prior authorization denial rate for post-acute care remained relatively stable during the period reviewed. However, the number of post-acute care service requests CVS subjected to prior authorization increased by 57.5 percent, far higher than the company's roughly 40 percent growth in enrollment during that period.

  - One program that CVS developed suggested the company should focus on cases it assigned "a significant probability to be denied."

[1] Casey Ross & Bob Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, STAT (Mar. 13, 2023), https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/.

- In a May 2019 presentation, CVS determined that it had saved more than $660 million the previous year by denying prior authorizations requests its Medicare Advantage beneficiaries submitted for inpatient facilities. A majority of these savings came from "denied admissions."

- CVS's testing of a predictive model for inpatient admissions for the company's Medicare Advantage beneficiaries showed that a model built to "Maximize Approvals" jeopardized profits by approving too many cases the company felt should be denied. Subsequent documents indicated that the rate of these "Mistake" approvals for post-acute care admissions was 10 times higher during testing than it was for acute hospital admissions.

- Facing pressure to cut costs in the Medicare Advantage division, in April 2021 CVS deployed "Post-Acute Analytics," which used artificial intelligence to reduce the amount of money spent on skilled nursing facilities. CVS initially expected that it would save approximately $4 million per year, but within seven months, the company projected that an expanded version of the initiative would save the company more than $77 million over the next three years.

- Documents reveal that CVS saw a consistent correlation between increasing prior authorization requirements and expanding savings. A presentation for a March 2022 meeting devoted to prior authorization automation stated that the company had "de-prioritized" a plan to reduce the overall volume of prior authorizations, concluding that the impact on lost savings was "too large to move forward."

- Humana's denial rate for long-term acute care hospitals, the most expensive type of post-acute care, grew by 54 percent between 2020 and 2022, after it held training sessions devoted to prior authorization requests for that type of facility.

  - In the fall of 2019, Humana modified the templates it provided reviewers to communicate decisions on prior authorization requests and appeals of prior authorization denials. One lead medical director noted that changes made to templates for two types of post-acute care facilities were "important for denial purposes" and should be added so as to enhance the company's ability "to uphold a denial on appeal."

  - Humana temporarily relaxed some prior authorization requirements during the coronavirus Public Health Emergency, and the company's denial rate for long-term acute care hospitals in 2021 was lower than it had been in 2019. After being told in an October 2021 email that that there had been "a lot of discussion" about the templates used for evaluating prior authorization requests for these facilities, a Humana senior medical director led two presentations for reviewers about how requests for long-term acute care hospitals should be evaluated.

- These presentations were given to far more of the company's reviewers than similar presentations in 2020. They also included strategies for explaining denials to providers. In one of these presentations, from December 2021, Humana stressed to reviewers that the post-acute facility was a "*high-cost intervention*" [italics in original] and urged them to pose "surprise questions" to recommending providers as a "gut check."

- After some of its medical reviewers objected to suggesting hospice, which is not covered by Medicare Advantage, as an alternative to long-term acute care hospitals, medical directors decided to remove the hospice reference from response letters, but some training materials for evaluating requests for these facilities continued to reference hospice as an alternative.

- Evidence obtained by the Subcommittee to date does not indicate the extent to which Humana may be using automation or predictive technologies to deny prior authorization requests. However, the company has contracted with naviHealth since 2017, and Humana policies suggest contractors had greater latitude about predictive technologies. Humana tended to use AI to mean "augmented intelligence" rather than artificial intelligence, but an August 2020 policy document did not make this distinction when discussing arrangements with contracted parties, stating "Certain third parties may utilize Artificial Intelligence systems in support of services being provide to Humana and are covered within the scope of these guidelines, where applicable."

While the Subcommittee continues to investigate the use of predictive technologies by Medicare Advantage insurers, the data obtained so far is troubling regardless of whether the decisions reflected in the data were the result of predictive technology or human discretion. It suggests Medicare Advantage insurers are intentionally targeting a costly but critical area of medicine—substituting judgment about medical necessity with a calculation about financial gain.

Based on the results of this investigation, PSI makes the following recommendations:

1. The Centers for Medicare & Medicaid Services ("CMS") should begin collecting prior authorization information broken down by service category. The data the agency currently requires insurers to submit leaves it unclear whether insurers are using prior authorization to target particular types of care.

2. CMS should conduct targeted audits if insurer prior authorization data reveal notable increases in adverse determination rates. Once the agency has service category data, it could more efficiently allocate resources by targeting audits at insurers whose submissions indicate significant increases in denial rates.

3. CMS should expand regulations for insurers' utilization management committees to ensure that predictive technologies do not have undue influence on human reviewers. Even if predictive technologies are solely used to approve requests, nurses and doctors reviewing

cases may face pressure to rubber-stamp the recommendations of algorithms and artificial intelligence.

BACKGROUND

1. Medicare Advantage as an alternative to Medicare

Medicare, the federal health insurance program for Americans aged 65 and older, provides a range of health services for seniors. Medicare Advantage is a private plan alternative to traditional Medicare that is required to provide the same minimum levels of coverage as Medicare. Insurance companies with Medicare Advantage plans contract with the Medicare program and receive payments for providing services on a capitated, or per beneficiary, basis.

The Medicare program has had some private health plan options since it began. The earliest incarnation permitted health maintenance organizations (HMOs) to allow seniors to continue using their preferred physician from their employer-based plan.[2] Risk-based coverage, in which private organizations agree to cover all enrollee healthcare needs in exchange for a set payment, began in 1985.[3] The Balanced Budget Act of 1997[4] created Medicare Part C, then called Medicare+Choice.[5] Medicare+Choice allowed Medicare beneficiaries to choose from among a broader array of private health plans than was previously allowed.[6] In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act ("MMA")[7] further expanded private insurance options, and renamed Medicare Part C Medicare Advantage.[8]

Traditional Medicare is divided into Part A (which covers most inpatient services, including stays in hospitals and post-acute care facilities, as well as hospice and home health care) and Part B (which covers outpatient care, medical supplies, and preventative services).[9] Traditional Medicare is sometimes called fee-for-service ("FFS") Medicare, because the government directly pays providers based on

[2] Robert A. Berenson & Bryan E. Dowd, *Medicare Advantage Plans at a Crossroads—Yet Again*, 27 HEALTH AFFAIRS 29, 30 (2008).

[3] Thomas G. Mcguire et. al., *An Economic History of Medicare Part C*, 89(2) THE MILBANK Q. 289, 290, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270/.

[4] Balanced Budget Act of 1997, Pub. L. No. 105-33, § 111 Stat. 251, 270 (1999).

[5] CTRS. FOR MEDICARE & MEDICAID SERVS., *Health Plans – General Information* (Sept. 10, 2024), https://www.cms.gov/medicare/enrollment-renewal/health-plans.

[6] SOC. SEC. ADMIN., *Program Operations Manual System - HI 00208.066 The Medicare Advantage (MA) Program* (2022) https://secure.ssa.gov/poms.nsf/lnx/0600208066.

[7] Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173 § 117 Stat. 2066 (2003).

[8] CTRS. FOR MEDICARE & MEDICAID SERVS., Part C – Medicare Advantage and 1876 Cost Plan Expansion Application (2019).

[9] MEDICARE, What's Medicare?, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last visited July 11, 2024).

predetermined fee schedules or systems.[10] Medicare Part C covers all Part A and B services except hospice.[11] Medicare Part D covers outpatient prescription drugs and, like Part C, is a capitated program.[12] Enrollees in Traditional Medicare usually select a separate Medicare drug plan, while Medicare Advantage plans typically include prescription drug coverage.[13] Along with covering all of the services (except hospice care) covered by FFS Medicare, Medicare Advantage plans may offer supplemental benefits, such as dental care, gym memberships, and, in some cases, meals and non-medical transport.[14]

2. The Growth of Medicare Advantage

The additional benefits offered, along with offers of limits on out-of-pocket expenses for covered services, are among the reasons for the considerable growth in Medicare Advantage enrollment over the past two decades.[15] In 2003, when MMA was enacted, Medicare Advantage plans constituted only 13 percent of Medicare enrollment.[16] By 2023, a majority of those eligible for Medicare were enrolled in a Medicare Advantage plan, representing more than 30 million of nearly 60 million Medicare-eligible seniors.[17] As it has grown, the industry has also become increasingly concentrated. In 2008, the three largest Medicare Advantage insurers enrolled 32 percent of Medicare Advantage beneficiaries; by 2023, the three largest Medicare Advantage insurers (UnitedHealthcare, CVS, and Humana)—the three companies from whom the Subcommittee has sought information—enrolled 58 percent of all Medicare Advantage beneficiaries.[18]

Despite the surge in enrollment, a growing number of hospitals and healthcare provider networks say Medicare Advantage insurer practices make it challenging to stay in business. A March 2024 survey of health systems revealed that 19 percent had stopped accepting one or more Medicare Advantage plans in

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[10] Paulette C. Morgan, Phoenix Voorhies, CONG. RSCH. SERV., IF10885, Medicare Overview (2024).

[11] *Id.*

[12] CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicare Part D – Direct and Indirect Remuneration (DIR)* (July 16, 2018), https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-direct-and-indirect-remuneration-dir (Drugs that must be administered by a physician are covered under Medicare Part B).

[13] MEDICARE, *How to get prescription drug coverage* (last visited July 11, 2024), https://www.medicare.gov/drug-coverage-part-d/how-to-get-prescription-drug-coverage.

[14] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105527, Medicare Advantage, Plans Generally Offered Some Supplemental Benefits, but CMS Has Limited Data on Utilization (2023) (The range of supplemental benefits MA plans could offer expanded in 2019, and then expanded further in 2020, with a new class of benefits for the chronically ill).

[15] *See e.g.* Sarah Jane Tribble, *Medicare Advantage Is Popular, but Some Beneficiaries Feel Buyer's Remorse*, KFF HEALTH NEWS (Jan. 23, 2024), https://kffhealthnews.org/news/article/health-202-medicare-advantage-buyers-remorse/.

[16] Yash M. Patel & Stuart Guterman, *The Evolution of Private Plans in Medicare*, at 1,5, THE COMMONWEALTH FUND (2017), https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2017_dec_patel_evolution_private_plans_medicare_managed_care_ib.pdf.

[17] Meredith Freed et al., *Medicare Advantage 2024 Spotlight: First Look*, KFF (Nov. 15, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-2024-spotlight-first-look/.

[18] Stuart Hammond et al., *The Medicare Advantage program: Status report,* MEDPAC, at 8 (2024), https://www.medpac.gov/wp-content/uploads/2023/10/MedPAC-MA-status-report-Jan-2024.pdf.

2023, and that 61 percent of health systems are either considering ceasing to accept all Medicare Advantage patients within the next two years, or will definitely do so.[19] In March of this year, for example, Connecticut's Bristol Hospital announced that it was eliminating 60 positions, a decision the hospital's president attributed to delays in payment and coverage rejections by Medicare Advantage insurers.[20]

3. The Growth of Prior Authorization in Medicare Advantage

Both traditional Medicare and Medicare Advantage must cover services that are "reasonable and necessary for the diagnosis or treatment of an illness or injury."[21] Under Traditional Medicare, patients receive care at Medicare-certified facilities, and the facility or a provider then submits a report of their costs to Medicare Administrative Contractors for processing and reimbursement determination.[22] These facility or provider claims are also subject to various compliance and auditing efforts to prevent improper payments.[23] Because they take place after care (and sometimes after payment) has been provided, these processes are sometimes called "retrospective review."[24] Medicare Advantage insurers, by contrast, frequently require patients and providers to obtain prior authorization before receiving care.[25]

Prior authorization was rare in both private and government-sponsored insurance until the 1980s and the transition from "provider-based utilization review," in which doctors and hospitals audited the necessity of medical services after they had been delivered, to "utilization management by third parties," like

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[19] HFMA Health System, *HFMA Health System CFO Pain Points 2024: Margin Challenges & Opportunities for Vendors*, at 2 (2024), https://www.hfma.org/wp-content/uploads/2024/03/Overview-2024-CFO-Pain-Points-Study.pdf.

[20] Don Stacom, *Bristol Hospital Making Staff Cuts President Blames Medicare Advantage Insurers' Payments*, The Hartford Courant (March 18, 2024, 6:00 AM), https://www.courant.com/2024/03/15/rising-costs-medicare-advantage-abuse-force-job-cuts-at-local-ct-hospital-president-says/.

[21] Ctrs. for Medicare & Medicaid Servs., *Medicare Coverage Determination Process* (Sept. 10, 2024), https://www.cms.gov/medicare/coverage/determination-process.

[22] 42 CFR § 405.1801(b)(1); 42 CFR § 413.24.

[23] Ctrs. for Medicare & Medicaid Servs., *Medical Review and Education* (Sept. 10, 2024), https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education.

[24] The Social Security Act initially prohibited prior authorization for Medicare services, (*See* U.S. Dep't of Health & Hum. Servs., MLN Matters SE0916, *Medicare Parts A and B Coverage and Prior Authorization*, https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE0916.pdf), but the Act has since been amended to allow prior authorization in specified cases; for example, CMS publishes an annual list of durable medical equipment, prosthetics, orthotics, and supplies ("DMEPOS") that may be subject to prior authorization. Ctrs. for Medicare & Medicaid Servs., Table 13: Master List of DMEPOS Items Potentially Subject to Face-To-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/FINAL-RULE-MASTER-LIST-of-DMEPOS-Subject-to-Frequent-Unnecessary-Utilization-2018-03-30.pdf.

[25] Along with medical necessity determinations, which are supposed to be the purview of doctors and nurses, Medicare Advantage insurers also make "administrative" determinations, which involve assessing the terms of a member's plan and can be made by non-clinical employees.

insurance companies.[26] Surveys of employee health benefits plans indicate that, in 1983, only 14 percent of such plans required prior authorization for inpatient hospital admissions, and that, in 1984, only five percent of workers nationwide were covered by such requirements.[27] When the process began to become more common, in the late 1980s, the "main strategy" of "high-cost case management" was to "discuss and negotiate appropriate care rather than to refuse prior authorization of benefits explicitly," with denial rates estimated to fall between one to two percent.[28]

In 2022, Medicare Advantage insurers received more than 46 million prior authorization requests, and either fully or partially denied about 3,400,000 of them, or about 7.4 percent.[29] While prior authorization is not a verdict on what course of treatment a patient must pursue, a denial often forces a patient to either pay for the service out of pocket—if they can afford to—or forgo it entirely. Patients have the right to appeal denials but, in 2022, patients sought reconsideration of less than 10 percent of denied requests.[30]

While the use of prior authorization has expanded significantly for all types of insurance since the 1980s, its use in Medicare Advantage plans has particularly increased in the last five years. The American Journal of Managed Care found that the share of Medicare Advantage enrollees in a plan requiring prior authorization for at least one category of healthcare services was 72.6 percent in 2019, which was similar

[26] COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, INST. OF MED., *Controlling Costs and Changing Patient Care?: The Role of Utilization Management* 43 (Bradford H. Gray & Marilyn J. Field eds., 1989).

[27] *Id.* at 14.

[28] *Id.*

[29] Jeannie Fuglesten Biniek et al, *Use of Prior Authorization in Medicare Advantage Exceeded 46 million requests in 2022,* KFF (August 8, 2024), https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/.

[30] *Id.* When a prior authorization request, or other instance of denied coverage, occurs, there are five levels of appeals that MA beneficiaries and providers can pursue. When a MAO denies a prior authorization request, it must alert the beneficiary of their right to file an initial appeal, which is known as a "request for reconsideration." If the MAO denies the reconsideration, or it does not meet the statutorily required deadline to respond, the request is automatically referred to the second level of appeal, which is handled by the Independent Review Entity ("IRE"), a body that maintains their own doctors and is hired by CMS. Maximus is the current IRE. If the claim is denied again by the IRE, the process for MA beneficiaries mirrors that of FFS Medicare, with the potential to appeal further to the Office of Medicare Hearings and Appeals, the Medicare Appeals Council, and eventually a federal judge. *See generally* U.S. DEP'T OF HEALTH & HUM. SERVS., *The Appeals Process* (last visited July 16, 2024), https://www.hhs.gov/about/agencies/omha/the-appeals-process/index.html.

to the rate it had been in 2009.[31] But by 2023, the Kaiser Family Foundation reported that 99 percent of Medicare Advantage enrollees were in a plan requiring prior authorization for some services.[32]

The expansion of prior authorization has created friction for providers and patients, and faces a backlash within the medical field.[33] A 2023 survey of physicians from the American Medical Association found that 73 percent of physicians reported that the number of prior authorizations for medical services had increased somewhat or had increased significantly in the last five years.[34] The survey also found that 78 percent of physicians reported that prior authorization sometimes led to abandoned treatment, and that 24 percent said that the practice had led to a "serious adverse event" for patients in their care.[35] Media reports on hospital and provider groups that have stopped accepting Medicare Advantage patients cite "excessive prior authorization denial rates," along with an allegedly slow pace of Medicare Advantage insurer reimbursement for claims that are approved, as the primary reason.[36]

4. Algorithms, Artificial Intelligence, and Automation

The widespread use of prior authorization became practical to implement only with computer technology and the "proliferation of information resources, assessment tools, and organizations that [made] case-by-case review of proposed services feasible on a large scale."[37] Beginning in the early 2000s, there were efforts to "expand [prior authorization] into an electronic dialogue" that could result in must faster

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[31] Hannah T. Neprash et al., *The Extent and Growth of Prior Authorization in Medicare Advantage*, 30 AM. J. OF MANAGED CARE 85 (2024).

