Department of
HUMAN SERVICES

Iowa Medicaid Enterprise
Review of State Fair Hearing Appeals

April 2020

Executive Summary

The purpose of this report is to provide analysis of Medicaid Managed Care Organization (MCO) member appeals for the period of January 1, 2018 to June 30, 2019. This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the provider or MCO, or overturned by an administrative law judge (ALJ).

An appeal may be initiated by a Medicaid member, or their representative(s), following a decision by the MCO to deny or limit items or services. Following the adverse action by the MCO, the member receives a letter explaining the reason for the denial or limitation of benefits. The member has 60 days from the date of the letter to initiate the appeal process.

The initial appeal process includes an internal first level review between the member and the MCO during which members have the right to appeal the adverse action. The MCO has 30 days to complete the first level review and report, in writing, the findings of the internal review to the member. If the member does not agree with the MCO's decision, the member can file an appeal with the state through the state fair hearing (SFH) process within 120 days of the MCO's decision. The SFH process allows the member the opportunity to present their case to an ALJ for review. SFH appeals are legal proceedings, similar to a non-jury trial in a court of law, in which an impartial ALJ presides over the hearing. In order to be eligible for SFH, an appeal must go through the internal MCO first level review process, have been filed within the expected time frame, and an adverse Notice of Decision must have been sent to the member or legal representative(s). Any one of these issues alone will make an appeal ineligible.

The Department's Quality Improvement Organization (QIO) reviewed SFH appeals filed during the reporting period to determine if the MCO's initial decision to deny the service request was consistent or inconsistent with Iowa Administrative Code (IAC) and/or state and federal criteria. The QIO clinical review team consisted of physicians, nurses, licensed social workers, and subject matter experts with experience in the Iowa Medicaid Enterprise (IME).

During the reporting period, the MCOs serving Iowa Medicaid included AmeriHealth Caritas Iowa, Inc. (ACIA), Amerigroup Iowa, Inc. (AGP), and UnitedHealthcare Plan of the River Valley (UHC).

Iowa Medicaid implemented managed care on April 1, 2016. In November 2017, ACIA withdrew from Iowa Medicaid and their members transitioned to UHC. ACIA was responsible for any grievances or appeals for dates of service through November 2017. Providers had 180 days from the date of service to bill ACIA, and ACIA maintained claims processing for a minimum of 12 months after their termination date. Beginning July 1, 2017, the appeal timeframe increased from 90 to 120 days. The member/provider had 30 days to submit a first level review request and the MCO had

another 30 days to render a decision. The member/provider then had up to 120 days to file a state fair hearing request. UHC left the program on June 30, 2019.

During the reporting period, 1,384 appeal requests were submitted for SFH review. Of these, 51 were overturned by an ALJ. When compared to the MCO member appeals from calendar year (CY) 2017, there was a 15 percent decrease in the number of appeals submitted for SFH and a four percent increase in the number of overturned appeals by an ALJ.

It is also notable that due to ACIA leaving the Iowa Medicaid program, UHC's long-term services and supports (LTSS) member enrollment increased more than 400 percent during the reporting period, while AGPs increased by 47 percent. However, UHC's appeals as percentage of the total were actually lower than AGP's. During this reporting period, less than .001 percent of the total eligible services were appealed.

The table below outlines the membership of the three MCOs during this reporting period and the number of LTSS members for each MCO. One MCO may receive more appeals than another merely because it serves more members. While any member can appeal a decision by an MCO to deny or limit items or services, LTSS members tend to receive more services throughout their plan of care.

MCO	Number of Members	Number of LTSS Members
ACIA*	0	0
AGP	240,982	11,734
UHC	394,531	26,574

ACIA withdrew from Iowa Medicaid in November 2017; therefore, at the end of the reporting period, there were no active members. The last appeal filed for ACIA was in July of 2018.

Key Findings

Of the total appeal requests completed, four percent of those resulted in an overturned decision by an ALJ, which is a one percent increase from CY2017. Decisions that were overturned by an ALJ are the primary focus of this report.

