INSIDE INVESTIGATOR

NEWS

Blumenthal releases scathing Medicare Advantage report

by Brandon Whiting
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Yesterday, Connecticut US Senator Richard Blumenthal (D), Chair of the Senate Permanent Subcommittee on Investigations (PSI) released a report including the findings of its investigation into **Medicare Advantage.** The report studied UnitedHealthcare, Humana, and CVS, the three largest Medicare Advantage providers, and found evidence that they disproportionately used prior authorization to deny stays in skilled nursing facilities, inpatient rehab, and long-term acute care hospitals to boost profit.

“Insurance companies say that prior authorization is meant to prevent unnecessary medical services. But the Permanent Subcommittee on Investigations has obtained new data and internal documents from the largest Medicare Advantage insurers that discredit these contentions,” said Blumenthal. “In fact, despite alarm and

criticism in recent years about abuses and excesses, insurers have continued to deny care to vulnerable seniors —simply to make more money. Our Subcommittee even found evidence of insurers expanding this practice in recent years."

Scrutiny of Medicare Advantage, which has been Connecticut's state retiree health plan since 2017, has grown alongside its increasing proliferation nationwide. Per the report, only 13% of those enrolled in Medicare had a Medicare Advantage plan when it was first implemented in 2003. As of 2023, over half of Medicare-eligible seniors have a Medicare Advantage plan.

PSI procured over 280,000 pages of documents from the three providers in furtherance of its investigation, which began on May 17, 2023. PSI found that from 2019-2022, providers denied prior authorization requests for post-acute care, which is non-emergency transitional or rehabilitative care, at significantly higher rates than they did for other types of care. Furthermore, denial rates on these preauthorizations continued to rise year-over-year.

The report provided skilled nursing facilities, inpatient rehabilitation facilities and long-term acute care hospitals as examples of post-acute care facilities. Because these facilities typically provide longer-term care, they are more expensive for insurers to cover, making them excellent targets for providers looking to cut costs and increase profitability. The report cited the findings of a **2022 audit** done by the Department of Health and Human Services, Office of Inspector General, to highlight this point.

"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," reads the report. "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."

UnitedHealthcare's pre-authorization denial rate for post-acute care rose significantly over the three year span studied, growing from 10.9% in 2020, to 16.3% in 2021, and 22.7% in 2022. These numbers are significantly higher than its overall denial rate, which averaged out to 7.5% over the same timeframe.

Humana's preauthorization denial rate for post-acute care also rose, albeit less dramatically, from 20.7% in 2019 to 24.6% in 2022. In 2022, its post-acute care denial rate was over 16 times higher than its overall pre-authorization denial rate, which was 1.33% on average over the same time span.

CVS was the only provider that maintained a relatively steady rate of denials for post-acute care, with it rising slightly from 24.1% in 2019 to 25.9% in 2022. However, it had the highest average denial rate for post-acute care of all three providers, while also having the highest average rate of denials overall, averaging 9.3% from 2019-2022. It also increased the amount of post-acute service requests that required preauthorizations over the three years by 57.5%.

"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," read the report. "By 2022, CVS was denying prior authorization of post-acute care facilities more than all other types of service requests combined."

Per the report, a May 2019 presentation showed that CVS saved over $660 million in inpatient-facilities-related medical costs for Medicare Advantage members in 2018, with a majority of these savings coming from denied requests.

The report evaluated internal documents and memos of each company that would indicate these growth in denial rates have been driven by profit motive, not patient outcomes. The report also analyzed the increased usage of artificial intelligence by providers to process claims, indicating a link between the use of AI and the increase in denials.

"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," read the report. "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."

UnitedHealthcare was found to have first tested out two algorithmic systems, one titled the HCE Auto Authorization Model and the other named Machine-Assisted Prior Authorization (MAP), in 2021, for the purpose of sorting pre-authorization requests into those that could be auto-approved and those that would require human review. MAP was found to have produced faster handle times in the management of claims and an increase in denial rates, and was subsequently approved for use in an April 2021 meeting.

Optum, a subsidiary of UnitedHealthcare's parent company that provides tech services for several insurance providers, was also found to have been on the market for AI claims screening technology. Optum purchased a company called naviHealth in May 2020, the creators of an algorithm called mH Predict, which is used to assess outcomes for patients provided post-acute care, specifically those admitted to skilled nursing facilities. The report found that in 2022, the first year in which naviHealth managed UnitedHealthcare's pre-authorization claims for skilled nursing facilities, its denial rate increased to 12.6% compared to a 2019 denial rate of 1.4%.

CVS was reported to have found profitability by increasing the total number of pre-authorization requests required for care, while at the same time reducing its number of claims review staff, using AI to offset the difference.

"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," read the report. "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."

The report found Humana to be the least reliant on AI in terms of its pre-authorization review processes but found training materials that walked claims review staff through the best ways to issue pre-authorization denials and win appeals of prior denials, while also stressing the high costs associated with long-term acute care hospitals. Other documents show there was discomfort among employees regarding policies that suggested claims review staff suggest hospice to Medicare Advantage holders as an alternative to long-term care.

"Humana's training materials for long-term acute care hospitals continued to emphasize their high cost, limited usefulness, and position hospice as an alternative," read the report.

Ultimately, the report concluded by recommending that CMS, the federal agency that oversees Medicaid, should collect prior authorization information broken down by service category, conduct audits if insurers' data reveal notable increases in pre-authorization denials, and should expand regulations for AI claim reviewing technologies.

"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," concluded the report. "Insurers can and must do better, for the sake of the American healthcare system and the patients the government entrusts to them."

Carolyn

October 18, 2024 at 8:30 pm

Why no Congressional hearings? They seem to hold hearings for every other thing, no matter how inconsequential.

Anthony Johnson

October 20, 2024 at 7:27 am

Seriously – the report is based on findings from 2019 – 2022 – why didn't Blumenthal do something then? Why do we need a supplemental report to review these report findings? This is what is wrong with Congress – nothing done until an election year and now they want to look like heros.

Mr W

October 20, 2024 at 10:09 am

There is also a huge amount of corruption going on in DSS…we have plenty of documentation proving it.