[32] Nancy Ochieng et al., *Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, KFF (Aug. 9, 2023), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

[33] In the last few years, the insurers covered by this investigation have pared back some prior authorization requirements in response to concerns from providers and the public. *See, e.g.,* Press Release, UnitedHealthcare, "Prior authorization reduction equals nearly 20 percent of overall volume," (August 1, 2023), https://www.uhcprovider.com/en/resource-library/news/2023/medical-prior-auth-code-reduction-august.html; Claire Wallace, Humana rolls back Medicare Advantage prior authorization policy, BECKER'S ASC (August 3, 2022), https://www.beckersasc.com/ophthalmology/humana-rolls-back-medicare-advantage-prior-authorization-policy.html; Paige Minemyer, *Aetna to roll back controversial prior authorization policy for cataract surgery,* FIERCE HEALTHCARE (June 30, 2022), https://www.fiercehealthcare.com/payers/aetna-roll-back-controversial-prior-authorization-policy-cataract-surgery. These changes have not reduced prior authorization requirements for post-acute care.

[34] *Measuring Progress in Improving Prior Authorization*, AM. MED. ASS'N, at 1 (2023), https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.

[35] *Id.*

[36] Jakob Emerson, *Hospitals are dropping Medicare Advantage plans left and right*, BECKER'S HOSPITAL CFO REPORT (Dec. 14, 2023), https://www.beckershospitalreview.com/finance/hospitals-are-dropping-medicare-advantage-left-and-right.html.

[37] COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, *Controlling Costs and Changing Patient Care?: The Role of Utilization Management,* at 43.

approvals of requests, but "complex care situations" remained difficult to address.[38] In recent years, rapid advances in artificial intelligence and related technologies have shown the potential to transform utilization management once again, by automating the processing of prior authorization requests.[39]

The U.S. surgeon general has suggested that, properly applied, these technologies may help address clinician "burnout" by reducing the burden of prior authorization and other administrative tasks.[40] The structure of automation technologies varies considerably both across the healthcare industry and within the companies that employ them, but insurers developing these initiatives consistently state that they may only approve requests for care, and that any final denials for reasons of medical necessity must come from physician reviewers.[41] However, in 2023, media reports indicated that naviHealth, a company owned by UnitedHealthcare's parent company UnitedHealth Group that contracted with multiple Medicare Advantage insurers, was using artificial intelligence technologies to fix lengths of stay for patients at various inpatient facilities, and in some cases to determine whether those patients should be admitted at all.[42]

5. Medicare Criteria and Coverage Regulations

Medicare Advantage is required to cover "all services that are covered by Part A and Part B of Medicare."[43] In other words, while Medicare Advantage insurers are permitted to offer additional benefits that are not available in Traditional Medicare, they may not deny coverage of the "basic benefits" that *are* available in Traditional Medicare. In determining whether a particular service or procedure would be available under traditional Medicare, Medicare Advantage insurers may rely on several different types of rules and evidence.[44]

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[38] Leslie Lenert et al, *Could an artificial intelligence approach to prior authorization be more human?*, 30 JAMIA 989, 990-91 (February 21, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10114030/pdf/ocad016.pdf.

[39] *See, e.g.,* McKinsey & Company, *AI ushers in next-gen prior authorization in healthcare* (April 19, 2022), https://www.mckinsey.com/industries/healthcare/our-insights/ai-ushers-in-next-gen-prior-authorization-in-healthcare/. Each of the companies that are the

[40] U.S. DEP'T OF HEALTH & HUM. SERVS., *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022) at 58, https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf.

[41] *See* Letter from CVS to PSI, July 27, 2023; Letter from Humana to PSI, July 7, 2023; Letter from UnitedHealthcare to PSI; Letter from UnitedHealthcare to PSI, June 7, 2023.

[42] Ross & Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need*, Casey Ross & Bob Herman, *How UnitedHealth's acquisition of a popular Medicare Advantage algorithm sparked internal dissent over denied care*, STAT (July 11, 2023), https://www.statnews.com/2023/07/11/medicare-advantage-algorithm-navihealth-unitedhealth-insurance-coverage/, Casey Ross & Bob Herman, *UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care*, STAT (Nov. 14, 2023), https://www.statnews.com/2023/11/14/unitedhealth-algorithm-medicare-advantage-investigation/, Casey Ross & Bob Herman, *UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients*, STAT (Dec. 28, 2023), https://www.statnews.com/2023/12/28/medicare-advantage-united-health-navihealth-rehab-care-restrictions/.

[43] 42 C.F.R. § 422.101(a) (2019).

[44] Along with federal statutes, like the Social Security Act, and CMS regulations, there are: National Coverage Determinations ("NCDs") which are developed by CS and apply nationwide (42 C.F.R. § 405.1060(a)); Local Coverage

CMS began issuing new regulations in 2023 related to prior authorization and the criteria Medicare Advantage insurers may use in approving or denying requests.[45] These new regulations, some of which went into effect on January 1, 2024, noted that, in recent years, CMS had "received numerous inquiries regarding Medicare Advantage organizations' use of prior authorization and its effect on beneficiary access to care."[46] Among other changes, the rule clarified that prior authorization policies for coordinated care plans may only be used to "confirm the presence of diagnoses or other medical criteria" or ensure that a service or procedure is "medically necessary," and that, in deciding whether to cover a particular service requested by a provider, plans may only use "internal coverage criteria" when traditional Medicare criteria are not "fully established."[47] It remains unclear whether these new regulations will have an effect in reducing delays or denials of care.[48] Some companies subject to these changes have said that they could limit future growth and profitability.[49]

6. Post-Acute Care Cost and Incentives

Seniors are more likely to have comorbidities that complicate their recovery from an illness or injury that is treated in a hospital—the "acute" phase of their healthcare. Properly prescribed treatment in post-acute care facilities can increase older adults' "functional autonomy" and reduce the likelihood of returning to a hospital.[50] Post-acute care facilities include: skilled nursing facilities, which offer short-term care and rehabilitation services, including physical and occupational therapy, and speech-language pathology

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Determinations ("LCDs"), which are developed by Medicare Administrative Contractors and apply in particular geographic areas (*See generally* MEDICARE, *Local Coverage Determinations (LCD) challenge* (last visited July 16, 2024), https://www.medicare.gov/claims-appeals/local-coverage-determinations-lcd-challenge); Internet-Only Manuals, such as the Medicare Benefit Policy Manual, which are published by CMS and offer "day-to-day operating instructions" for Medicare Advantage insurers and others (*see generally*, CTRS. FOR MEDICARE & MEDICAID SERVS., *Internet-Only Manuals (IOMs)* (last visited July 16, 2024), https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms); and third-party databases of clinical support criteria that help Medicare Advantage insurers apply coverage rules and determine whether a requested service is medically necessary. As is explained in greater detail below, regulatory requirements about when Medicare Advantage insurers may rely on criteria other than statutes, regulations, NCDs, or LCDs changed beginning in 2024.

[45] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 88 Fed. Reg. 22120 (April 12, 2023).

[46] *Id.*

[47] *Id.*

[48] Lane Koenig, Martin Allen, and Mollie Gurian, Comments at the American Medical Rehabilitation Providers Association Spring Conference (March 18, 2024).

[49] See, for example, Humana CFO Susan Marie Diamond's remarks from the company's fourth quarter 2023 earnings call: "We did have an expectation as a result of those changes that we will see a larger number of inpatient authorizations approved." Refinitiv., Humana Inc. Earnings Call Transcript (Jan. 25, 2024) at 18, https://humana.gcs-web.com/static-files/3f9806ef-70cc-4761-a257-b8adbe53c201.

[50] Yuh-Chun Wang et al., *Post-Acute Care as a Key Component in a Healthcare System for Older Adults*, 23(2) ANNALS OF GERIATRIC MED. AND RSCH. 54, 56 (2019).

services;[51] inpatient rehabilitation facilities, which may offer therapeutic services similar to those of skilled nursing facilities but are intended for patients requiring intense rehabilitation;[52] and long-term acute care hospitals, which treat chronically critically ill patients needing care for an extended timeframe.[53]

Under traditional Medicare, Medicare Part A covers medically necessary stays in each of these facilities.[54] Since at least 2019, criteria governing when a post-acute facility admission is appropriate have not changed substantially, with the exception of a period during the coronavirus-related Public Health Emergency ("PHE").[55] From March 1, 2020 to the declared end of the PHE on May 11, 2023, some admissions requirements were temporarily relaxed to allow these facilities to relieve overcrowded hospitals.[56]

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[51] MEDPAC, March 2024 Report to the Congress: Medicare Payment Policy, 167 (2024).

[52] *Id. at* 229.

[53] MEDPAC, *Long-Term Care Hospitals Payment System* (Oct. 2023), https://www.medpac.gov/wp-content/uploads/2022/10/MedPAC_Payment_Basics_23_LTCH_FINAL_SEC.pdf.

[54] MEDICARE, *Skilled Nursing Facility (SNF) Care* (last visited July 12, 2024), https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care; MEDICARE, *Inpatient Rehabilitation Care* (last visited July 12, 2024), https://www.medicare.gov/coverage/inpatient-rehabilitation-care; MEDICARE, *Long-Term Care Hospital Services* (last visited July 12, 2024), https://www.medicare.gov/coverage/long-term-care-hospital-services.

[55] Criteria for admission to skilled nursing facilities are defined at 42 C.F.R. § 409, Subpart D. (This section is titled "Requirements for Coverage of Posthospital SNF Care" and, along with the "Criteria for skilled services and need for skilled services" (§ 409.32). It contains an explanation of the requirement that a beneficiary must spend at least three days at an acute hospital prior to admission to a skilled nursing facility (§ 409.30). CMS has noted that Medicare Advantage insurers "may waive the 3-day minimum." MEDICARE, *Skilled Nursing Facility (SNF) Care*. The criteria for inpatient rehabilitation facilities are contained at 42 C.F.R. § 412.622(a)(3).

In practice, however, Medicare Advantage insurers typically rely on and cite in communications with patients and providers the more detailed criteria found in the Medicare Benefit Policy Manual, a CMS "Internet-only Manual." (*See* note 44). Chapter 8 of the Medicare Benefit Policy Manual provides medical necessity criteria for skilled nursing facilities (U.S. DEP'T OF HEALTH & HUM. SERVS., *Medicare Benefit Policy Manual: Coverage of Extended Care (SNF) Services Under Hospital Insurance*, (2021)), while the criteria for inpatient rehabilitation facilities are contained in Chapter 1 (U.S. DEP'T OF HEALTH & HUM. SERVS., *Medicare Benefit Policy Manual: Inpatient Hospital Services Covered Under Part A*, (2021)). (A more recent version of Chapter 1 has been released with updates that were made outside the period covered by this investigation; the version attached contains updates that were made during this period.) CMS's update of Chapter 1, released on Aug. 6, 2021, included "changes regarding the physician supervision requirement" of Chapter 1, § 110.4. U.S. DEP'T OF HEALTH & HUM. SERVS., *Medicare Benefit Policy Manual: Internet Only Manual Updates to Publication 100-02* (2021), https://www.cms.gov/files/document/r10892BP.pdf.

Criteria for admission to long-term acute care hospitals are not spelled out in the Medicare Benefit Policy Manuals. As a result, Medicare Advantage insurers typically use third-party providers of medical necessity criteria when making these determinations. However, Congress and CMS have established rules for long-term acute care hospitals themselves, defining when they are paid at a "qualifying" rate as opposed to a "site-neutral" rate based on the characteristics of the discharged patient. § 412.522(b).

[56] *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19* (May 10, 2023), https://www.cms.gov/files/document/long-term-care-facilities-cms-flexibilities-fight-covid-19.pdf; CTRS. FOR MEDICARE & MEDICAID SERVS., *Medicare COVID-19 PHE Waivers & Flexibilities*, https://www.cms.gov/files/document/1-medicare-covid-19-phe-waivers-flexibilities.pdf; 42 C.F.R. § 412.622(a)(4) (2001). Notably, CMS waived the requirement that patients spend three inpatient days in an acute hospital to qualify for admission to a skilled nursing facility, waived the "60 percent" rule for patient composition at inpatient

Medicare Advantage beneficiaries have consistently had lower utilization rates of post-acute care services than Traditional Medicare beneficiaries.[57] Previous attempts to determine whether certain types of care are disproportionately impacted by prior authorization have, while acknowledging the limits of available data, pointed to post-acute care. At its November 2023 meeting, the Medicare Payment Advisory Commission ("MedPAC") revealed an analysis of prior authorization denials appealed to the Independent Review Entity, the first level of appeal for Medicare Advantage beneficiaries after the insurers themselves. The analysis indicated that roughly half of all such appeals were related to stays in inpatient rehabilitation facilities.[58]

In 2022, the Department of Health and Human Services, Office of Inspector General ("HHS OIG") released a report on their study of a sample of prior authorization and payment requests that had been denied by Medicare Advantage insurers in 2019.[59] This review, which followed other HHS OIG examinations of prior authorization in 2015 and 2018, found that 13 percent of the denied requests during the period reviewed should have been approved.[60] HHS OIG noted that if that denial rate were to apply to all of 2019, it would mean that Medicare Advantage insurers would have rejected 84,812 prior

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rehabilitation facilities, and, with authorization from Congress in the CARES Act, waived the "site neutral" payment rate for long-term acute care hospitals. While Medicare Advantage plans are not required to follow all of these requirements or their waiver (*See* note 48), as discussed in Finding No. 4, some did relax requirements during this period, including temporary suspensions of prior authorization at post-acute facilities in certain parts of the country.

[57] Laura Skopec et al., *Home Health and Postacute Care Use in Medicare Advantage and Traditional Medicare*, 39 Health Affairs 837, 837 (2020). Some studies have found that, despite lower utilization of post-acute care, Medicare Advantage beneficiaries had equivalent or better outcomes, such as lower likelihood to return to a hospital. *See, e.g.* Amit Kumar et al., *Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data*. PLoS MED. 15(6):e1002592, (June 26, 2018), https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002592. Studies comparing utilization and outcomes between MA and FFS tend to rely on data from 2018 or earlier. *See generally,* Nancy Ochieng & Jeannie Fuglesten Biniek, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature*, KFF (Sept. 16, 2022), https://www.kff.org/report-section/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature-appendix/.

[58] MEDPAC, *Evaluating Access in Medicare Advantage: Network Management and Prior Authorization* (Nov. 2023), https://www.medpac.gov/wp-content/uploads/2023/03/MA-access-MedPAC-11.23.pdf. During the November meeting, staff with the Medicare Payment Advisory Commission raised the possibility of "self-selection," in which some seniors may deliberately enroll in Traditional Medicare rather Medicare Advantage in order to avoid prior authorization. MEDICARE PAYMENT ADVISORY COMM'N, Public Meeting Transcript at 8 (Nov. 3, 2023), https://www.medpac.gov/wp-content/uploads/2023/03/November-2023-meeting-transcript-SEC.pdf. While self-selection may occur in the context of known, ongoing needs like cancer treatment or psychiatric care—the two examples provided by MedPAC staff—the need for post-acute care overwhelmingly arises following unplanned medical emergencies, like a fall or a stroke, that occur after a patient has already made an enrollment decision. Self-selection is therefore unlikely to influence the rate at which patients need or seek post-acute care.