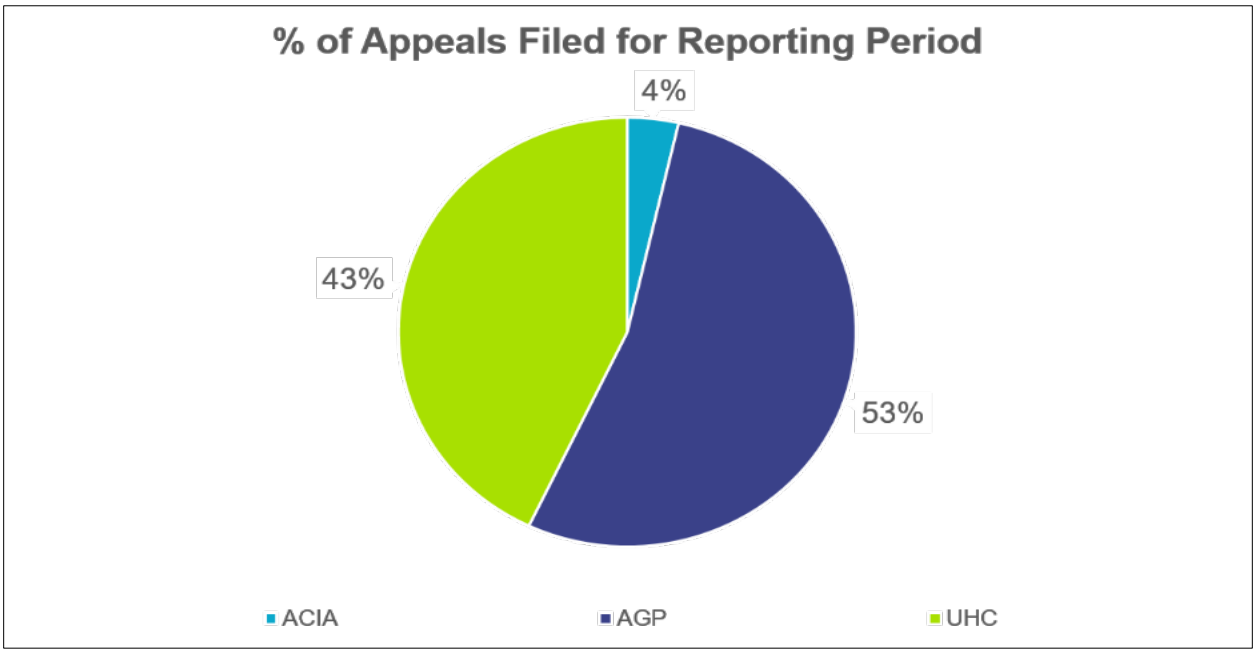
Table 1 and Graph 1 below depict the number and percentage distribution of appeal requests received, categorized by MCO. Of the total requests filed, four percent involved ACIA enrolled members, 53 percent involved AGP members, and 43 percent involved UHC members.

Table 1

MCO	Number of Appeals	Percent of Total Appeals
ACIA	50	4%
AGP	740	53%
UHC	594	43%
Total	1,384	100%

Number and percentage of appeal requests received by MCO

Graph 1



Number and percent distribution of appeal requests received

Requests for appeals during the reporting period were categorized by the type of action taken. These actions were:

- Withdrawn prior to the appeal hearing.
- Dismissed prior to or during the appeal hearing.
- Overturned by the ALJ.
- Case was determined to not be appeal eligible.

An appeal request is withdrawn when the member has decided they no longer wish to proceed with the appeals process. An appeal request is dismissed when the MCO has decided to grant the previously denied item or service and thus an appeal hearing is no longer necessary. Overturned means the appeal was heard by an ALJ and the original denial of the requested item or service is found to be incorrect.

Table 2 and Graph 2 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only four

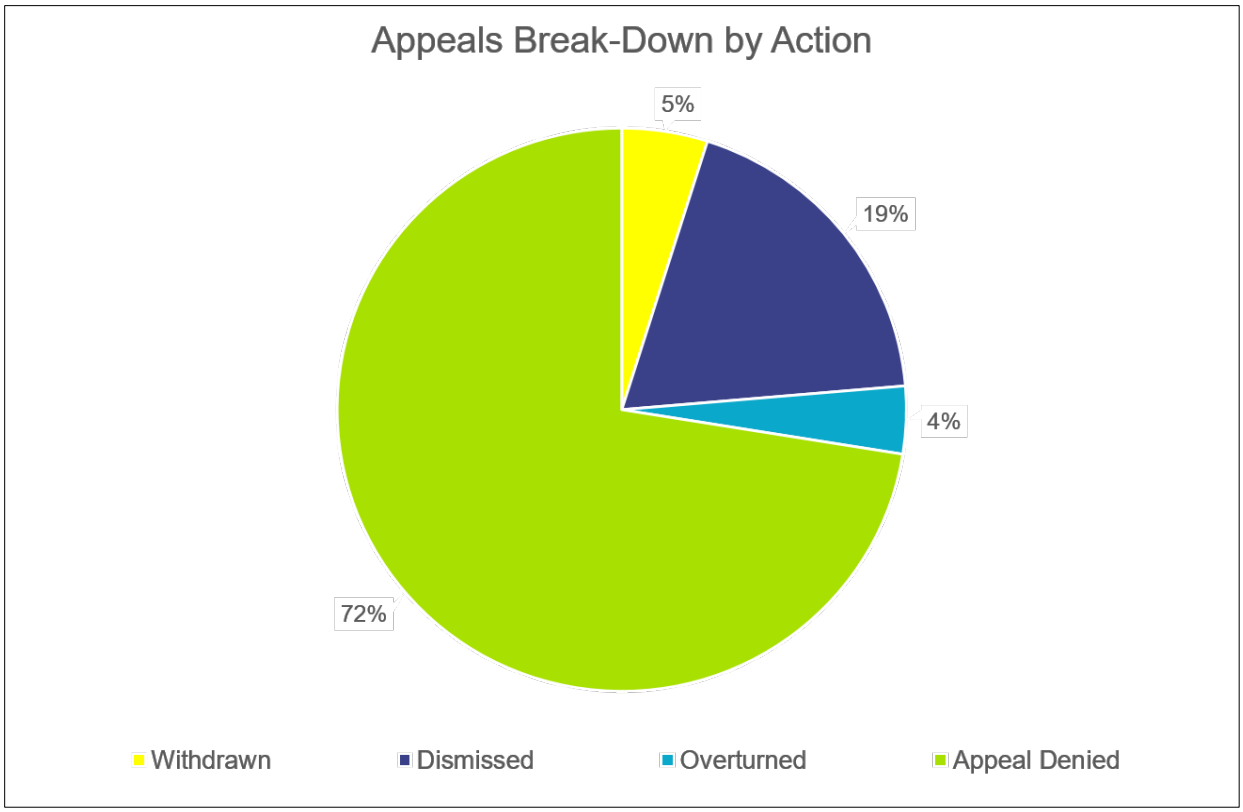
percent resulted in overturned decisions by an ALJ and 72 percent of the requests were determined to be not eligible for an appeal.