[59] U.S. DEP'T OF HEALTH & HUM. SERVS., OEI-09-18-00260, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (2022).

[60] *Id.* at 9.

authorization requests that met Medicare coverage rules and should never have been denied in the first place.[61]

HHS OIG's 2022 audit noted that stays in post-acute care facilities were among the most likely areas for wrongfully denied prior authorization requests. In particular, Medicare Advantage insurers "denied requests for transfers to post-acute care facilities that met Medicare coverage rules, claiming that beneficiaries' needs could be met at a lower, less costly level of care."[62]

HHS OIG also noted that post-acute care was an area where "the potential incentive for insurers to deny access to services and payment in an attempt to increase profits" was particularly strong because of the difference in price between certain care settings—for example, treatment through home health rather than in a skilled nursing facility.[63] According to MedPAC, in 2022, the average cost of 30 days of home health visits was approximately $1,907, while the average cost of a stay in a skilled nursing facility was approximately $14,650.[64] Although Medicare Advantage insurers do not have to pay the rates set by Traditional Medicare and can negotiate different rates with facilities, it is likely that they can still experience significant cost savings by moving beneficiaries to lower levels of care.[65]

CMS's 2024 prior authorization regulations also demonstrated a particular concern with how the practice is impacting access to post-acute care. The regulations state that the requirement of matching the coverage obligations of traditional Medicare means that a Medicare Advantage insurer "may only deny a request for Medicare-covered post-acute care services in a particular setting if the [insurer] determines that the Traditional Medicare coverage criteria for the services cannot be satisfied in that particular setting."[66] A memo providing further clarification of the new regulations, released in February 2024, said that while Medicare Advantage insurers were still permitted to apply prior authorization to post-acute care, the

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[61] *Id.*

[62] *Id.* at 16.

[63] *Id.* at 2.

[64] These figures are derived using the method laid out by HHS OIG (*Id.* at 2) but with updated data for 2022: taking total fee-for service spending in this category of post-acute care and dividing it by the total number of stays (or 30-day periods in the case of home health). *See* MEDPAC, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM, at 106 (overall), 108 (skilled nursing facilities), 113 (home health) (2024), https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_Sec8_SEC.pdf.

[65] Two studies examining payments to providers by Medicare Advantage plans begin by acknowledging that "little is known" about the plans' reimbursement practices. *See* Erin Trish et al., *Physician Reimbursement in Medicare Advantage Compared with Traditional Medicare and Commercial Health Insurance*, 177 AM. MED. ASS'N 1287; Jared Lane K. Maeda et al., Medicare Advantage, *How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare with Medicare Fee-for-Service Prices?*, INQUIRY, Jan. 2018, at 7. Both studies concluded that, for most services, Medicare Advantage payments to hospitals and physicians are slightly lower but similar to those of traditional Medicare. However, although the negotiated rates may be similar between the two programs, delays related to prior authorization, such as days spent in a hospital bed while awaiting approval for transfer to a post-acute facility, may diminish providers' "reimbursement realization levels" for Medicare Advantage plans. *See* Eric Meinkow et al., *The "Advantage" in Medicare Advantage for Providers,* GUIDEHOUSE (July 28, 2023), https://guidehouse.com/insights/healthcare/2023/the-advantage-in-medicare-advantage-for-providers.

[66] 88 FR 22189.

"flexibility" granted to these insurers "does not replace the obligation for [Medicare Advantage] plans to cover all basic benefits consistent with the established coverage criteria for Traditional Medicare."[67]

THE SUBCOMMITTEE'S INQUIRY AND METHODOLOGY

The Subcommittee sought data about prior authorization requests and denials between 2019 and 2022 from three of the largest Medicare Advantage insurers: UnitedHealthcare, Humana, and CVS. This date range aligned with increases in concern from patients and providers that prior authorization was threatening seniors' wellbeing and the viability of medical practices. The time period also overlapped with reporting showing that Medicare Advantage insurers were expanding their use of AI and other methods of automating the processing of healthcare claims.[68] In order to understand whether prior authorization was disproportionately impacting certain areas of care, PSI sought year-by-year breakdowns of these figures for post-acute care facilities, information which is not publicly reported. The Subcommittee obtained data broken down by type of post-acute care facility in order to understand how utilization differed among skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals, each of which has different criteria for admissions, and different financial implications for insurers.

Along with data about prior authorization requests, PSI strove to understand the processes the companies use to evaluate these requests. This has included explanations of how companies divide this work between their employees and those of contracted entities, and the number of claims or requests for which each worker is responsible at the various levels of the review process. PSI also collected documents used in training workers evaluating prior authorization requests, and explanations of the procedures used to evaluate or measure these workers and determine their prospects for advancement.

The Subcommittee has also obtained documents related to the use of algorithms, AI, and other predictive technologies, including the way the companies use these technologies in the context of prior authorization and other utilization management practices. PSI requested documents regarding the decisions to adopt and incorporate these technologies, and the institutional measures the companies set up to monitor them. The Subcommittee also received briefings from officials with all three companies related to these topics.

Documents obtained by PSI include meeting agendas and minutes for numerous groups or committees within the companies, including internal bodies that discussed methods of extracting further savings from healthcare; presentations, policy statements, and training exercises; communications with healthcare providers and medical groups; contracts with third parties assisting in the prior authorization process; statements to regulators and responses to other government inquiries; savings-and-expenditure

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[67] Memorandum from Ctrs. for Medicare & Medicaid Serv. to All Medicare Advantage Organizations and Medicare-Medicaid Plans (Feb. 6, 2024) at 6-7 (on file with the Subcommittee).

[68] Ross & Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need.*.

projections; and internal emails sharing or discussing each of these. PSI has so far reviewed more than 280,000 pages of documents from the three companies.

FINDINGS

1. UnitedHealthcare, Humana, and CVS used prior authorization to target costly but critical post-acute care

The Subcommittee's analysis of data obtained from UnitedHealthcare, Humana, and CVS shows that, across all three companies, prior authorization requests for post-acute care services for Medicare Advantage enrollees were denied at substantially higher rates than prior authorization requests for other types of care. PSI collected data from the three companies on their annual use of prior authorization for Medicare Advantage beneficiaries in skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. The Subcommittee also sought overall data for all requests for prior authorization for Medicare Advantage enrollees. This allowed the Subcommittee to compare how often prior authorization requests were denied for post-acute care services relative to all types of care.

The data provided by the companies show that, not only did insurers deny prior authorization for post-acute care more often than other services, but that the rate of denial was substantially higher for some companies. For UnitedHealthcare and CVS, 2022 denial rates for prior authorization of post-acute care services were approximately three times higher than the companies' overall denial rates. In the case of Humana, rates for 2022 were over 16 times higher.

Figure 1: Initial Adverse Determination Rates, Overall and for Post-Acute Care, by Insurer and by Year

Year	UnitedHealthcare		Humana		CVS	
Adverse Determination Rate	Overall	PAC	Overall	PAC	Overall	PAC
2019	7.3%	8.7%	1.3%	20.7%	11.6%	24.1%
2020	7.2%	10.9%	1.1%	20.2%	9.5%	24.6%
2021	7.7%	16.3%	1.4%	22.1%	7.3%	24.8%
2022	7.6%	22.7%	1.5%	24.6%	8.8%	25.9%

Sources: UnitedHealthcare New Exhibit A, July 17, 2023; HUM-PSI-0045741-43, HUM-PSI-0045745-48, HUM-PSI-0045750-53, HUM-PSI-0045756-59; CVS-PSI-159395, CVS-PSI-178014, Letter from CVS to PSI, March 29, 2024).

There is no statutory or regulatory requirement that Medicare Advantage insurers approve prior authorization requests at the same rates across medical sub-fields, and admission to post-acute care facilities is governed by distinct medical necessity criteria.[69] But as is addressed more fully below, the

[69] *See* Background, Sections 5-6.

extent of the variation in an insurer's denial rates is currently unknown to regulators. Further, although post-acute care facilities represent a significant share of all prior authorization denials, they represent only a portion of all prior authorization requests, meaning that an insurer's denial rate for post-acute care could increase significantly from one year to the next even as the insurer's overall denial rate, which is publicly available, appears relatively unchanged. At the facility level, these changes can be striking. For example, between 2019 and 2022, UnitedHealthcare's denial rate for skilled nursing facilities increased by a factor of nine.[70]

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[70] *See* Appendix, Table 1. There is no indication that the population of Medicare Advantage beneficiaries changed during the time period covered by this report in ways that would diminish their need for post-acute care. In an analysis of payments to skilled nursing facilities by Medicare Advantage and Traditional Medicare, MedPAC found that Medicare Advantage consistently paid lower rates and concluded that, for the each of the years from 2019 to 2021, the key factors influencing treatment cost—age, comorbidities, and ability to function independently—were so similar between the two populations that they could not explain the difference in payments. *See* MEDPAC, MARCH 2021 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2021) at 215 (https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch7_sec.pdf); MEDPAC, MARCH 2022 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2022) at 255 (https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch7_SEC.pdf); EDPAC, MARCH 2023 REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY (2023) at 223 (https://www.medpac.gov/wp-content/uploads/2023/03/Ch7_Mar23_MedPAC_Report_To_Congress_SEC.pdf).

An analysis of 2021 data by America's Health Insurance Plans, a lobbying group for insurers, found that relative to Traditional Medicare, Medicare Advantage had a slightly higher share of enrollees older than 75, and a slightly lower share of enrollees who described their health status as "very good" or "excellent"—both potential indicators that the need for post-acute care among Medicare Advantage beneficiaries was, if anything, higher than those in Traditional Medicare. AHIP, *Medicare Advantage Demographics Report* (January 10, 2024), https://ahiporg-production.s3.amazonaws.com/documents/202312-AHIP_MA-Demographics-Report-v05.pdf.

2. *UnitedHealthcare's denial rate for prior authorization requests for post-acute care significantly increased at the same time the company was launching initiatives to automate the process*

In 2019, UnitedHealthcare issued an initial denial to 8.7 percent of the post-acute care prior authorization requests it received; by 2022, it denied 22.7 percent of all such requests, an increase of 172 percent.[71] Yet UnitedHealthcare's overall prior authorization denial rate changed little, going from 7.3 percent in 2019 to 7.6 percent in 2022.[72]

a. *A UnitedHealthcare committee approved an "auto authorization model" after learning that it resulted in faster review times and increased denials*

PSI obtained internal documents from UnitedHealthcare indicating that initial testing of at least one of type of predictive technology during the period reviewed revealed that it increased adverse determinations. As early as February 2021, UnitedHealthcare's Utilization Management Program Committee ("UMPC") has been responsible for deciding which services will be subject to prior authorization.[73] Minutes from the UMPC's inaugural meeting in February 2021 describe it as a body intended to ensure that the company's utilization management efforts were "working broadly as is intended."[74] In March 2021, UPMC committee members received a presentation on the "HCE Auto Authorization Model."[75] The model sorted requested medical procedures into those that could be "auto approved" and those that were "force pended,"[76] meaning set aside for the Clinical Coverage Review team, a group of clinical and non-clinical personnel who evaluate prior authorization requests. In assessing whether something would be auto-approved, the model that was being considered relied on several "weights," including the service's current denial rate, its potential for what the company deemed "Fraud, Waste and Abuse," and the amount of money that could be saved by automating an approval rather than expending the additional labor of human reviewers.[77]

The algorithm is built based upon category measurements: • Annual volume of the procedure • Percent of time only one procedure is on a request • Denial Rate • Unit Cost • Fraud, Waste and Abuse • Savings per auth	Follow-up [Redacted - Business Sensitive] to organize an ad hoc UMPC meeting for vote on the model

Minutes from the March 19, 2021 meeting of UnitedHealthcare's Utilization Management Program Committee. Source: UHC-PSI-00005000.

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[71] *See* UnitedHealthcare New Exhibit A.

[72] *Id.*

[73] UHC-PSI-00004991. Criteria for determining whether a service should require prior authorization include whether there is an "opportunity to improve consistent application of evidence based clinical guidelines," whether the service is new and requires "qualifying criteria for safe and effective treatment outcomes," and the "Value of applying pre-service review."

At a UMPC meeting the following month, on April 16, 2021, committee members were introduced to another new technology initiative: integrating Machine-Assisted Prior Authorization ("MAP") into UnitedHealthcare's Utilization Management Modernization effort.[78] The minutes for this meeting described MAP generally and noted that, while it was "never a valid source to justify approval or denial of a case[,]" it was a "tool" that "[p]oints the clinician to significant sources of primary evidence" used in evaluating a prior authorization request."[79] When committee members asked "whether the software creates potential risk of bias," they were told that the doctor or nurse reviewing the case was responsible for verifying that "the primary evidence is acceptable."[80] They were also told that internal testing showed that MAP had reduced the time it took to review a prior authorization request by six to ten minutes.[81]

According to the minutes of the April 16 UMPC meeting committee members asked whether the HCE Auto Authorization Model had been activated for Optum, a subsidiary of UnitedHealthcare's parent company that provides healthcare technology services to many different insurers, not just UnitedHealthcare.[82] Minutes from the UMPC meeting indicate that the model had not yet been activated but that initial testing had produced "faster handle times" for cases as well as "an increase in adverse determination rate," which was "validated based on finding contraindicated evidence missed in the original review."[83] The committee voted to approve integrating the MAP technology.[84]

The Committee also discussed whether the HCE tool is currently used in Optum care. It been enabled for CCR but has not yet been activated.. The goal is to turn it on by 6/1/21. UAT testing will be done on both Sleep Study and Vein CPT codes as they are high volume and high review time. . Where this has been deployed, Optum Care is seeing faster handle times in terms of being able to review quicker as well as an increase in adverse determination rate that was validated based on finding contraindicated evidence missed in the original review.

Minutes from the April 16, 2021 meeting of UnitedHealthcare's Utilization Management Program Committee. Source: UHC-PSI-00005008.

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[74] UHC-PSI-00004990-91. UMPC also makes decisions about which types of services are subject to other utilization management techniques, including concurrent review and post-service review. Although UnitedHealthcare contracts with more than 100 third-party entities to assume financial risk for the healthcare of various segments of its membership, these entities are generally bound to follow the policies set by UMPC. *See* UHC-PSI-00004991.

[75] UHC-PSI-00004999. "HCE" refers to UnitedHealthcare's Healthcare Economics department.

[76] UHC-PSI-00004999.

[77] UHC-PSI-00005000.

[78] UHC-PSI-00005007.

[79] UHC-PSI-00005007-08.

[80] UHC-PSI-00005008.

[81] *Id.*

[82] *Id.*

[83] UHC-PSI-00005008. This document does not indicate that the model took prior authorization denials away from clinicians, but instead that clinicians using the technology denied requests at a higher rate.

[84] *Id.*

Minutes from a UMPC meeting the following month show that UMPC committee members, while discussing the auto authorization model, expressed concern about the costs of "increasing manual review rates" in the UnitedHealthcare division responsible for Medicare Advantage plans.[85] At that meeting, the committee voted to tentatively approve the model, agreeing to return later to assess whether "some of the rules should be changed from auto decision to force pend."[86]

Taken together, these documents suggest that (1) UnitedHealthcare was evaluating the use of automated prior authorization procedures; (2) the company knew from testing that at least one of these automation technologies resulted in an increase in the share of those requests being denied; (3) this model was associated with less time spent evaluating prior authorization requests; and (4) the company was interested in reducing the money it spent on human reviewers of cases for the group covering Medicare Advantage plans. All of this was taking place as UnitedHealthcare's post-acute care denial rate was set to surge: It went from 10.9 percent in 2020, to 16.3 percent in 2021, to 22.7 percent in 2022. Although these documents and public statements from UnitedHealthcare indicate that final denials of prior authorization requests could come only from human reviewers, media reports indicate that UnitedHealthcare sought to achieve cost savings during this period by setting performance goals for reviewers that included strictly hewing to algorithmic recommendations.[87]

b. Prior authorization denials for skilled nursing facilities accelerated significantly once naviHealth began managing post-acute care for Medicare Advantage beneficiaries

In March 2021, around the same time the UMPC began considering the automated authorization model, the agenda for the meeting of another UnitedHealthcare internal committee, the Vendor Change Project, announced that the division responsible for Medicare Advantage patients would be "moving" post-acute care services to naviHealth—the company behind nH Predict, an algorithm linked in media reports to AI-powered denials of care.[88]

Optum acquired naviHealth in May 2020.[89] Evidence previously obtained by the Subcommittee suggests that, before naviHealth became a subsidiary of UnitedHealth Group, its nH Predict algorithm was being used to influence outcomes for patients prior to any evaluation by their own post-acute providers. For example, a document obtained by the Subcommittee labeled "Skilled Nursing Facility – nhPredict Outcome" appears to show naviHealth's algorithm being used to determine the needed extent of post-

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[85] UHC-PSI-00005011.

[86] *Id.*

[87] Ross & Herman, *UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care*.

[88] UHC-PSI-00025086; Ross & Herman, *Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need.*

[89] Heather Landi, *Optum scoops up post-acute care company NaviHealth, Fierce Healthcare* (May 26, 2020), https://www.fiercehealthcare.com/payer/optum-scoops-up-post-acute-care-software-startup-navihealth.

acute care for a patient who was admitted to a skilled nursing facility on June 3, 2019.[90] The naviHealth document appears to project that the patient would require 16.6 days of post-acute care based on the experiences of "similar patients." According to the patient's attorney, naviHealth did in fact issue a coverage denial on the patient's 17th day in the facility.[91]

Data obtained by PSI show that, while UnitedHealthcare's prior authorization denial rates increased for each type of post-acute facility during the period covered by this report, the increases were particularly striking for skilled nursing facilities. In 2019, the insurer issued an initial denial to 1.4 percent of requests for admission to a skilled nursing facility. But in 2022—the first full year in which naviHealth was managing them for UnitedHealthcare—the insurer denied 12.6 percent of such requests: in other words, its 2022 denial rate for skilled nursing facilities was nine times higher than it was three years before.

Figure 2: UnitedHealthcare Initial Adverse Determinations for Skilled Nursing Facilities

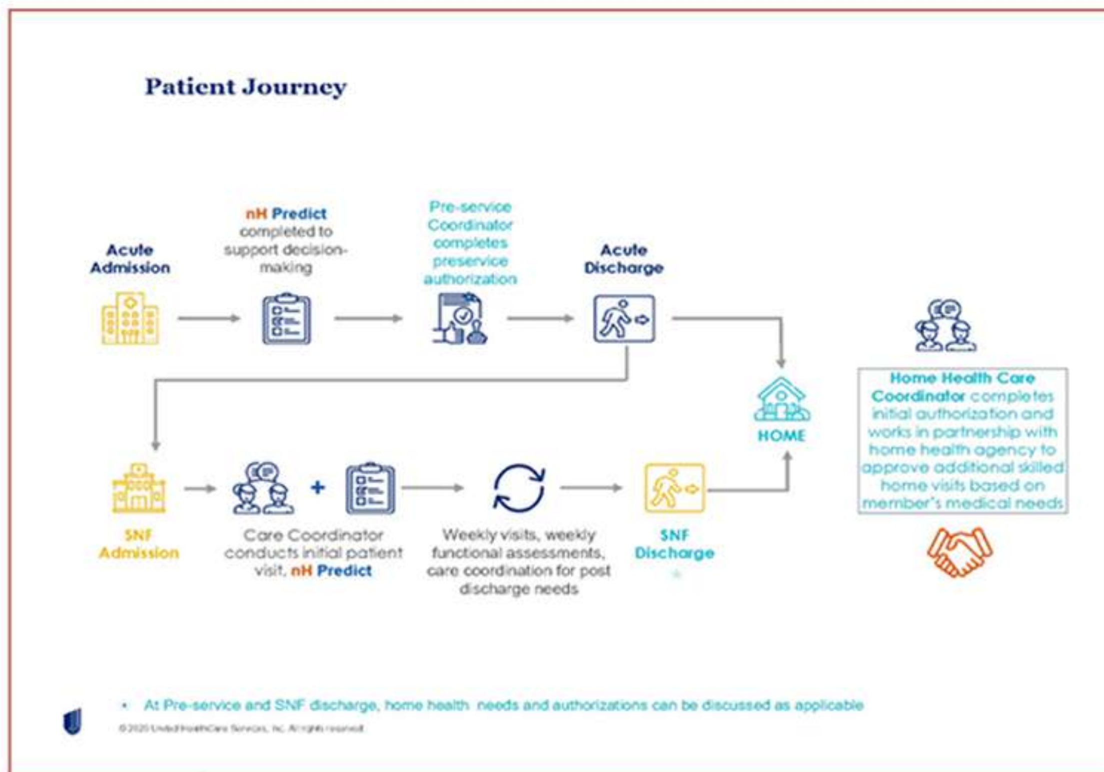
Year	Denial Rate	Number of Requests
2019	1.4%	215,469
2020	4.1%	198,453
2021	7.3%	252,873
2022	12.6%	272,687

Source: Letter from UnitedHealthcare to PSI, July 16, 2024.

[90] *Examining Health Care Denials and Delays in Medicare Advantage: Hearing Before the Subcomm. On Investigations of the S Comm. on Homeland Sec. and Gov. Aff's, 118th Cong.,* at 81 (May 17, 2023), https://www.hsgac.senate.gov/wp-content/uploads/CHRG-118shrg52437.pdf.

[91] *Id.* at 16.

A UnitedHealthcare presentation about naviHealth from January 2022 included a graphic laying out the "Journey" of a hypothetical patient following hospitalization.[92]



Source: UHC-PSI-00032029

Notes typed beneath the graphic included things to "SAY" and things to "KNOW."[93] The first item under "KNOW" stated "The process begins when a patient admits to acute. In acute, the naviHealth Care Coordinator completes nH Predict to determine optimal [post-acute care] placement. For Health Plan patients, the Care Coordinator issues an authorization for PAC placement. For value-based care (BPCI, ACO, etc.) the Care Coordinator works with hospital discharge planning to: 1) influence PAC placement and 2) ensure ongoing change management for acute to PAC discharge planning process."[94]

Along with the depiction of the "Patient Journey" showing when and whether a beneficiary would spend time in a skilled nursing facility or return home, the January 2022 naviHealth presentation also included

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[92] UHC-PSI-00032029.

[93] *Id.* It is not clear who wrote the notes or for whom they were intended. PSI call with UnitedHealthcare, October 9, 2024.

[94] *Id.* According to UnitedHealthcare, to the extent the graphic or included notes suggest that nH Predict made prior authorization determinations about admission to skilled nursing facilities, the document is in error, because the algorithm did not make prior authorization decisions about facilities admissions. Letter from UnitedHealthcare to PSI, October 10, 2024. Media reports indicate that nH Predict, along with establishing lengths of stay in a facility, was also

information about a "home health management solution" that naviHealth had launched for UnitedHealthcare's Medicare Advantage members in Georgia and would expand to other markets throughout the year.[95] This "technology centered Home Health [utilization management] model" would create savings by "reducing home health visits/episode."[96] Early metrics from Georgia indicated "changes in provider behavior," and that naviHealth's "prior authorization oversight" had enabled it to identify instances of "excess" home health services.[97]

Data from UnitedHealthcare indicate that, at the same time it was significantly increasing denials of skilled nursing facilities, home health use by the company's beneficiaries was increasing. The insurer's prior authorization denial rates for home health services declined during the period covered by this report. But there was a vast increase in the number of Medicare Advantage beneficiaries using these services: in naviHealth's first full year of managing post-acute care for UnitedHealthcare, the insurer processed more than four times as many home health prior authorization requests as it did the year before, far beyond the company's growth in enrollment.[98]

Figure 3: UnitedHealthcare Initial Adverse Determinations for Home Health Care

Year	Denial Rate	Number of Requests
2019	3.0%	19,283
2020	2.2%	17,323
2021	3.5%	88,960
2022	1.7%	356,606

Source: UnitedHealthcare New Exhibit A, July 17, 2023

HHS OIG's 2022 report noted that one of the most common sources of problematic prior authorization denials involved Medicare Advantage insurers claiming "that the patients did not need intensive therapy

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applied to determine whether a patient should be admitted in the first place. Ross & Herman, *UnitedHealth used secret rules to restrict rehab care for seriously ill Medicare Advantage patients*.

[95] UHC-PSI-00032020; UHC-PSI-00032027.

[96] UHC-PSI-00032031; UHC-PSI-00032033.

[97] UHC-PSI-00032036.

[98] According to UnitedHealthcare, the growth in the number of prior authorization requests occurred as a result of business strategies unconnected with adverse determinations for skilled nursing facilities. In some instances, UnitedHealthcare began imposing prior authorization on the provision home health services for which it previously was not required. Call with UnitedHealthcare, October 9, 2024. UnitedHealthcare also expanded its presence in the field in response to CMS's decision to change the standard unit of payment for home health care, beginning Jan. 1, 2020, from 60 days to 30 days. Letter from UnitedHealthcare to PSI, October 10, 2020; Press Release, CMS, *CMS finalizes calendar year 2019 and 2020 payment and policy changes for Home Health Agencies and Home Infusion Therapy Suppliers* (October 31,

or skilled care, and that their needs could be met at a lower level of care, such as home health services at the patient's residence," even when these less intense options "were not clinically sufficient to meet the patients' needs."[99] Data obtained by the Subcommittee do not reveal how many of UnitedHealthcare's Medicare Advantage home health prior authorizations came from beneficiaries who had been denied admission to a skilled nursing facility.[100] Former UnitedHealthcare employees have reportedly said naviHealth technology helped drive UnitedHealthcare's efforts to shift patients' recovery from skilled nursing facilities to their homes.[101]

c. *UnitedHealthcare sought to use machine learning to "flag" cases that were likely to be appealed*

After naviHealth began managing post-acute Medicare Advantage patients for UnitedHealthcare, the company used a system for providers to enter information needed for prior authorization requests that was similar to the Decision Point of Care ("DPOC") system UnitedHealthcare already employed.[102] When a provider recommended a patient be placed at a post-acute facility like a skilled nursing home, naviHealth allowed the provider to enter patient information either through an online portal known as nH Access or through a "Rapid Review Authorization" over the phone.[103]

In April 2022, naviHealth issued a "Work Instruction" to its Pre-Service Coordinators intended to "align[] the phone and nH Access process."[104] The instruction guided the coordinators through the questions the company asked to collect information it used to make prior authorization decisions. For each of the five potential sections through which a call could pass, the instructions warned coordinators

2018), https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-calendar-year-2019-and-2020-payment-and-policy-changes-home-health-agencies-and-home. UnitedHealthcare also stated that "patients and families have come to prefer home health services" in part because of the covid-19 pandemic. Letter from UnitedHealthcare to PSI, October 10, 2020. For Traditional Medicare beneficiaries, the utilization rate of home health in 2022 was 1.3 percent lower than it was in 2021. MEDPAC, A DATA BOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM, at 113.

[99] U.S. DEP'T OF HEALTH & HUM. SERVS., *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,* at 116.

[100] UnitedHealthcare stated that beneficiaries may choose home health as a result of CMS requirements that limit stays in skilled nursing facilities and other "Posthospital Extended Care" facilities to 100 days, and that require a co-pay after 20 days in such a facility. 42 C.F.R. § 409.85, *see also* U.S. DEP'T OF HEALTH & HUM. SERVS., *Medicare Benefit Policy Manual: Duration of Covered Inpatient Services* (2019). This requirement has been in place since April 1983 and did not change during the period addressed by this report. Medicare Program; Hospital Insurance Entitlement and Benefits, 48 FR 12526, 12548.

[101] *See* Ross & Herman, *How UnitedHealth's acquisition of a popular Medicare Advantage algorithm sparked internal dissent over denied care*, Ross & Herman, *UnitedHealth pushed employees to follow an algorithm to cut off Medicare patients' rehab care*.

[102] Letter from UnitedHealthcare to PSI, Aug. 11, 2023.

[103] UHC-PSI-00004498, Letter from UnitedHealthcare to PSI, Aug. 11, 2023.

[104] UHC-PSI-00004498.

"IMPORTANT: Do NOT guide providers or give providers answers to the questions. The goal is to ensure the appropriate members are admitted to the appropriate level of care in a timely manner."[105]

On December 7 2022, a group of UnitedHealthcare employees held a meeting devoted to an "AI/MLOpportunity" for naviHealth.[106] According to an email from a UnitedHealthcare director of clinical value, this "workgroup" had been established with the goal of "making the correct decision early in the process in order to avoid the potential for an appeal and overturned decision."[107] The director of clinical value wrote that, in the Dec. 7 meeting, the group had discussed how to use "AI/ML" to improve "our ability to collect adequate clinical on the front end of the process" and to "identify cases which may result in an appeal (using appeal data), and take action earlier."[108] In an email in preparation for a follow-up meeting about AI and machine learning, the director of clinical value sought to understand, among other things, "how nH Access, PAAN, and ICUE communicate," and "whether or not nH Access pushes back on requests when they are incomplete? (i.e. checklist)."[109]

An email recapping the January 9, 2023 follow-up meeting stated that it began by noting, "In the [post-acute care] space"—specifically in skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals—"we've experienced a high level of appeals and appeal overturn rates."[110] According to the email, a naviHealth employee at the meeting had noted that prior authorization requests for post-acute care services that were entered into UnitedHealthcare's online provider portal were moved to another platform and from there onto naviHealth.[111] In other words, while naviHealth had managed post-acute care services for UnitedHealthcare for over a year at that point, some provider requests for facilities admissions for Medicare Advantage beneficiaries—approximately 15 percent of naviHealth's prior authorizations—were still coming through UnitedHealthcare's main provider portal, which was structured differently than naviHealth's portal.[112] The naviHealth employee addressed a project that was

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[105] UHC-PSI-00004499-4505.

[106] UHC-PSI-00032297. "ML" is an abbreviation for "machine learning," a technique used to train AI algorithms with large volumes of data.

[107] UHC-PSI-00032296

[108] *Id.*

[109] UHC-PSI-00032297. PAAN refers to Prior Authorization Automated Notification, UnitedHealthcare's primary online provider portal. (Letter from UnitedHealthcare to PSI, July 17, 2023). UnitedHealthcare's 2022 Care Provider Administrative Guide for Medicare Advantage plans refers to refers to ICUE as the Integrated Clinical User Experience (UHC-PSI-00001073), and public filings from UnitedHealthcare describe it a "clinician-facing web-based clinical platform." Proposal from UnitedHealthcare to the La. Dep't of Health (2020), https://ldh.la.gov/assets/medicaid/RFP_Documents/MCO/Proposals/UHC/04.-2.10-Technical-Proposal-Redacted.pdf.

[110] UHC-PSI-00032296.

[111] *Id.*

[112] *Id.*

underway to integrate these platforms, noting that naviHealth's "checklist" structure made it much less likely that requests for post-acute care facilities received there would require follow-up with providers.[113]

According to the recap, this presentation was followed by an employee from Optum discussing, among other things, "Auto determination."[114] The meeting concluded with a question for future consideration: whether it would be possible to "leverage ML on the appeal population," compare it to prior authorization data, and "flag cases that are like [*sic*] cases for appeal" in order to "identify what is driving those trends and what we could do in the clinical review process to change the outcome of the appeal."[115]

These workgroup discussions took place as the company was preparing to close out a year in which its prior authorization denial rate for post-acute care facilities had increased by roughly 40 percent over the previous year. One response to the "high level of appeals" UnitedHealthcare was experiencing was to "mak[e] the correct decision early in the process in order to avoid the potential for an appeal and overturned decision," and the workgroup evidently believed naviHealth's platform could help do this by collecting more of the information needed for prior authorization early in the process.[116] However, the emails also note that UnitedHealthcare wanted to use machine learning to "Identify cases which may result in an appeal" or "flag cases that are like cases for appeal."[117] This suggests UnitedHealthcare's efforts at making "the correct decision" may have been targeted at those cases it determined to be likely to be appealed, rather than wrongful denials generally. As KFF has noted, while only a small percentage of all Medicare Advantage prior authorization denials are ever appealed, insurers internally overturn the vast majority of those that are.[118]

3. CVS knew prior authorization denials generated huge savings, and subjected more and more post-acute care requests to the process

During the period covered by this report, CVS developed several technologies to hasten or automate prior authorization. The company has consistently stated that these technologies could not issue final denials, although the human reviewers who did issue such denials would have been able to see the results of the recommendations of these technologies.[119]

Between 2019 and 2022, the number of post-acute care service requests CVS subjected to prior authorization increased by 57.5 percent, far higher than the roughly 40 percent growth the company experienced in enrollment during that period; meanwhile, the number of total requests subject to prior

[113] UHC-PSI-00032296.