Table 2

Action	Appeals Filed	
Withdrawn	66	5%
Dismissed	247	19%
Overturned	51	4%
Not Appeal Eligible	953	72%
TOTAL	1,317	100%

Breakdown of appeal decisions by action

Graph 2



Breakdown of appeal decisions by action

Appeals Withdrawn

An appeal is withdrawn when the member decides they no longer wish to proceed with the appeal process.

Of the total appeal requests received, 66 were withdrawn. UHC had the highest percentage of appeals withdrawn at 64 percent.

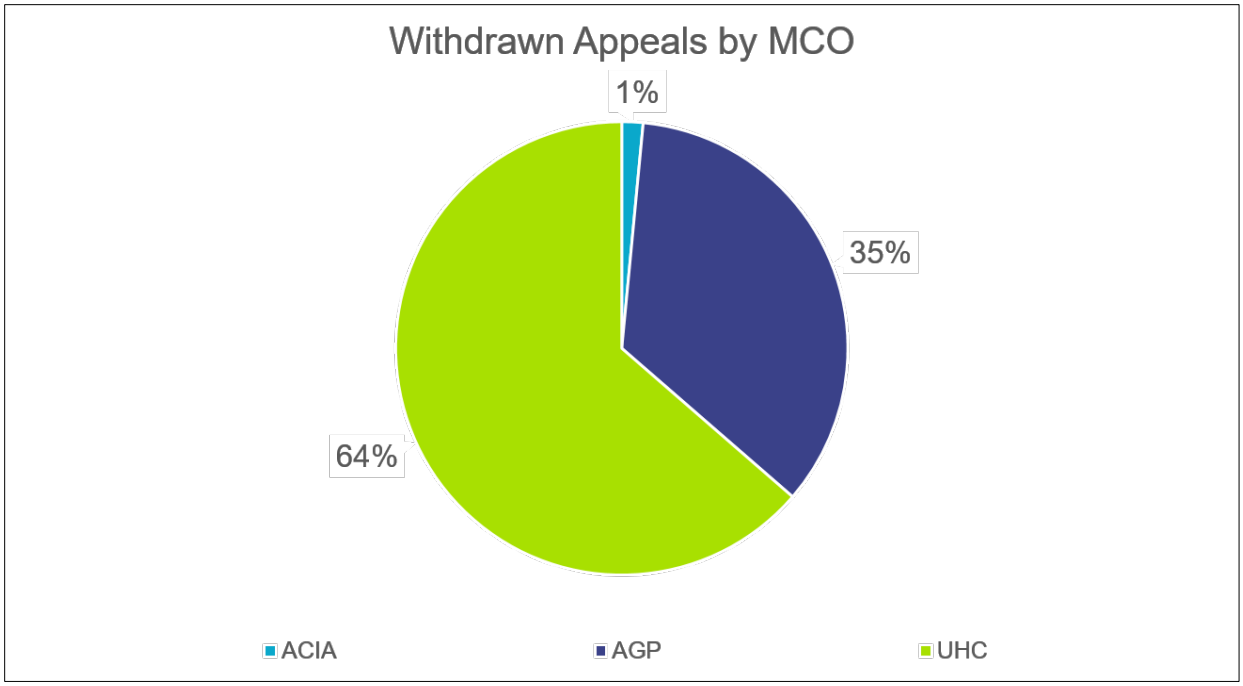
Table 3 and Graph 3 display the appeal volume breakdown for withdrawn appeal requests. Of the 66 appeal requests withdrawn, one percent involved ACIA member appeal requests, 35 percent involved AGP member appeal requests, and 64 percent involved UHC member appeal requests. When looking at the total of appeals filed by MCO, ACIA had less than one percent of withdrawn appeals, while AGP accounted for two percent, and UHC had three percent.

Table 3

MCO	Number of Appeals	Number of Withdrawals	Percent of Withdrawals	Percent of Appeals
ACIA	50	1	1%	0.1%
AGP	740	23	35%	2%
UHC	594	42	64%	3%
TOTAL	1,384	66	100%	5%

Breakdown of withdrawn appeals by MCO

Graph 3



Breakdown of withdrawn appeals by MCO

Appeals Withdrawn (continued)

Table 4 and Graph 4 display, by MCO, the number of cases where the clinical review team found the original MCO decision to deny or limit benefits to be consistent or inconsistent with the IME and/or state and federal review criteria. Of the 66 withdrawn appeals, the clinical review team concluded that 27 percent of the time, or 18 of the 66 MCO withdrawals, were considered inconsistent with how the clinical review team would have evaluated the cases using state and federal criteria along with IAC.