[114] UHC-PSI-00032296. UnitedHealthcare documents periodically refer to HCE's automated authorization model as the "auto determination" model. *See*, *e.g.* UHC-PSI-00005007.

[115] UHC-PSI-00032297.

[116] UHC-PSI-00032296.

[117] UHC-PSI-00032296-97.

[118] Fuglesten Biniek et al, *Use of Prior Authorization in Medicare Advantage Exceeded 46 million requests in 2022*.

[119] Email from CVS to PSI, April 8, 2024. CVS has said that reviewers were "not directed to review those notes, nor to base their evaluation of a claim on those notes."

authorization almost exactly mirrored the rate of growth in enrollment.[120] Along with some increases in post-acute care facility denial rates, CVS appears to have increased the rate at which it subjected these claims to the prior authorization process. By 2022, CVS was denying prior authorization of post-acute care facilities more than all other types of service requests combined.[121]

Figure 4: CVS Enrollment and Prior Authorization Requests, 2019/2022

Year	Overall Requests	Post-Acute Care Requests	Enrollment
2019	858,879	149,717	2,231,000
2022	1,218,569	235,848	3,169,000
Growth	41.9%	57.5%	42.0%

Sources: Press Release, CVS, CVS Health Reports First Quarter Results (May 1, 2019), cvshealth.com/content/dam/enterprise/cvs-enterprise/pdfs/ingestion/cvs-health-q4-2018-earnings-pr.pdf; Press Release, CVS Health Reports Strong First Quarter Results (May 4, 2022), https://s2.q4cdn.com/447711729/files/doc_financials/2022/q1/Q1-2022-Press-Release.pdf. CVS-PSI-159395, Letter from CVS to PSI, March 29, 2024.

a. *Savings from prior authorization denials vastly exceeded savings from automated approvals*

In internal utilization management analyses, CVS distinguished between savings on "administrative costs," which were based on the salaries and time commitments of the people reviewing claims, and savings on "medical costs," which were derived from not having to pay for services, including those that were denied through prior authorization.[122] For example, according to a May 2019 presentation, CVS avoided

[120] As noted above, these enrollment figures reflect enrollment as of March in each year.

[121] This assessment refers to prior authorization requests that CVS manages internally. CVS delegates evaluation of prior authorization of "technical or otherwise specialized service requests" to Evicore. *See* Letter from CVS to PSI, March 29, 2024. Evicore represents more than 60 percent of prior authorization volume for CVS in a given year, and although the denial rates for service categories it handles do not approach those of post-acute care, and remained stable throughout the period covered by this report, it also experienced significant volume growth. *See* Letter from CVS to PSI, April 30, 2024.

In some documents obtained by PSI, CVS distinguishes between plans provided by Aetna and those provided by Coventry; Coventry underwent a rebranding in 2018, but the two entities have been "the same company" since 2013. *See* Press Release AETNA INC., Aetna Coventry New Name and Logo, (June 18, 2018), https://www.aetna.com/document-library/healthcare-professionals/documents-forms/aetna-coventry-rebranding-discussion-guide.pdf.

[122] CVS-PSI-146291.

more than $660 million in inpatient facilities-related medical costs for its Medicare Advantage members in 2018.[123] Other documents indicate that a majority of these savings came from "denied admissions."[124]

With some exceptions, the company's automation initiatives during this period were primarily targeted at reducing administrative costs rather than medical costs.[125] The distinction, however, was not always clear-cut. In January 2022, a senior employee emailed their boss with a list of goals for the year that included

[123] CVS-PSI-173612.

[124] CVS-PSI-173612; CVS-PSI-142463. The charts in both of these documents are labeled "Concurrent Review." *See* note 136. While data displayed in the chart at CVS-PSI-142463 is for CVS's Commercial division, the graphic notes that the trend described "is consistent across lines of business and funding types."

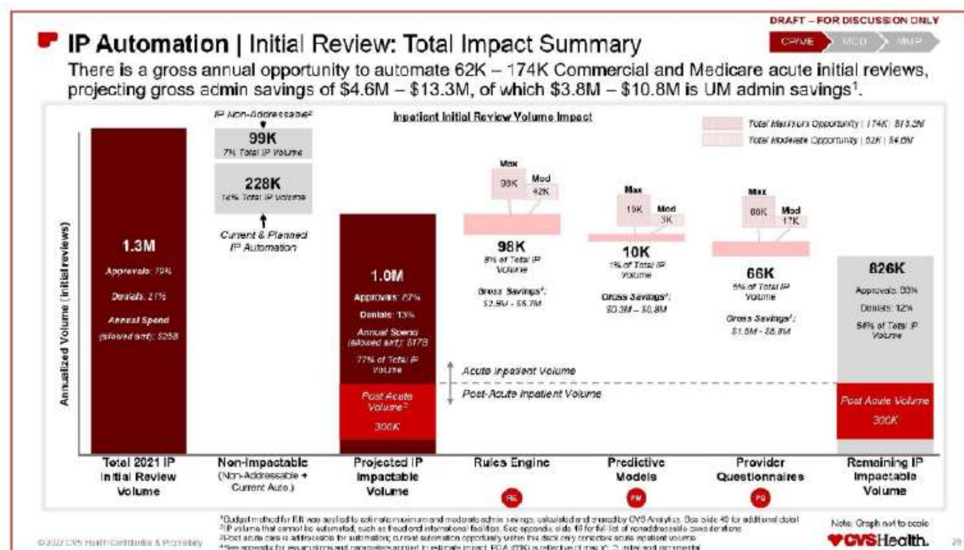
[125] One exception was Post-Acute Analytics, an automation effort focused on medical costs, addressed below.

"MD referral rate," meaning the frequency with which prior authorization requests were forwarded on to doctor-reviewers.[126] Later that day, their boss responded:

> *I think we need to be careful and not use MD referral rate. This suggests more is better. What we really want is MD denial rate, and we need to make sure it's calculated the same by everyone. In my opinion, we should show how this is to be calculated in any exhibits, i.e. denials/volume=rate and we should expect, if successful in reducing unnecessary MD referrals, to see this percentage go up over time.*[127]

Although the email specified that the company was seeking to reduce only "unnecessary" referrals to doctor-reviewers, it also implied that the "success[]" of the company's process for limiting the number of "unnecessary" cases doctors reviewed would be connected to doctors' denial rates, an arrangement that could amplify pressure on doctors to deny cases.

Materials from this time demonstrate that CVS knew denials of facilities claims represented a larger source of savings than automation. For example, in an October 2022 Automation Update, CVS estimated that automated approvals of as many as 174,000 initial reviews of inpatient admissions would generate at most $13.3 million in administrative savings across all of the company's lines of business.[128]



Source: CVS-PSI-170609

By contrast, in the same presentation, CVS estimated that its 225,000 denials of this type of claim had generated $2.5 billion in medical cost savings.[129]

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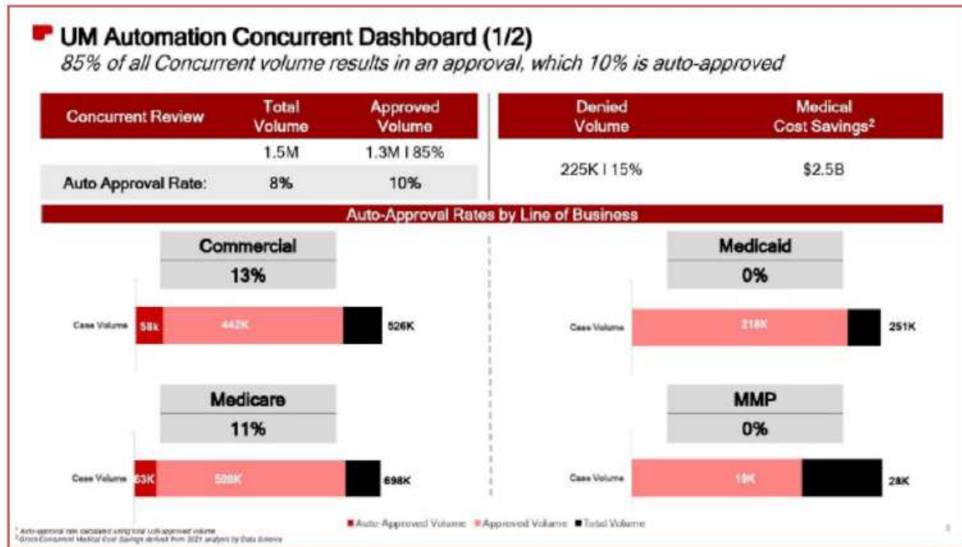
[126] CVS-PSI-169353. A corporate organization chart showing the sender and the recipient can be found at CVS-PSI-167885.

[127] CVS-PSI-169352.

[128] CVS-PSI-170609.

[129] CVS-PSI-170588.



Source: CVS-PSI-170588

While the chart does not break down savings by line of business, Medicare Advantage beneficiaries represented the largest share of these denials: if the $2.5 billion were proportionally distributed, denials of these Medicare Advantage claims would represent $1.1 billion in savings.[130]

b. *CVS developed a data-driven strategy of focusing on prior authorization requests with "a significant probability to be denied"*

CVS provides Medicare Advantage plans through its subsidiary Aetna Inc., which it acquired in 2018.[131] CVS's National Participating Provider Precertification List ("NPL") Committee develops the list of services and procedures requiring prior authorization.[132] The factors the NPL Committee examines in deciding whether to subject a service to prior authorization include "Medical costs and return on investment," how frequently patients seek the service, and its "potential for overutilization."[133] For

[130] CVS-PSI-170587. This calculation comes from multiplying the ratio of Medicare Advantage denials to total denials (99,000/225,000) by $2.5 billion in savings from denials. An alternative method, using Medicare Advantage's share of total case volume (698,000/1,503,000) yields a similar figure, roughly $1.16 billion.

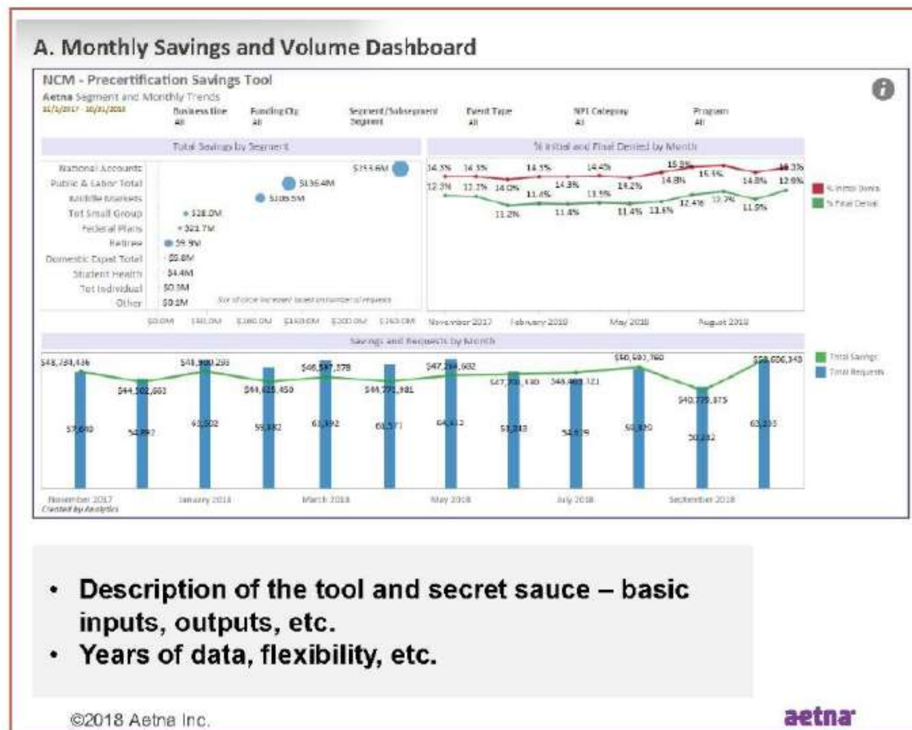
[131] Angelica Peebles, *CVS Creates New Health-Care Giant as $69 Billion merger with Aetna Officially Closes*, CNBC (Nov. 28, 2018, 10:52 AM), https://www.cnbc.com/2018/11/28/cvs-creates-new-health-care-giant-as-69-billion-aetna-merger-closes.html.

[132] CVS-PSI-138796.

[133] *Id.*

Medicare Advantage plans, Aetna's Care Management Program has "mechanisms" to "detect potential under or over-utilization of services."[134]

In January 2019, CVS's Clinical Service and Platform Solutions committee was developing a presentation that included a chart about the "Precertification Savings Tool" comparing monthly savings from prior authorization to the number of requests required.[135] Internal CVS documents generally used the term "Precertification" to address prior authorization of surgeries and other discrete procedures, while prior authorizations for inpatient facilities were addressed under "Concurrent Review."[136] The chart, which covered November 2017 through October 2018 and contained data for all CVS lines of business, not just Medicare Advantage, showed that as the number of requests the company imposed increased, so did the savings it netted:



Source: CVS-PSI-142344

A comment left on one version of presentation asked for the chart to include a description of the "secret sauce" behind the savings tool,[137] which a subsequent email described as its ability to "ingest" two years

[134] CVS-PSI-140772.

[135] CVS-PSI-142344.

[136] Aetna's Care Management Program has four utilization management components: Precertification, Concurrent Review, Proactive Discharge Planning, and Retrospective Review. CVS-PSI-140760. In the healthcare world, "precertification" and "prior authorization" are often treated as synonyms, both meaning utilization management decisions about a service made before it is administered. *See, e.g.*, Preauthorization – Glossary, HEALTHCARE (last visited July 15, 2024) https://www.healthcare.gov/glossary/preauthorization/. "Concurrent Review," meanwhile, usually refers to utilization management techniques applied to patients who have already been admitted to a facility. *See, e.g.* ANGELO P. GIARDINO, ROOPMA WADHWA, UTILIZATION MANAGEMENT (2024), *https://www.ncbi.nlm.nih.gov/books/NBK560806/*. At

of patient data.[138] The correlation between savings and prior authorization would hold true throughout the period covered by this report: An agenda for a March 2022 meeting devoted to prior authorization automation stated that there remained "significant opportunity in increasing auto-approvals," but that the company had "de-prioritized" a plan to reduce the overall volume of prior authorizations, concluding that the impact on lost savings was "too large to move forward."[139]

In January 2019, CVS was able to project that the number of precertification requests that year in the division responsible for the company's Medicare Advantage beneficiaries would grow by 16 percent compared to 2018, but the size of the clinical team responsible for reviewing them would decrease by 9 percent, from 242 people to 220.[140] In other words, even as CVS was planning to add more precertification requests to its Medicare Advantage line of business, it was decreasing the number of people responsible for reviewing those requests.

This was possible because CVS was developing initiatives related to automation and predictive technologies. One of these initiatives, dubbed "Project Moses," was initially described as a "fully scaled Auto-Approval Automation initiative" that would allow CVS to "optimize volume and focus on codes that have a 'significant' probability to be denied."[141] (Although this document appeared in a strategy presentation from March 2019, according to CVS Project Moses was not implemented until August 2020 and, by that time, was applied to a limited number of procedure groups.)[142]

c. CVS data modeling revealed how 'Mistake' approvals of post-acute care requests threatened profitability

A September 2019 presentation, titled "Utilization Management Overview," presented four "Utilization Management Metrics," one of which was the rate at which its members were spending time in post-acute

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times CVS appears to consider "prior authorization" to include both precertification and concurrent review. *See, e.g.*, CVS-PSI-146687. While CVS documents obtained by PSI sometimes classify initial admission decisions as falling under precertification and concurrent review (*See, e.g.*, CVS-PSI-165673 and CVS-PSI-165681), for the most part they are placed under concurrent review (*See, e.g.*, CVS-PSI-173612).

CVS has consistently required that all "inpatient confinements," including stays at post-acute care facilities, be subject to "precertification." *See, e.g.*, AETNA, *Procedures, Programs, and Drugs that Require Precertification* (Dec. 21, 2021) https://www.aetna.com/content/dam/aetna/pdfs/health-care-professionals/2021-precert-list.pdf., CVS-PSI-140891. The data that PSI has obtained for this report include determinations about admissions to post-acute care services (*See* CVS-PSI-159395; CVS-PSI-178014; Letter from CVS to PSI, March 29, 2024) and the term "prior authorization" is used throughout the body of this report to avoid confusion. Where CVS documents distinguish between "Precertification" or "Concurrent Review," this report makes that distinction clear.

[137] CVS-PSI-142344.

[138] CVS-PSI-142333.

[139] CVS-PSI-147142, CVS-PSI-147144.

[140] CVS-PSI-142352.

[141] CVS-PSI-142581. The quotation marks that surrounded the word "significant" were in the original document. It is not clear from the document or other information obtained by PSI who or what was being quoted.

[142] Letter from CVS to PSI, October 10, 2024.

care facilities.[143] The chart indicated that CVS Medicare Advantage beneficiaries spent fewer days per thousand beneficiaries in these facilities in 2018 than they did in 2017.[144] This held true for skilled nursing facilities, inpatient rehabilitation facilities, and long-term acute care hospitals. CVS projected usage for each of these facilities would fall even further in 2019.[145]

During this time, CVS also began developing a model "for all inpatient authorizations that predicts probability of approval."[146] Although the model was not implemented until May 2023 and was ultimately applied only to skilled nursing facilities, it was first shared in a November 2019 Clinical Services and Platform Solutions presentation, which indicated the model was "trained" on CVS prior authorization requests for 2017 and the first three quarters of 2018, and then tested on requests submitted to CVS in the final quarter of 2018 and the first four months of 2019.[147] According to the presentation, the model ran the test requests twice, calibrated at two different "levels": one to "Maximize savings" and another to "Maximize auto-approvals."[148]

For requests submitted by the company's Medicare Advantage beneficiaries, while the "Maximize savings" level produced a net savings of roughly $3.6 million, the "Maximize auto-approvals" level produced a net loss of more than $400,000.[149] The reason was the difference in the two levels' "Mistake" rate–the rate at which the model automatically approved requests CVS personnel felt should have been denied–and what CVS calculated to be the ensuing "Medical Cost Loss (Errors)."[150] The level for maximizing savings had a "Mistake" rate of 1.5 percent, while the level for maximizing approvals had a "Mistake" rate of 2.1 percent.[151] Applied across nearly half a million requests from Medicare Advantage beneficiaries, this 0.6 percent difference translated into more than $8 million in additional "Medical Cost Loss" for the Maximizing Approvals level.[152]

The Clinical Services and Platform Solutions presentation also identified as a "Key Priority" building a "separate model" for post-acute authorization requests.[153] Another Clinical Services and Platform Solutions presentation later that month contained a break-down of admissions model results into sub

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[143] CVS-PSI-160963.

[144] *Id.*

[145] *Id.*

[146] CVS-PSI-161586.

[147] CVS-PSI-161593, Call with CVS, October 10, 2024.

[148] CVS-PSI-161593. Maximizing savings entailed automatically approving all cases in which the estimated savings from administrative reduction were "always greater than estimated medical cost loss," while maximizing auto-approvals entailed automatically approving all cases in which the administrative cost savings were equivalent to medical loss costs. *See* CVS-PSI-162196.

[149] CVS-PSI-161593.

[150] *Id.*

[151] *Id.*

[152] *Id.*

[153] CVS-PSI-161586. As is the case in some other documents, CVS here used the term "sub-acute."

categories; this break-down was done for the "Maximize Savings" channel, but not for the "Maximize auto-approvals" channel.[154] The break-down showed automated approvals for post-acute admissions had by far the highest rate of medical cost loss: while the "Mistake" rate for acute admissions was 0.5 percent, for post-acute admissions it was 5.2 percent.[155] Another presentation for a meeting of the group the following month described the development of a predictive auto-approval model focused on inpatient admissions.[156] The presentation listed "suggested" automatic approval percentages for the model. While the suggested auto-approval rate for the company's overall Medicare Advantage division would be 12.2 percent, the rate for Medicare Advantage post-acute care admissions would be 2.0 percent.[157]

These models were not used to make facilities admissions decisions during the years addressed by this report, but instead as a way to gather and analyze data.[158] These documents suggest that, by the end of 2019, CVS had learned that "mistake" approvals of post-acute care posed particular risk of financial consequences, and was calibrating its automation strategy to prevent approvals of cases it felt ought to be denied. In March 2020, an internal presentation listed developing the ability to "predict volume of appeals as a result of [utilization management] denials" as a "top priority."[159] CVS had already collected necessary data, and planned to develop an initial version of the model for predicting appeals by the following month, though the model was not ultimately implemented.[160]

d. *CVS began use artificial intelligence to reduce spending at post-acute facilities amid pressure to reduce costs in its Medicare Advantage division*

Although CVS developed the ability to automate some requests for admissions to post-acute care facilities, its automation strategy focused on prior authorization requests for particular procedures and services.[161]

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[154] CVS-PSI-161819. When this model was eventually implemented, it was applied only to skilled nursing facilities, but the data discussed here was based on all post-acute facilities. CVS stated that as it "focused" on the "maximize savings" approach, "references to maximizing auto approvals became less frequent in internal materials," but that the company "continued to strive" to automatically approve more cases. Email from CVS to PSI, October 14, 2024.

[155] *Id.* The document uses the phrase "non-acute." In other documents, CVS has used "non-acute" (CVS-PSI-145542) and "sub-acute" (CVS-PSI-160953) interchangeably with post-acute.

[156] CVS-PSI-144356.

[157] CVS-PSI-144359. The document uses the phrase "non-acute." *See* note 149.

[158] Call with CVS, October 10, 2024

[159] CVS-PSI-145048.

[160] CVS-PSI-145048, Call with CVS, October 10, 2024.

[161] A September 2022 "Automation Update" stated that decisions about initial admissions to post-acute care facilities were "addressable" by automation. CVS-PSI-147764. This chart presents figures for the automation of "Initial Review" of acute inpatient determinations, and footnote three at the bottom of the page notes that "Post-acute care is addressable for automation." CVS's deployed two primary programs for automation of prior authorization requests for post-acute care: a "predictive model" that "auto approves requests with a high probability of approval based on historical experience," and a "rules engine" that "auto approves prior authorization requests based on a defined set of criteria." (*See* Letter from CVS to PSI, July 27, 2023; CVS also provided descriptions of these technologies in a briefing of the Subcommittee on Sept. 14, 2023). CVS began building a "Facility level predictive model" in early 2022 (CVS-PSI-170444) and by October 2022 the model was evaluating requests at 26 facilities serving the insurer's Medicare Advantage beneficiaries (CVS-PSI-170633). Also in the fall of 2022, CVS had developed the ability to apply its rules engine to both

By the end of 2022, CVS projected that prior authorizations requests related to facilities were automated at about one-seventh the rate of surgeries and other procedures.[162] And while the company's automation initiatives under consideration during this period were primarily targeted at administrative costs, by increasing the number of cases that could be approved with reduced human involvement, some were targeted at medical costs, by reducing what it spent on services received by beneficiaries. One of these was "Post-Acute Analytics," which promised "Real time patient monitoring with AI technology and EMR integration optimizing [skilled nursing facility] utilization," which had "Medical Cost Savings as its primary "Value Driver."[163]

UM Strategic Innovation Portfolio

Pipeline Prioritization (1/2)

Priority Rank	Initiative	Description	Value Driver	One-Time Investment ($M)	Cumulative Gross Savings ($M)*	Run Rate Savings ($M)*	Phase	New vs. Extension
1	**Provider Questionnaire Expansion** (outpatient & inpatient) **& Bed Day Automation**	• Implement capability for 10 procedure groups for auto-approval at the provider's point of care submission and achieve 35% clinical review	Admin cost savings	$4.6	$17.2	$5.0	Data Analysis, Bus Case Dev	Extension
2	**Medicaid Acceleration**	• Deliver cost savings through expansion of technical capabilities: Rules Engine, Predictive Models, NPL Optimization, and Fax Hub	Admin & Medical cost savings	$3.1	$47.0	$6.0-$7.0	Data Analysis, Bus Case Dev	Extension
3	**Conversational AI at Intake**	• Automate responses to incoming provider calls for inquiries and automate UM case creation via phone	Admin cost savings	$12.2	$10.0-$15.0	$5.0-$6.0	Data Analysis, Bus Case Dev	New
4	**Post Acute Analytics** (PAA)	• Real-time patient monitoring with AI technology and EMR integration optimizing SNF utilization	Medical cost savings	$5.7	$10.0-$15.0	$5.0-$6.0	Opportunity Identification	New
5	**UM Volume Insourcing Expansion** (Radiation Oncology)	• Insource UM function for outpatient radiation therapy currently delegated to eviCore	Admin cost savings	$6.2	$27.9	$5.3	Data Analysis, Bus Case Dev	Extension
6	**Clinical Decision Summary Expansion**	• Implement data contextualization capabilities to achieve assisted approvals (35% productivity improvement)	Admin Cost savings	$8.3	$17.8	$5.3	Data Analysis, Bus Case Dev	Extension

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*Financial figures are based on a 3-year time frame, except for Medicaid Acceleration, which is based on a 5-year time frame

Proprietary

Source: CVS-PSI-146411

Post-Acute Analytics began to be listed among ideas for future "utilization management modernization" efforts in February 2021.[164] On April 21, 2021, a CVS vice president for utilization management emailed a team of co-workers, saying she had just finished a meeting in which she was asked "to identify $19.5 million in 2022 savings for the Medicare [line of business]."[165] The request, she wrote, was to "identify these possible savings opportunities along with Information about what we have to stop doing to meet this

"facilities" and "diagnoses" (CVS-PSI-147754), after determining that that presented the best opportunity for savings from reduced personnel costs to outweigh "erosion" by medical cost mistakes. (CVS-PSI-170962).

[162] CVS-PSI-170587-88. The document indicates that while 76 percent of Medicare Advantage "precertifications" were automatically approved, this was the case for only 11 percent of decisions about facility admissions and length of stay (what the company often called "concurrent review.")

[163] CVS-PSI-146411. Although identified as an "Initiative" in CVS documents, Post Acute Analytics was the name of a vendor. Call with CVS, October 10, 2024.

[164] CVS-PSI-165475.

[165] CVS-PSI-166050.

target. We need this by the middle of next week."[166] Among the proposed solutions was "Deploy PAA?," an abbreviation the company sometimes used for Post-Acute Analytics.[167] Later that day, another person who had been in the meeting wrote, "They need the moves fast for their bid."[168] Based on the timing, "bid" appears to refer to the bids that insurers submit to CMS for Medicare Advantage plans they would offer in the coming year.[169] Of the ideas to emerge from this group, the largest amount of savings was attributable to post-acute analytics.[170]

The initiative began in the insurer's Medicare Advantage plans in Ohio and Kentucky, but by July 2021, it was developing plans to expand it to the rest of the division.[171] By the fourth quarter of 2022, it had been approved in 16 states.[172] The initial projection was that the project would save the company $10 to $15 million over the ensuing three years.[173] But by November 2021, the company projected that it would generate $77.3 million in medical cost savings in that period.[174] If the analytics program were successful, the company planned to establish a "post-acute medical affairs review team" which would be evaluated in part on volume of reductions in skilled nursing facility and inpatient rehabilitation facility stays.[175]

4. Humana's denial rate at long-term acute care hospitals jumped significantly after prior authorization training sessions emphasized denials

Between 2020 and 2022, the rate at which Humana denied requests for prior authorization for stays at long-term acute care hospitals increased by 54 percent. While Humana has contracted with naviHealth to manage certain post-acute care services since 2017,[176] documents obtained by the Subcommittee so far do not indicate whether predictive technologies were behind this change. Instead, the data PSI has obtained from Humana, along with internal company documents, reveal that its prior authorization denial rate for long-term acute care hospitals jumped significantly following training sessions on how to evaluate requests for these services. The confluence of the increase in adverse determinations rates and the training sessions, which contained materials emphasizing the facility's costs and strategies for communicating

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[166] CVS-PSI-166050.

[167] CVS-PSI-166050.

[168] CVS-PSI-166049.

[169] The email was sent April 21, and each year insurers are required to submit their bids to CMS by the first Monday in June, *See* CTRS. FOR MEDICARE & MEDICAID SERVS., Part C – Medicare Advantage and 1876 Cost Plan Expansion Application at 8 (2025), https://www.cms.gov/files/document/cy-2025-medicare-advantage-part-c-application.pdf.

[170] CVS-PSI-166053.

[171] CVS-PSI-147508.

[172] CVS-PSI-170438.

[173] CVS-PSI-146411.

[174] CVS-PSI-167961.

[175] CVS-PSI-147520. CVS ended Post-Acute Analytics in 2023, after the period covered by this report. Letter from CVS to PSI, October 10, 2024.

[176] HUM-PSI-0045673.

denials with providers, suggests that Humana's emphasis on cost pressures boosted denials for these facilities.

a. Humana crafted templates to respond to post-acute prior authorization requests that enabled them to "uphold a denial on appeal"

In the fall of 2019, Humana was working on the templates it gave its case reviewers to communicate decisions to providers on prior authorization requests and appeals of prior authorization denials.[177] This involved multiple rounds of modifying the company's "Decision Matrix for Facilities" in October, November, and December of 2019.[178] On December 16, 2019, a lead medical director emailed final revisions of two templates to a senior compliance professional for market clinical strategies in Humana's healthcare services division.[179] That lead medical director had modified two templates: one for denials at inpatient rehabilitation facilities, and another for denials at long-term acute care hospitals.[180] The changes generally made the language in the letters easier to understand, and accurately stated CMS criteria for these facilities.[181] The changes were "important for denial purposes," the medical director wrote in an email sharing his suggestions, "so I feel that these should be added to the initial review team templates as well particularly the LTAC criteria as those are the biggest reasons we are able to uphold a denial on appeal."[182] (Long-term acute care hospital is sometimes abbreviated as "LTAC.")

Internal documents obtained by the Subcommittee show that upholding appealed denials of prior authorizations is important to Humana's business. A presentation that appears to have been used for training about the appeals process noted, "Our star rating is affected by the rate we are overturned by Maximus."[183] Maximus is a third-party contracted by CMS to review appeals of denials in the Medicare Advantage program.[184] The "star rating" is the publicized rating, out of five stars, assigned to Medicare Advantage plans. Star ratings play an important role in which plan a beneficiary ultimately selects within a

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[177] HUM-PSI-0053271.

[178] HUM-PSI-0053275-78 (October); HUM-PSI-0053254-57 (November); HUM-PSI-0053320-23 (December).

[179] HUM-PSI-0053228.

[180] *Id.* As above addressed in note 55, while the commonly used medical necessity criteria for inpatient rehabilitation facilities and skilled nursing facilities come from sections of CMS's Medicare Benefit Policy Manual, there is no comparable entry for long-term acute care hospitals. Common practice has long been to rely on third-party providers of clinical guidelines. *See* Barbara Gage et al., *Long-Term Care Hospital (LTCH) Payment System Monitoring and Evaluation,* at 133 (CTRS. FOR MEDICARE & MEDICAID SERVS., 2007), https://www.cms.gov/medicare/medicare-fee-for-service-payment/longtermcarehospitalpps/downloads/rti_ltchpps_final_rpt.pdf. Humana uses guidelines from MCG, one of two companies (the other is InterQual) who dominate the market for third-party care guidelines.

[181] Suggested changes to inpatient rehabilitation facility templates are found at HUM-PSI-0053255 and HUM-PSI-0053233. Suggested changes to long-term acute care hospital templates are found at HUM-PSI-0053322.

[182] HUM-PSI-0053228.

[183] HUM-PSI-0039813. Although the word "Date" was written on the front of this presentation, no date was visible, and the company was unable to determine when the presentation was created or distributed. *See* Email from Humana to PSI, May 22, 2024.

[184] CTRS. FOR MEDICARE & MEDICAID SERVS., *Review by Part C Independent Review Entity (IRE)* (last visited July 15, 2024), https://www.cms.gov/medicare/appeals-grievances/managed-care/review-part-c-independent-entitiy.

given Medicare market.[185] Because only about 12 percent of all Medicare Advantage denials are ever appealed to Maximus, even a relatively small increase in the number of overturned denials in a given year could diminish the marketability of a Medicare Advantage plan.[186]

Any immediate changes the revisions might have produced, however, were muted by the arrival of the COVID-19 pandemic. Periodically throughout 2020 and 2021, in line with federal COVID-19 guidelines and reports of diminishing hospital bed availability, Humana announced temporary suspensions of prior authorization requirements for skilled nursing facilities in certain parts of the country.[187] Sometimes these announcements also included the suspension of prior authorization for inpatient rehabilitation facilities or long-term acute care hospitals.[188] In 2020, the denial rate dropped for all three types of facilities.[189] These periodic suspensions continued in 2021 and early 2022, but after 2020 the denial rates for prior authorization requests for post-acute care facilities began to increase, particularly for long-term acute care hospitals.