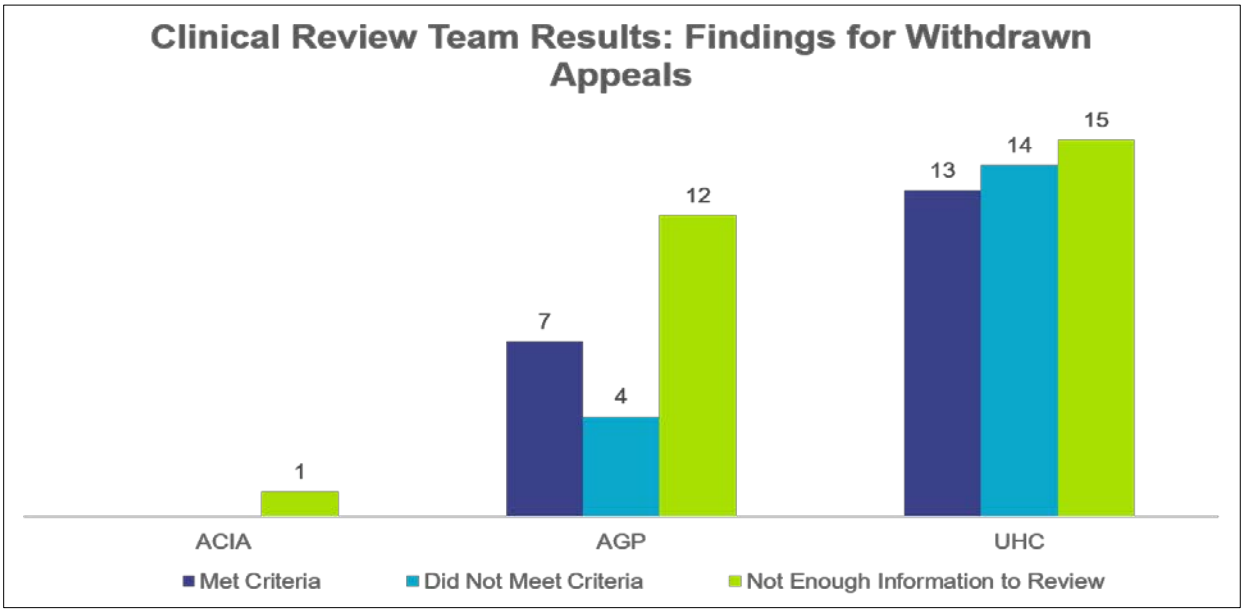
When looking at each MCO, the IME clinical review team was unable to come to a conclusive decision on ACIA's one withdrawn appeal. However, the IME clinical review team concluded that their decision would have been different from the original MCO decision 17 percent of the time for AGP and 33 percent for UHC. The clinical review team was unable to come to a conclusive decision on 28 withdrawals, or 42 percent of the total 66 withdrawn appeals due to lack of information.

Table 4

MCO	Met Criteria	Percent Met	Did Not Meet Criteria	Percent Did Not Meet	Not Enough Information	Percent of Appeals with Not Enough Information	Total Withdrawn Appeals
ACIA	0	0%	0	0%	1	100%	1
AGP	7	30%	4	17%	12	52%	23
UHC	13	31%	14	33%	15	36%	42
TOTAL	20	30%	18	27%	28	42%	66

Withdrawn appeals clinical review outcome

Graph 4



Withdrawn appeals clinical review outcome

Appeals Dismissed

An appeal is dismissed when the MCO has decided to grant the previously denied item or service and an appeal hearing is no longer necessary.

Of the 1,384 appeals filed, UHC had the highest percentage of dismissed appeals at 13 percent. Of the 247 total dismissals, UHC also had the highest percentage of dismissals at 71 percent.

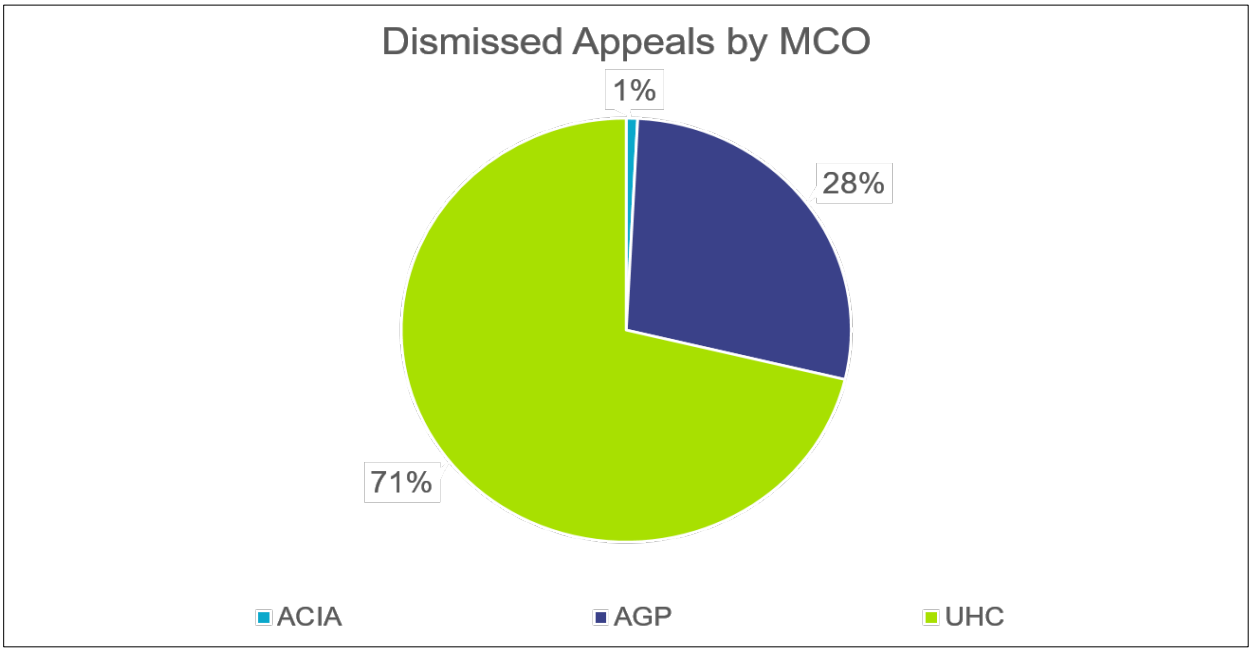
Table 5 and Graph 5 show the appeal volume breakdown for appeal requests that were dismissed. Of the 247 dismissed appeals, one percent of ACIA member appeal requests were dismissed, 28 percent of AGP member appeal requests were dismissed, and 71 percent of UHC member appeal requests were dismissed. Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals completed for each MCO; ACIA had less than one percent, AGP had 5 percent, and UHC had 13 percent.

Table 5

MCO	Number of Appeals	Number of Dismissals	Percent of Dismissals	Percent of Appeals
ACIA	50	2	1%	0.1%
AGP	740	69	28%	5%
UHC	594	176	71%	13%
TOTAL	1,384	247	100%	18%

Breakdown of dismissed appeals by MCO

Graph 5



Breakdown of dismissed appeals by MCO

Appeals Dismissed (continued)

Table 6 and Graph 6 display, by MCO, the number of cases where the clinical review team found the original MCO decision to deny or limit benefits to be consistent or inconsistent with the IME and/or state and federal review criteria. Of the 247 dismissals, the clinical review team concluded that 49 percent of the time, or in 121 of the 247 MCO dismissals, the original decision to deny or limit benefits was inconsistent with how the clinical review team would have evaluated the cases using state and federal criteria along with IAC.

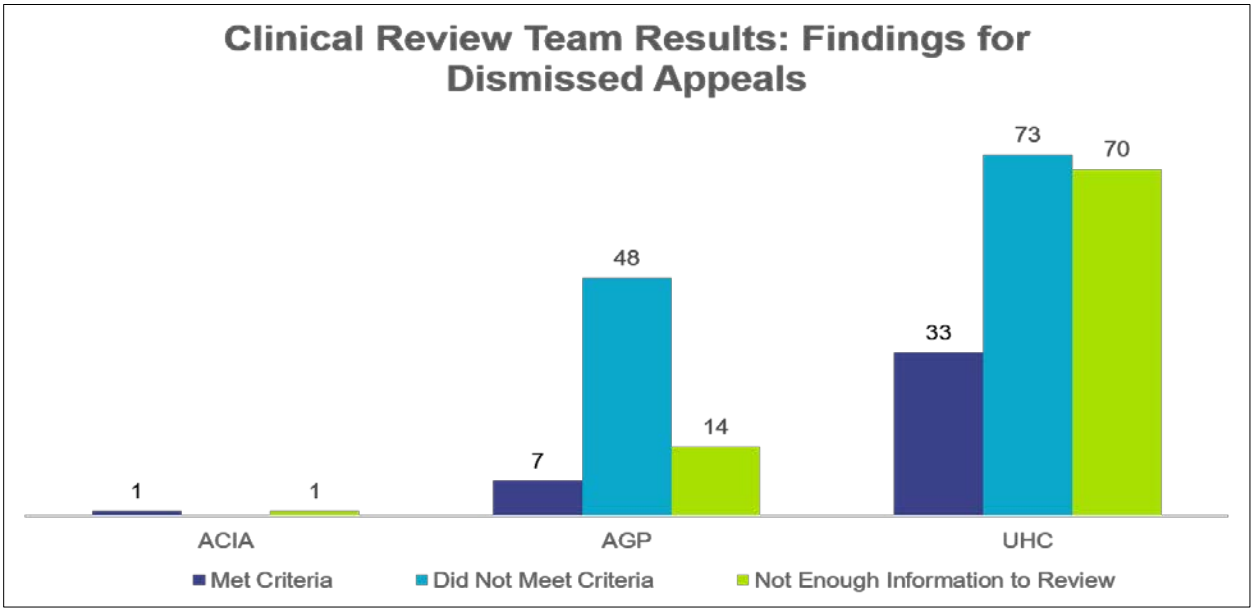
When looking at each MCO, ACIA had only one appeal with enough information to review and the clinical review team concluded that their decision would not be different. However, it would be different 70 percent of the time for AGP, and 41 percent of the time for UHC. The clinical review team was unable to come to a conclusive decision on 85 dismissals, or 34 percent of the total 247 dismissed appeals due to lack of information.