Figure 5: Humana Initial Adverse Determinations, by Year and By Facility Type

	SNFs		IRFs		LTACHs	
Year	Denial Rate	Requests	Denial Rate	Requests	Denial Rate	Requests
2019	7.1%	80,300	55.4%	24,129	57.3%	7,067
2020	4.5%	49,716	42.3%	28,737	39.9%	7,219
2021	4.9%	64,113	49.5%	31,098	49.5%	9,154
2022	6.3%	65,897	51.3%	32,752	61.4%	8,882

Source: HUM-PSI-0045741-43, HUM-PSI-0045745-48, HUM-PSI-0045750-53, HUM-PSI-0045756-59.

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[185] *What are Medicare Star Ratings?*, HEALTHPARTNERS (last visited July 15, 2024), https://www.healthpartners.com/blog/what-are-medicare-star-ratings.

[186] MEDPAC, *Evaluating Access in Medicare Advantage*. Insurers' fear of being overturned could also potentially explain why, although only a small share of denials are appealed, more than 80 percent of those appeals are overturned internally by the companies themselves before reaching Maximus, the "Independent Review Entity." *See* Fuglesten Biniek et al, *Use of Prior Authorization in Medicare Advantage Exceeded 46 million requests in 2022*.

[187] *See, e.g.* HUM-PSI-0050280-83.

[188] *See, e.g.* HUM-PSI-0050048-49*;* HUM-PSI-0050067.

[189] As is evident from the chart in this section, the number of service requests requiring prior authorization also fell significantly for skilled nursing facilities. This is why, although the denial rate fell for each type of post-acute facility, the overall denial rate for post-acute care services (displayed in the chart found in Finding 1) increased slightly: a higher share of the total services being sought at Humana were for facilities with higher denial rates.

Although overall skilled nursing utilization did decline during the public health emergency, MedPAC has found that, at least for FFS Medicare, the decline between 2017 and 2019 was comparable to the one from 2019 to 2021, suggesting that structural factors beyond the pandemic are also playing a role. *See* MEDPAC, *DATABOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM*, at 101 (2023), https://www.medpac.gov/wp-content/uploads/2023/07/July2023_MedPAC_DataBook_SEC_v2.pdf.

b. *Humana training sessions for requests for long-term acute care hospitals emphasized cost and provided strategies for handling denials*

Between May 2020 and December 2021, Humana devoted at least four "Case Concordance Conferences" to long-term acute care hospital admissions. The conferences are bi-weekly meetings for members of Humana's Medicare prior authorization clinical review teams to promote "accuracy and consistency throughout [Humana's] prior authorization process."[190] The conferences, which ranged over many service categories, not just post-acute care, typically offered a fact pattern that includes anonymized information about a patient and their condition, then asked the participating staff to choose how to respond to a service request submitted by the patient's healthcare provider.[191]

The 2020 conferences took place in May and June of that year. Documents from these conferences show that both involved seven Humana reviewers submitting evaluations of requests for admission to long-term acute care hospitals.[192] While the reviewers at the May conference were mostly in agreement, with six of seven agreeing that the request should be denied,[193] the June conference was more divided, with four reviewers voting to deny the stay at the long-term acute care hospital and three to approve it.[194]

The next two case concordance conferences on long-term acute care hospital admissions took place in November and December of 2021, and featured changes in both form and content. They included far more people, with 128 reviewers in November and 125 reviewers in December.[195] Unlike the 2020 conferences, the 2021 conferences included polls taken both before and after a presentation about the facilities.[196] The 2021 conferences contained more material explaining accepted criteria for long-term acute care hospitals, all of which reflected commonly used guidelines, but they also contained materials that could assist clinical staff in explaining denials to providers.

For example, a PowerPoint presentation for the November conference—at which the correct answer was to deny admission because the patient could be treated at a lower level of care—included a "vignette" in which a lower-level placement, like a skilled-nursing facility, might decline to accept a patient with complex or costly needs, noting that in such cases patients are usually approved for long-term acute care hospitals.[197]

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[190] Letter from Humana to PSI, Nov. 22, 2023.

[191] *See, e.g.*, HUM-PSI-0032700-21.

[192] HUM-PSI-0033107-10; , HUM-PSI-0033283-89.

[193] HUM-PSI-0033107-10.

[194] HUM-PSI-0053499.

[195] HUM-PSI-0032801 (November), HUM-PSI-0032760 (December). These numbers reflect the number of reviewers who submitted "pre-conference" evaluations. For both 2021 conferences, a second poll was taken after the presentation, which some reviewers apparently did not complete. The final poll for the November 2021 conference included 111 people (HUM-PSI-0032816), while the final poll for the December 2021 conference included 107 (HUM-PSI-00327775).

[196] HUM-PSI-0032807, HUM-PSI-0032762, HUM-PSI-0032801, HUM-PSI-0032816, HUM-PSI-0032760, HUM-PSI-0032775.

[197] HUM-PSI-0032817.

The presentation indicated that this was not a reason to approve a long-term acute care hospital placement, reminding case reviewers that the patient could simply remain in an acute hospital and that "usually these issues can be sorted out and [a lower-level-of-care placement] 'becomes' available."[198] A PowerPoint for the December 2021 conference—at which the correct answer was to deny admission because there was "no expectation of improvement"—noted that long-term acute care hospitals "are a *high cost intervention* that requires the same weight of deliberation in consideration of medical necessity as, for example, high risk/high cost procedures" [emphasis in original].[199] It urged reviewers, when talking with a patient's provider, to ask if there had been a "'goals of care' conversation," noting that "the 'surprise question' can be a 'gut' check."[200]

LTACH Talking Points

- **"How do you know that there is no benefit to a LTACH stay":** The prognostic scores can be calculated before a P2P or the ACH team can be asked to calculate these scores.
- On P2P: Probe about what specialists have said or if a 'goals of care' conversation has been done. While it is not as accurate as the prognostic scores, the "surprise question" can be used as a 'gut' check.
- **Pre-ICU functional status, comorbidities** and **age** all play a large role in prognosis.
- Admissions to LTACH are still a R+N decision. They are a ***high cost intervention*** that requires the same weight of deliberation in consideration of medical necessity as, for example, high risk/high cost procedures. (remember, they decided NOT to surgically intervene on this member)

Source: HUM-PSI-0032768

Given the late-in-the-year timing of the 2021 conferences and the differences from their 2020 counterparts, the shift in denial rates revealed by Humana's prior authorization data is striking: while Humana's denial rate for long-term acute care hospitals in 2021 remained about 14 percent lower than in 2019, its 2022 rate eclipsed the pre-pandemic rate by 7 percent.

Internal documents offer further evidence that these training sessions came at a time when Humana was placing a focus on long-term acute care hospitals. According to an October 2021 email from an employee in Humana's Market Clinical Strategies and Pharmacy Solutions, "there has been a lot of discussion about

[198] *Id.* Hospital associations have blamed similar practices for constraining bed availability for incoming acute patient. MASSACHUSETTS HEALTH & HOSPITAL ASSOCIATION, *Causes & Consequences: Inside the Healthcare Crisis*, at 7 (May 2024), https://www.mhalink.org/wp-content/uploads/2024/05/Inside-the-Healthcare-Crisis-MHA-Report.pdf.

[199] HUM-PSI-0032768. Although the fact pattern in both the November and December 2021 case concordance conferences suggested that the correct answer was to deny a prior authorization request, other Humana training materials do include fact patterns suggesting approval. See, e.g. HUM-PSI-45907-HUM-PSI-45910. (The presentation does not include a date, but metadata from the document place it in 2019.)

[200] *Id.*

the LTAC templates."[201] The employee wrote that they had reviewed the latest round of revisions to those templates, as well as "a few more IRE decisions that were unfavorable."[202] The email was sent to the Humana medical director who led the 2021 case conferences about long-term acute care hospitals and had, in late 2019, suggested the modifications that were "important for denial purposes" to the prior authorization templates.[203]

c. *Humana staff had concerns about suggesting hospice as an alternative to long-term acute care hospitals*

In a public 2022 blog post, MCG, the company that creates the care guidelines Humana uses to evaluate admissions to long-term care hospitals, noted that long-term care hospitals "care for a relatively small portion of Medicare beneficiaries but account for a substantial cost," with an average stay in fiscal 2020 running more than $47,000.[204] MCG's guidelines for long-term acute care hospitals requiring assessing whether palliative care, including hospice, is more appropriate.[205] The November 2021 case concordance conference included this requirement and ultimately recommended rejection of the sample case under the criteria that the patient had "no expectation of improvement."[206] Hospice is not covered by Medicare Advantage; it is covered under Traditional Medicare, which requires a physician to assess that a patient has six months or less to live.[207]

Internal documents reveal that some Humana employees found it challenging to recommend hospice as an alternative to long-term acute care hospitals. The agenda for a November 16, 2021 meeting of Humana's MD Template Governance Committee indicates that, during discussion of templates used for long-term acute care hospitals, there was a question "about whether hospice and/or comfort care is appropriate to mention."[208] Discussion revolved around the fact that some of doctors were "trained not to use it," but according to the agenda, Humana's lead medical director for its National Medicare Team indicated that current training and then-current language from the IRE indicated it should be used.[209] The November case concordance conference with the hospice recommendation was held the same day.[210]

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[201] HUM-PSI-0065182.

[202] *Id.*

[203] *Id.*

[204] This information comes from a white paper from MCG, the care guidelines company referenced in FN 95. Sabitha Rajan, *Long-Term Acute Care Hospitals: An Overview and Discussion of the Goals of Care* (MCG Health, 2006), https://info.mcg.com/rs/658-WJS-398/images/MCG-White-Paper-LTACH-2022.pdf. The average cost is derived by dividing the number of stays from the total associated cost.

[205] Humana's December case concordance conference addresses hospice as an alternative at multiple points. See, e.g. HUM-PSI-0032763, HUM-PSI-003275

[206] HUM-PSI-0032760.

[207] CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE HOSPICE BENEFITS,* at 4 (2023), https://www.medicare.gov/Pubs/pdf/02154-medicare-hospice-benefits.pdf.

[208] HUM-PSI-0072581.

[209] HUM-PSI-0072581.

[210] HUM-PSI-0032797.

The minutes of a February 10, 2022 meeting of Humana's Regional Inpatient Determination Template Workgroup—intended to provide a "centralized approach to oversee the template tools used by physicians who conduct [utilization management] inpatient reviews for Medicare Advantage Plans"—indicate that attendees discussed several templates used for evaluating requests for admission to a long-term acute care hospital.[211] Some members of the work group were "concerned" about letters sent to certain patients "sounding like we are denying [long-term acute care hospital stays] b/c the [member] has hospice/palliative needs."[212] Suggested modifications to this language did not pass at the February meeting.[213] By June 30, 2022, however, work group members were arguing for removing the reference to hospice from certain templates for these facilities for "not being member friendly (could be considered insensitive)."[214] There were "strong opinions to keep this verbiage because it is part of MCG criteria and a reason for denial," but medical reviewers ultimately decided to make the hospice option "variable" and use it "when it applies to the member situation."[215]

Even with these changes, however, Humana's training materials for long-term acute care hospitals continued to emphasize their high cost, limited usefulness, and position hospice as an alternative. In March 2023, an employee with Humana's medical director education division sent an email to the medical director who had overseen the 2021 case concordance conferences with the subject line "LTACH [Long-term acute care hospital] training slide for new Medicare MDs—-very first exposure."[216] The purpose was to seek comments on a "script" provided to the new physician reviewers. At one point the script noted that "a vast majority of these cases will not meet necessity criteria for [long-term acute care hospital admission]."[217] Elsewhere, the script stated that a long-term acute care hospital "is the most expensive post-acute setting for care. If unsure of decision for specific case, please reach out to an appropriate colleague for assistance."[218] And even though the hospice language had already been removed from denial letters sent to Medicare Advantage beneficiaries, on multiple occasions the script suggested reviewers consider whether hospice was more "appropriate."[219]

d. *Internal Humana policies appear to give naviHealth and other contractors greater latitude to exclude humans from decision making*

During the period covered by this investigation, Humana had several policies or "Standards" in place to govern the use of artificial intelligence. A standard on "Ethical Usage of Augmented Intelligence" from November 2022, stated "Artificial or Augmented Intelligence systems, machine learning algorithms, and

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[211] HUM-PSI-0066083.

[212] HUM-PSI-0066097.

[213] HUM-PSI-0066099.

[214] HUM-PSI-0065524; HUM-PSI-0065536.

[215] HUM-PSI-0065536.

[216] HUM-PSI-0061887.

[217] HUM-PSI-0061889.

[218] HUM-PSI-0061891.

[219] HUM-PSI-0061888-91.

other advanced analytical tools (collectively 'AI') are becoming more commonly used at Humana."[220] Humana's standard for "Corporate-Augmented Intelligence," created in August 2020 and updated in September 2022, stated that it would ensure responsible use of the technology by, among other things, "having the clinicians who use them retain decision-making authority in order to exercise appropriate levels of informed judgment in clinical matters."[221] These and other documents from the company tended to use "AI" to mean "augmented intelligence" rather than artificial intelligence. The November 2022 standard stated that this was because of the company's preference to "put humans in the loop for purposes of decision-making."[222]

However, Humana's Ethical Usage of Augmented Intelligence standard noted that "Certain third parties may utilize Artificial Intelligence systems in support of services being provided to Humana and are covered within the scope of these guidelines, where applicable."[223] Humana has had a contractual relationship with naviHealth since Aug. 1, 2017.[224] That agreement, which remained the effective contract between the two parties throughout the period covered by this investigation,[225] specifies that naviHealth would have the right to use protected health information "solely in connection with (i) naviHealth's 'LiveSafe' clinical decision support tool (or its successor) and related database(s); and (ii) reporting to Humana at an aggregate level."[226] (The agreement stated that patient information would be deidentified in accordance with federal law.)[227] LiveSafe was later renamed nH Predict, the algorithm that has been linked to automated denials of post-acute care.[228]

These documents indicate that Humana was investing in automating technologies and was aware of their potential for abuse. That the portion of the Ethical Usage guidelines devoted to third parties specifically referred to "Artificial Intelligence" rather than "Augmented Intelligence" suggest that naviHealth, as a contractor, may have had greater latitude to exclude humans from the decision-making process. But, as Humana's prior authorization training materials for long-term acute care hospitals demonstrate, stressing a facility's cost and providing ways to challenge providers who recommended their use can effectively enable human reviewers to increase denials, even when using accepted medical necessity criteria.

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[220] HUM-PSI-0004825.

[221] HUM-PSI-0004837-38.

[222] HUM-PSI-0004825.

[223] HUM-PSI-0004825.

[224] HUM-PSI-0045673.

[225] Letter from Humana to PSI, Dec. 8, 2023, at 3.

[226] HUM-PSI-0045677.

[227] *Id.*

[228] Mackenzie Bean, *The Importance of Care Coordination in a Value-Based World: Best Practice Approaches From Spectrum Health*, BECKER'S HOSPITAL REVIEW: CLINICAL LEADERSHIP (Mar. 6, 2017), https://www.beckershospitalreview.com/quality/the-importance-of-care-coordination-in-a-value-based-world-lessons-learned-by-spectrum-health.html (last visited Oct. 3, 2024).

RECOMMENDATIONS

1. CMS should begin collecting prior authorization information broken down by service category

Numerous findings in this report come from data that insurers are not required to report to regulators. Regulators already have in place an established system for collecting data about prior authorization from Medicare Advantage insurers. CMS can and should expand this system to start collecting prior authorization data broken down by service category. Doing so would enable regulators–and ultimately, the seniors weighing various plans, or deciding between Medicare Advantage and traditional Medicare–to see whether certain kinds of care are being singled out for denials.

Since at least 2005, federal regulations have required Medicare Advantage insurers to make available to the government information regarding, among other things, "the patterns of utilization of its services."[229] Among the categories of information that Medicare Advantage insurers are required to report are "organization determinations."[230] Organization determinations include prior authorization requests, covering the number of requests filed by providers in and out of the Medicare Advantage insurer's network, as well as how many of those requests received a "fully favorable," "partially favorable," or "adverse" determination.[231] Notably, these requirements do not require Medicare Advantage insurers to break down their prior authorization data by service category.