Table 6

MCO	Met Criteria	Percent Met	Did Not Meet Criteria	Percent Did Not Meet	Not Enough Information	Percent of Appeals with Not Enough Information	Total Dismissed Appeals
ACIA	1	50%	0	0%	1	50%	2
AGP	7	10%	48	70%	14	20%	69
UHC	33	19%	73	41%	70	40%	176
TOTAL	41	17%	121	49%	85	34%	247

Dismissed appeals clinical review outcome

Graph 6



Outcome of dismissed appeals clinical review

Appeals Overturned

An appeal is overturned when an ALJ, upon hearing the appeal, determines the original denial of the requested item or service was incorrect.

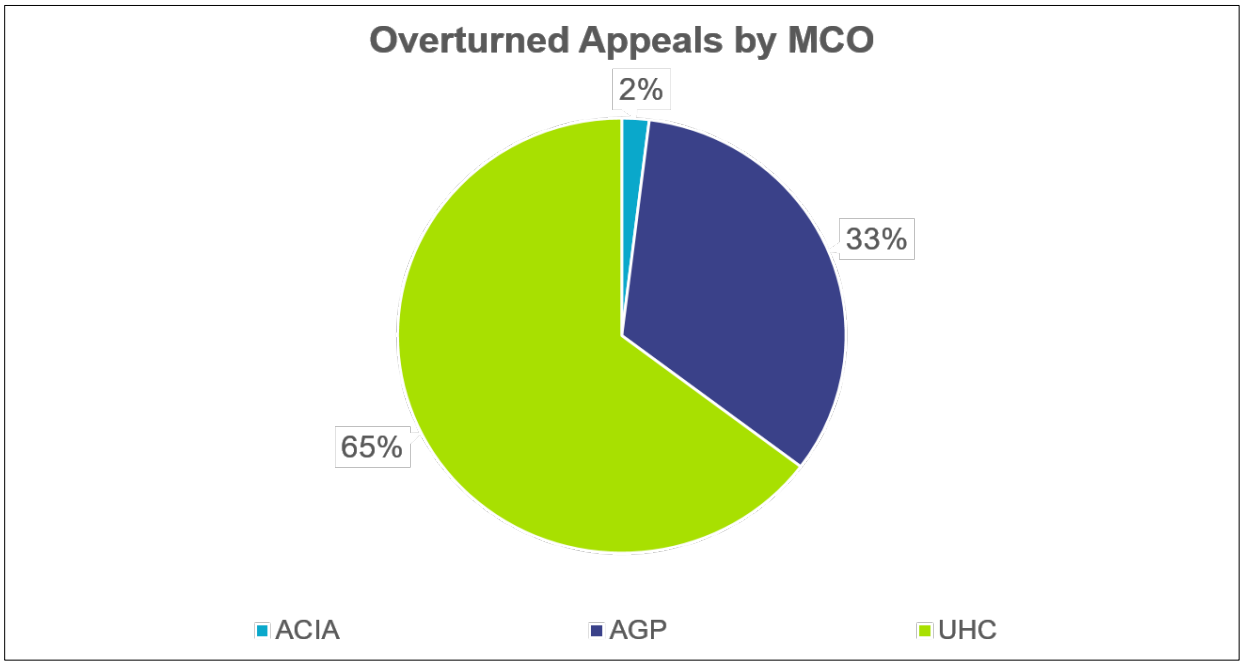
Table 7 and Graph 7 display the volume breakdown. Of the 51 overturned appeals, two percent involved ACIA enrolled members, 33 percent involved AGP enrolled members, and 65 percent involved UHC enrolled members. Of the total number of appeals filed, ACIA had less than one percent of their appeals overturned, AGP had one percent of their appeals overturned, and UHC had two percent of their appeals overturned.

Table 7

MCO	Number of Appeals	Number Overturned	Percent Overturned	Percent of Appeals
ACIA	50	1	2%	0.1%
AGP	740	17	33%	1%
UHC	594	33	65%	2%
TOTAL	1,384	51	100%	4%

Number of overturned appeals by MCO

Graph 7



Percentage of overturned appeals by MCO

Appeals Overturned (continued)