In recent years, CMS has sought suggestions for potential changes to the type of information Medicare Advantage insurers are required to report about prior authorization and other topics. In 2022, the agency issued a Request for Information seeking suggestions for how it might improve the Medicare Advantage program. Many of the questions the request posed concerned potential changes to data reporting requirements, including, "What data, whether currently collected or not, may be most meaningful for enrollees, clinicians, and/or MA plans regarding the applications of specific prior

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[229] 42 C.F.R. § 422.516 (2005).

[230] The Part C Report Requirements for 2024 may be found at: Ctrs. for Medicare & Medicaid Servs. et al., *Medicare Part C Reporting Requirements*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2024), https://www.cms.gov/files/document/cy2024-part-c-reporting-requirements.pdf. The Part C Technical Specifications may be found at: Ctrs. for Medicare & Medicaid Servs. et al., Medicare Part C Technical Specifications Document, CTRS. FOR MEDICARE & MEDICAID SERVS. (2024), https://www.cms.gov/files/document/cy2024-part-c-technical-specifications-02222024.pdf.

[231] Ctrs. for Medicare & Medicaid Servs. et al., *Medicare Part C Reporting Requirements* (2024).

authorization and utilization management techniques?"[232] The connection between these concepts and post-acute care was a common source of comments.[233]

Recent CMS regulations, including some that took effect in 2024 and others that will take effect in 2026, increase data provided to regulators and the public, including information about prior authorization. But despite requests that Medicare Advantage insurers be required to report prior authorization data by service category, CMS announced that it will still not require companies to provide service category information, reasoning that reporting data at the "service level could be overwhelming because of the volume of information presented."[234] As KFF has pointed out, even though this level of information "could be overwhelming for beneficiaries, it would still be useful for policymakers engaging in oversight."[235]

In August 2024, CMS indicated that it may be changing course, publishing a notice seeking comment on a proposal to expand the type of information it collects from health plans to include "Service Level Data."[236] Doing so, the agency reasoned, would "provide key data to CMS on the utilization of benefits, enhance audit activities to ensure plans are operating in accordance with CMS guidelines, and ensure appropriate access to covered services and benefits."[237] The comment period for the proposal closed October 8.[238]

CMS should move forward with this proposal. Without this information, it will be substantially more difficult to assess whether Medicare Advantage insurers are complying with the recently finalized regulations intended to ensure that they cover all services available under traditional Medicare, and that prior authorization only be used for the limited purposes CMS prescribed.[239] As this report demonstrates, Medicare Advantage insurers can calibrate their use of prior authorization to target certain costly services with significant potential impacts on patient health, yet have the overall organization determination data reported to CMS show little change. By specifically requesting data on prior authorization on post-acute

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[232] Request for Information on Medicare Program, 87 Fed. Reg. 46918, 46920 (Aug. 1, 2022).

[233] Medicare Program; Request for Information on Medicare Advantage Data, 89 Fed. Reg. 5907, 5908 (Jan. 30, 2024); *See also*, Comment from The National Committee for Quality Assurance on Medicare Advantage Program (Aug. 21, 2022); Comment from the American Hospital Association on the Medicare Advantage Program (Aug. 21, 2022).

[234] Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, 87 Fed. Reg. 76238, 76270 (Dec. 13, 2022).

[235] Jeannie Fuglesten Biniek et al., *Gaps in Medicare Advantage Data remain Despite CMS Actions to Increase Transparency*, KFF HEALTH NEWS (Apr. 10, 2024), https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-remain-despite-cms-actions-to-increase-transparency/.

[236] Agency Information Collection Activities: Proposed Collection; Comment Request, 89 FR 65359, 65359-60, https://www.govinfo.gov/content/pkg/FR-2024-08-09/pdf/2024-17773.pdf.

[237] *Id.* at 63560.

[238] *Id.* at 63569.

[239] Jeannie Fuglesten Biniek et al., *Gaps in Medicare Advantage Data remain Despite CMS Actions to Increase Transparency*.

care, and comparing it to overall prior authorization data, PSI was able to make the findings in this report not previously reported to CMS or to the public.

2. CMS should conduct targeted audits if insurer prior authorization data reveal notable increases in adverse determination rates

CMS conducts annual audits of Medicare Advantage insurers to ensure compliance with coverage obligations and other regulations.[240] Over the years these audits have found "widespread and persistent problems related to inappropriate denials of services," but they have failed to curb the issues documented in this report.[241] Over the past year, CMS has announced changes to its audit procedures that have the potential to improve some of the abuses addressed in this report. But, once it is able to collect prior authorization data by service category, it will be able, as this report does, to determine whether an insurer exhibited a significant increase in denial rates for a particular service category. Such a change may signal that insurers are failing to comply with coverage requirements and should prompt additional scrutiny from CMS's Division of Audit Operations.

One of the key concerns identified in the 2022 HHS OIG audit was that Medicare Advantage insurers frequently claimed that patients, whose providers had recommended a placement into a particular type of post-acute care facility, could be safely treated in a less-intense—and less costly—setting, even if these alternatives were not "clinically sufficient to meet the patient's needs."[242] Under existing audit protocols, this type of wrongful denial may be particularly difficult to monitor for post-acute care services because many of the criteria on which to evaluate medical necessity are open to interpretation: the patient's illness is "complex enough" to require further hospital care; the patient "need[s]" special nursing care; the patient needs "to be seen by a doctor every day."[243] Notable increases in adverse determination rates could help preserve CMS resources by indicating which procedures or contracts to target.

As part of a 2018 report on prior authorization, HHS OIG analyzed the reports of audits CMS conducted on Medicare Advantage insurers, and found that, in 2015, CMS cited 56 percent of the insurer contracts it audited for clinically inappropriate denials.[244] The report recommended that CMS "enhance oversight of [Medicare Advantage insurer] appeals data," yet, by the time HHS OIG's 2022 report was

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[240] CTRS. FOR MEDICARE & MEDICAID SERVS., *2022 Part C and Part D Program Audit and Enforcement Report* (2023), https://www.cms.gov/files/document/2022-program-audit-enforcement-report.pdf-0.

[241] U.S. DEP'T OF HEALTH & HUM. SERVS., *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, at 2.

[242] *Id.* at 16.

[243] These criteria come from the Humana template for the denials of long-term acute care hospitals, which in turn are derived from the MCG care guidelines "LTACH Level of Care Guideline." *See* HUM-PSI-0053321-22.

[244] U.S. DEP'T OF HEALTH & HUM. SERVS., OEI-09-16-00410, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials*, at 11 (2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

released, this had still not occurred.[245] The 2022 HHS OIG report suggested further updates to the CMS audit protocols; in the section of the report that included CMS's response, CMS stated that it agreed with some of the recommendations but "did not indicate whether it would consider targeting in its audits specific types of services that have a history of inappropriate denials."[246]

In October 2023, CMS issued a Health Plan Management System Memo announcing changes to its "2024 Oversight Activities."[247] The memo specified that the agency had modified its audit protocols in response to the new regulations referenced above. Specifically, beginning in 2024, the agency would "begin conducting both routine and focused audits" of Medicare Advantage insurers to assess their compliance with the new regulations.[248] A subsequent memo from December 2023, clarified that while "routine" audits would proceed as in years past and would apply to plans that had already been scheduled for audits, "focused" audits would target plans that weren't scheduled for audits and would be narrowly directed at compliance with the new coverage regulations.[249]

These changes do not appear to address the problems discovered by the Subcommittee. As this report notes, the coverage criteria for many stays in post-acute care facilities are flexible enough to enable denials whose wrongfulness would be difficult to detect without close inspection. CMS estimated that its 2024 audit protocols would enable it to "evaluate the [utilization management]-related performance of plans serving approximately 88 percent of people with [Medicare Advantage]."[250] It also stated that both routine and focused audits would "utilize physician reviewers to review denied requests to assess whether [Medicare Advantage insurers] are meeting new clinical coverage requirements."[251] But it is unclear from CMS's memos how, or how frequently, physician reviewers will be deployed. Given the enormous and growing size of Medicare Advantage, it remains very possible that the pool of wrongful denials detected will be too small to have the deterrent effect that the audit process intends.

As this report indicates, data about prior authorization denials broken down by service category could enable much more effective auditing. For example, between 2020 and 2022, UnitedHealthcare's initial adverse determination rate for post-acute care facilities increased by 108 percent, resulting in tens of thousands of additional denials. If CMS is concerned with ensuring that Medicare Advantage insurers are adhering to coverage requirements, such a substantial increase in denials for a single service category ought to be concerning. CMS could set fixed values for how large of a year-to-year increase could trigger

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[245] U.S. DEP'T OF HEALTH & HUM. SERVS., *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, at 5.

[246] *Id.* at 21.

[247] Memorandum from the Ctr. for Medicare to all Medicare Advantage Organizations HPMS 2024 Oversight Activities Memo (Oct. 24, 2023) (on file with the Subcommittee).

[248] *Id.*

[249] Memorandum from John A. Scott, Dir. of Medicare Parts C and D Oversight and Enf't Grp. to All Current and Prospective Medicare Advantage, Prescription Drug Plan, Section 1876 Cost, and Medicare-Medicaid Plan Org. (Dec. 19, 2023) (on file with the Subcommittee).

[250] *Id.*

[251] *Id.*

a new type of focused audit, and modify its audit protocols to allocate more physician reviewers to these cases.

3. CMS should expand regulations for utilization management committees to prevent predictive technologies from unduly influencing human reviewers

CMS has not provided sufficiently specific guidance on separating the use of predictive technologies from patient determinations regarding post-acute care. In a February 2024 memo aimed at providing further guidance on the appropriate use of AI and other predictive technologies, CMS stated that AI could be used to "assist" in predicting a patient's length of stay, but that medical necessity determinations had to be based on "the individual patient's circumstances."[252] But CMS did not provide any further specificity on *how* companies should endeavor to ensure that the predicted length of stay offered by AI did not influence the evaluation of an "individual patient's circumstances."

The findings detailed in this report show why such specificity is needed. Each of the companies that are the subject of the Subcommittee's inquiry maintains that its efforts to introduce automation into the prior authorization process could only result in approvals, and that any claims that were not approved had to be forwarded on to human reviewers. While this assertion may be true as a technical matter, evidence obtained by the Subcommittee suggests that, in some cases, Medicare Advantage insurers may be pressuring human reviewers to follow the recommendations of predictive technologies. At least one company's reviewers could see the input of various predictive technologies on claim files. At another, internal testing of an automated determination model showed that the model increased denial rates by finding information that human reviewers allegedly "missed."

Regulators could address this issue by modifying existing regulations on the bodies these companies employ to set rules for prior authorization and other utilization management techniques. Beginning in 2024, CMS began requiring that Medicare Advantage insurers who deploy utilization management in their plans maintain internal committees to govern its use.[253] These committees must set polices about prior authorization for the organization and, beginning in 2025, they must also publish an annual health equity analysis indicating how prior authorization is impacting enrollees with low-incomes or disabilities.[254] Earlier this year, CMS finalized additional regulations requiring that, by 2026, Medicare Advantage Insurers provide certain information about their prior authorization process in a series of

[252] Memorandum from Ctrs. for Medicare & Medicaid Serv. to All Medicare Advantage Organizations and Medicare-Medicaid Plans (Feb. 6, 2024).

[253] 42 C.F.R. § 422.137. Many insurers, including those covered by this investigation, already had similar committees before the requirement was enacted, and were allowed to "adapt or alter" existing committees to meet the new requirement. *See* 88 CFR, at 22213.

[254] 42 C.F.R. § 422.137 (2005). This analysis requires only overall prior authorization percentages, not a break-down by service category.

application programming interfaces ("APIs") including an API intended specifically for patients and another for providers.[255]

CMS could build on these existing regulations by (1) requiring that Medicare Advantage insurers disclose how predictive technologies are used in their prior authorization process, and (2) requiring utilization management committees to develop rules to ensure that predictive technologies are not influencing decisions by human reviewers. In response to comments to the proposed rules for APIs asking that insurers report, among other things, "how the [prior authorization] decision was made," the "software tools/artificial intelligence tools used," and the "persons involved in making the prior authorization decision," CMS concluded, "While these specific additional data and functionalities may provide value to providers at this time, we do not believe that the value outweighs the additional effort impacted payers would need to expend to add these data and functionalities."[256] But without this information, it is difficult to see how the agency would verify that insurers are using artificial intelligence only for permitted purposes.

CONCLUSION

Medicare Advantage has grown rapidly in recent years and is, as of 2023, larger than Traditional Medicare. Despite the enormous growth in enrollment, some two dozen health systems have announced over the past year that they will stop accepting Medicare Advantage beneficiaries, with hospitals and providers overwhelmingly citing frustration with prior authorization. Prior authorization was one of the tools given to insurers participating in the program to help them prevent harmful or unnecessary medical services, but as HHS OIG and others have warned, the structure of Medicare Advantage can incentivize companies to use the process to deny care to which patients are entitled. The evidence in this report demonstrates that this is likely occurring at a scale impacting tens of thousands of elderly Americans, and that denials are overwhelmingly occurring in costly but critical post-acute care.

Regulators collect certain information about Medicare Advantage insurers' use of prior authorization, but the opacity of the current system is part of what enables insurers to abuse it. The Subcommittee was able to analyze prior authorization data that Medicare Advantage insurers are not currently required to make public, and to examine internal documents from the insurers that provide context for the trends born out in this data. But many of the issues that most frustrate patients and providers remain cloaked in uncertainty. This is particularly true of insurers' use of automation and predictive technologies, which PSI continues to investigate. Media reporting on this issue indicates that many of the most disturbing practices, including using artificial intelligence to fix Medicare Advantage beneficiaries' lengths of stay in certain facilities, were accomplished through informal pressure campaigns on employees. Such wrongs

[255] Interoperability and Improving Prior *Authorization* Processes for Medicare Advantage Organizations, 89 Fed. Reg. 8758 (Feb. 8, 2024).

[256] *Id.* at 8798.

are unlikely to be captured in computer code or official communication, to say nothing of regulatory filings.

Although the Subcommittee's recommendations in this report are targeted at regulators, this should not distract from the fact that it is insurers who are using prior authorization to protect billions in profits while forcing vulnerable patients into impossible choices. This is particularly troubling when recent analyses indicate that Medicare Advantage is more expensive than Traditional Medicare, with one assessment concluding that, in 2024, the government spent 22 percent more to fund Medicare Advantage plans than it would have had those beneficiaries been enrolled in Traditional Medicare.[257] There is a role for the free market to improve the delivery of healthcare to America's seniors, but there is nothing inevitable about the harms done by the current arrangement. Insurers can and must do better, for the sake of the American healthcare system and the patients the government entrusts to them.

[257] MEDPAC, *DATABOOK: HEALTH CARE SPENDING AND THE MEDICARE PROGRAM* 134 (2023), https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_SEC.pdf.

APPENDIX

Table 1: Number of requests and denial rates by facility

Insurer Adverse Determination Rates by Type of Post-Acute Care Facility	***Skilled Nursing Facility***		***Inpatient Rehabilitation Facility***		***Long-Term Acute Care Hospital***	
	Denial Rate	*Number of Requests*	***Denial Rate***	*Number of Requests*		*Number of Requests*
UnitedHealthcare						
2019	1.4%	215,469	43.6%	34,476	53.7%	7,802
2020	4.1%	198,453	41.8%	34,546	50.9%	7,194
2021	7.3%	252,873	55.4%	45,682	69.2%	9,189
2022	12.6%	272,687	71.4%	46,395	83.7%	8,393
Humana						
2019	7.1%	80,300	55.4%	24,129	57.3%	7,067
2020	4.5%	49,716	42.3%	28,737	39.9%	7,219
2021	4.9%	64,113	49.5%	31,098	49.5%	9,154
2022	6.3%	65,897	51.3%	32,752	61.4%	8,882
CVS						
2019	18.8%	116,941	39.3%	27,441	61.7%	5,335
2020	19.0%	130,271	37.9%	34,680	66.0%	6,430
2021	18.0%	160,957	45.9%	35,995	65.5%	6,851
2022	19.7%	189,762	48.1%	39,468	72.5%	6,618

Sources: UnitedHealthcare New Exhibit A, July 17, 2023, Letter from UnitedHealthcare to PSI, July 16, 2024; HUM-PSI-0045741-43, HUM-PSI-0045745-48, HUM-PSI-0045750-53, HUM-PSI-0045756-59; CVS-PSI-159395, CVS-PSI-178014, Letter from CVS to PSI, March 29, 2024).