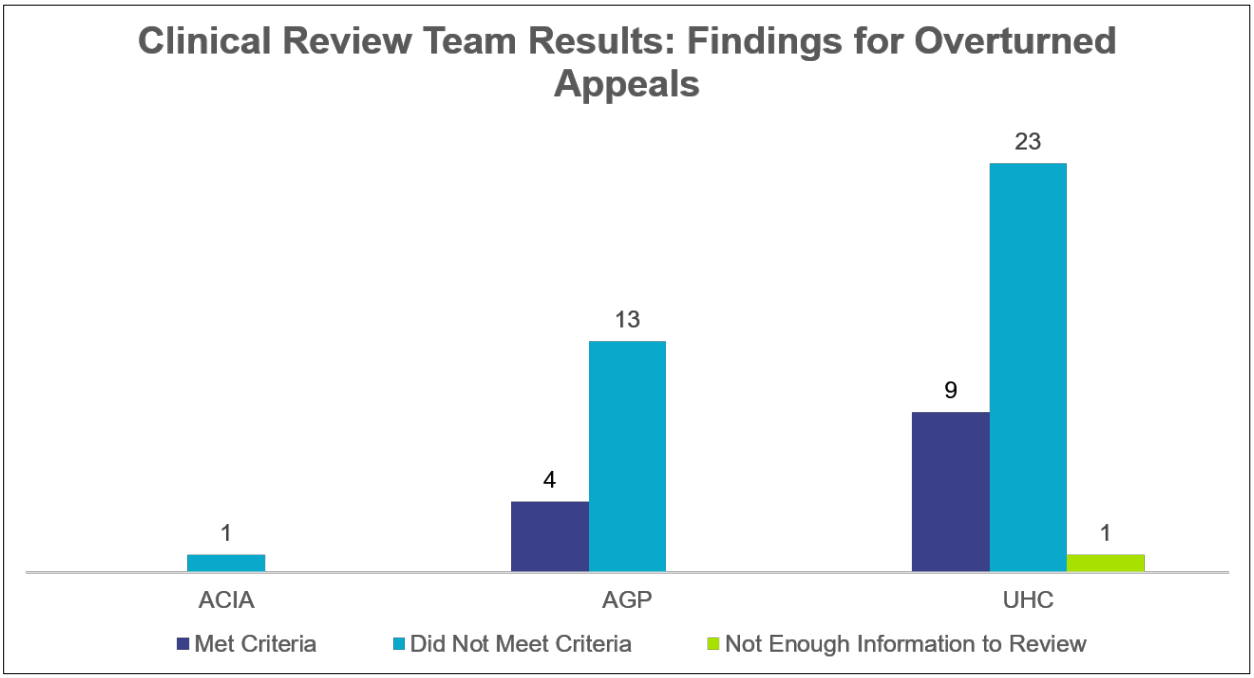
Table 8 and Graph 8 display, by MCO, the number of cases where the clinical review team determined whether the original decision to deny was consistent or inconsistent with state and federal criteria as well as IAC. Of the 51 overturned appeals, the IME concluded that 73 percent of the MCO denials were considered inconsistent with how the clinical review team would have evaluated the cases using the established criteria. When looking at each MCO breakdown, the IME clinical review team concluded that their decision would be different from the original denial decision 100 percent of the time for ACIA; 76 percent for AGP, and 70 percent of the time for UHC.

Table 8

MCO	Met Criteria	Percent Met	Did not Meet Criteria	% Did Not Meet	Not Enough Information	Percent of Appeals with Not Enough Information	Total Overturned Appeals
ACIA	0	0%	1	100%	0	0%	1
AGP	4	24%	13	76%	0	0%	17
UHC	9	27%	23	70%	1	3%	33
TOTAL	13	25%	37	73%	1	2%	51

Number and percentage of overturned clinical review outcomes

Graph 8



Clinical review outcomes for overturned appeals

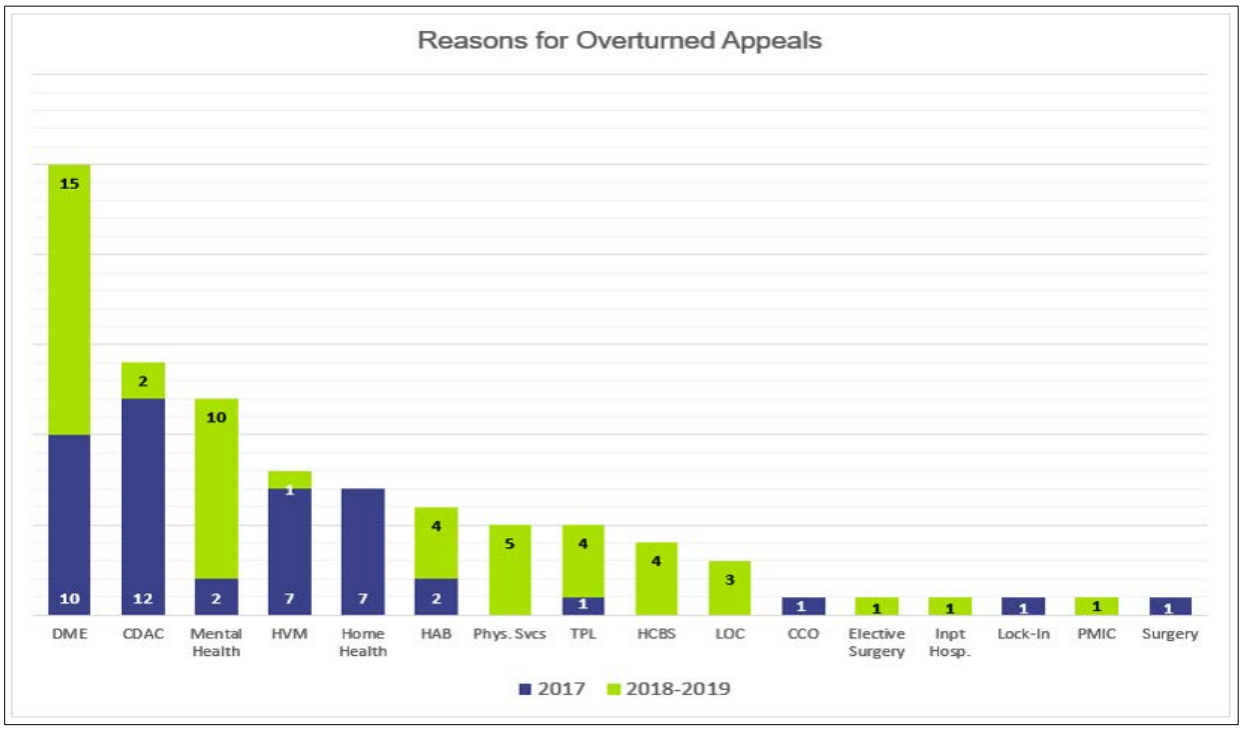
Table 9 and Graph 9 detail the number and percent of appeals overturned by the ALJ by category. The most frequently overturned services included Durable Medical Equipment (DME) and mental health services.

Table 9

Appeal Category	Number of Appeals Overturned	Percent of Appeals Overturned
Durable Medical Equipment (DME)	15	29%
Mental Health	10	20%
Physician Services	5	10%
Habilitation	4	8%
Home- and Community-Based Services (HCBS)	4	8%
Third Party Liability (TPL)	4	8%
Level of Care (LOC)	3	6%
Consumer Directed Attendant Care (CDAC)	2	4%
Elective Surgery	1	2%
Home and Vehicle Modification (HVM)	1	2%
Inpatient Hospital Services	1	2%
Psychiatric Medical Institutions for Children (PMIC)	1	2%
Total	51	100%

Number and percentage of overturned appeals by category

Graph 9



Number of overturned appeals by category (Any zero in a category for a reporting period was removed)

Analysis

In CY 17, Consumer Directed Attendant Care (CDAC) comprised the largest category of overturned appeals at 27 percent. For the current reporting period that number had dropped to four percent. DME appeals made up 20 percent of the overturned appeals in CY 17; however they rose to 29 percent in the current review period and became the most overturned category of appeal. DME was also the only category to remain in the top three categories of overturned appeals for both reporting periods.

This analysis also identified several opportunities for improvement:

- The submission of insufficient information to support a decision to deny a service request may have contributed to appeals being overturned by the ALJ.

- The MCOs need a better understanding of IAC in order to appropriately evaluate member requests for services. A broader understanding of IAC may result in a reduction in the number of total appeals.

- The MCOs should seek additional information from providers, when necessary, prior to making a decision on a member's request for service. This information may provide additional insight into the reasons for a member's request for service that allow for a more informed, defendable decision.

- Better education between the MCOs and providers regarding what services require a prior authorization (PA) and the requirements of each PA. Services may have been incorrectly denied or overturned due to incomplete PA requirements. In conjunction with the Process Improvement Work Group, the Department reviews PAs annually with the MCOs. Codes identified as having unnecessary PA requirements are then removed.

- Initial analysis points to a four percent increase in appeals overturned compared to CY 17; however, the number of appeals filed in total decreased by 15 percent. Information that would assist with quality reviews is still lacking in some areas. The Department should compel the MCOs to submit a full appeal, including the supporting documentation related to the original adverse decision, into the Appeals Information System. For this reporting period, 114 of the 364 appeals (31 percent) did not have enough information for an objective review.

Conclusion

- The MCOs must provide coverage for all Medicaid covered services and abide by IAC when making a decision to deny, reduce or limit a member's request for service. This is currently being monitored not only by the appeal review process described above, but also through reviewing a random sample of reduced, limited, or denied services, as well as the rational provided. Additional monitoring is achieved through attending members' case management meetings to analyze

care plans to ensure that the services discussed are actually being provided and then any denials, reductions, or limitations are based on the needs and goals of the member.

- As part of its oversight efforts, the Department plans to provide additional MCO, provider, and member education regarding the state's Medicaid policies and IAC. Moreover, additional communication between the MCOs and providers is necessary to ensure PA requirements are met.

- Additionally, the Department will continue to provide policy clarifications to the MCOs and continue to work with providers to review PA requirements in addition to working with the MCOs to remove unnecessary PA requirements.

- It is also recommended that an analysis of the 953 appeals filed deemed ineligible for appeal be performed as this number represents 72 percent of all appeals filed during the reporting period. This seems to be a trend as in the CY17 reporting period, 80 percent of appeals were also deemed not appeal eligible. This large percentage may mask some underlying issues or improvement opportunities that may not otherwise be identified.

Glossary of Terms

Term	Definition
Withdrawn	The member has decided they no longer wish to proceed with the appeal process
Dismissed	The MCO has decided to grant the previously denied item or service and an appeal hearing is no longer necessary
Overturned	The appeal was heard before an ALJ and the original denial of the requested item or service is found to be incorrect
Not Appeal Eligible	An appeal is deemed ineligible for the State Fair Hearing Appeal process if: 1- The Internal MCO first level review process has not been completed 2- If the appeal is not filed within the expected time frame 3- The absence of an adverse Notice of Decision to the member or legal representative(s)
ALJ	Administrative Law Judge
AGP	Amerigroup Iowa, Inc.
ACIA	AmeriHealth Caritas Iowa, Inc.
UHC	United Healthcare Plan of the River Valley, Inc.
MCO	Managed Care Organization
IAC	Iowa Administrative Code
FFS	Fee-for-Service
CDAC	Consumer Directed Attendant Care
CCO	Consumer Choice Option
DME	Durable Medical Equipment
HAB	Habilitation
Lock-In	A program to restrict members to certain providers to avoid drug seeking or other misuse of Medicaid
TPL	Third Party Liability
Adverse Decision	A decision that results in a denial, reduction or limitation of services
LTSS	Long Term Services and Supports
SFH	State Fair Hearing
First Level Review	The first step in the member appeal process. The member appeals to their MCO.