Department of HUMAN SERVICES

Iowa Medicaid Enterprise
Review of State Fair Hearing Appeals

July 1, 2020

Executive Summary

The purpose of this report is to provide an analysis of Medicaid Managed Care Organization (MCO) member appeals for the time period July 1, 2019 through December 31, 2019. This includes appeals that have been dismissed, withdrawn, or overturned.

In this report, the Iowa Department of Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the MCO, or overturned by an administrative law judge (ALJ). Additionally, because denied appeals were such a large portion of the appeals overall, the clinical review team analyzed and recommended technical assistance in order to assist in reducing the number of appeals deemed ineligible for State Fair Hearing.

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, meaning 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 appeals process within 120 days of the MCO's decision. The state fair hearing appeals process allows the member the opportunity to present their case to an ALJ for review. State fair hearing appeals are legal proceedings similar to a non-jury trial in a court of law in which an impartial ALJ presides over the hearing.

The Department's Quality Improvement Organization (QIO) reviewed state fair hearing appeals filed July 1, 2019 to December 31, 2019, 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, 369 appeal requests were submitted for review. Of these, six were overturned by an ALJ and are the primary focus of this report.

In 2019, the MCOs serving Iowa Medicaid included Amerigroup Iowa, Inc. (AGP), Iowa Total Care (ITC), and UnitedHealthcare Plan of the River Valley (UHC). (UHC left the program on June 30, 2019. However, members had 120 days to file an appeal, which accounts for the 41 UHC member appeals in this report.) The table on the following page outlines the membership of the two MCOs during this reporting period. One MCO may receive more appeals than another MCO because it serves more members. The table on the next page also includes the number of long-term services and supports (LTSS) members for each MCO. 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
AGP	386,338	20,560
ITC	265,667	11,688

When UHC left the Managed Care Program, their members were transferred to either AGP or ITC. Some former UHC members still filed appeals of services received while with UHC during this reporting period of July 1, 2019 to December 31, 2019. The numbers shown are an average between Q1 and Q2 of SFY2020.

Key Findings

In the reporting period of July 1, 2019 to December 31, 2019, there were 896,243 unique, appealable services provided to members by the MCOs. Members appealed 369, or 0.04%, of the total appealable services. Moreover, of the total appealable services completed, only 0.0007 percent of those ultimately resulted in an overturned decision by an ALJ.

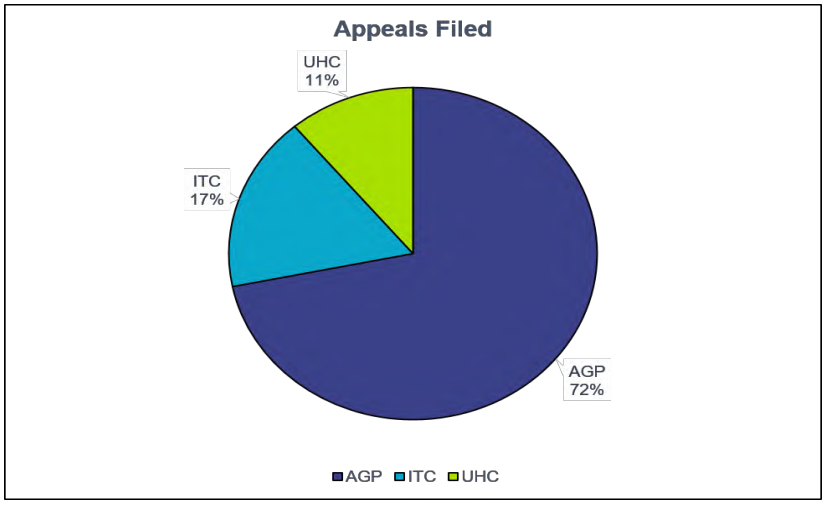
Table 1 below and Graph 1 depict the number and percentage distribution of appeal requests received, categorized by MCO. Of the total requests filed, 72 percent involved AGP enrolled members, 17 percent involved ITC enrolled members, and 11 percent involved UHC enrolled members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	265	72%
ITC	63	17%
UHC	41	11%
Total	369	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 determined not to be appeal eligible (see glossary).

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.

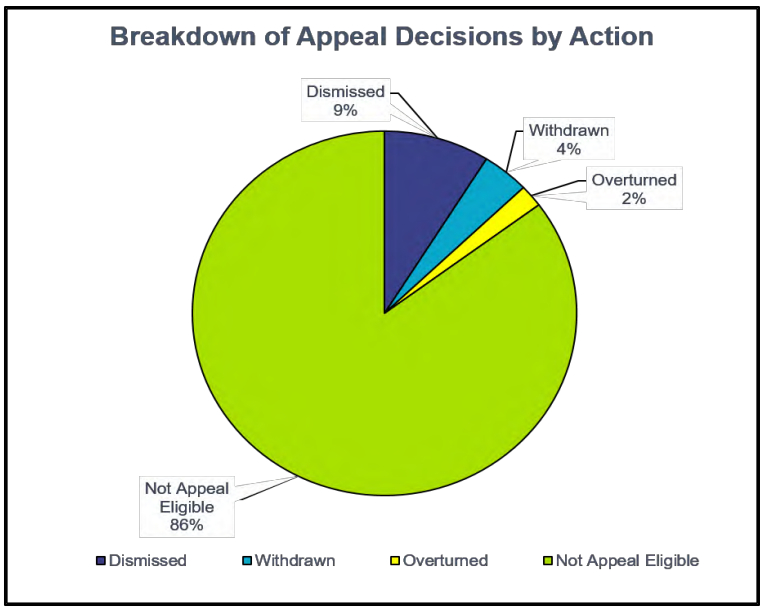
Table 2 and Graph 2 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only two percent resulted in overturned decisions by an ALJ and nearly 86 percent of the requests were determined not to be eligible for appeal.

Table 2

Action	Appeals Filed	
Withdrawn	13	4%
Dismissed	31	9%
Overturned	6	2%
Not Appeal Eligible	311	86%
TOTAL	361	100%

Breakdown of appeal decisions by action. Percentages are rounded to the nearest tenth. This does not reflect all appeal outcome categories.

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, 13 were withdrawn. Comparing the percentage of appeals withdrawn compared to the number of appeals filed for each MCO, ITC had the highest percentage of appeals withdrawn at five percent.

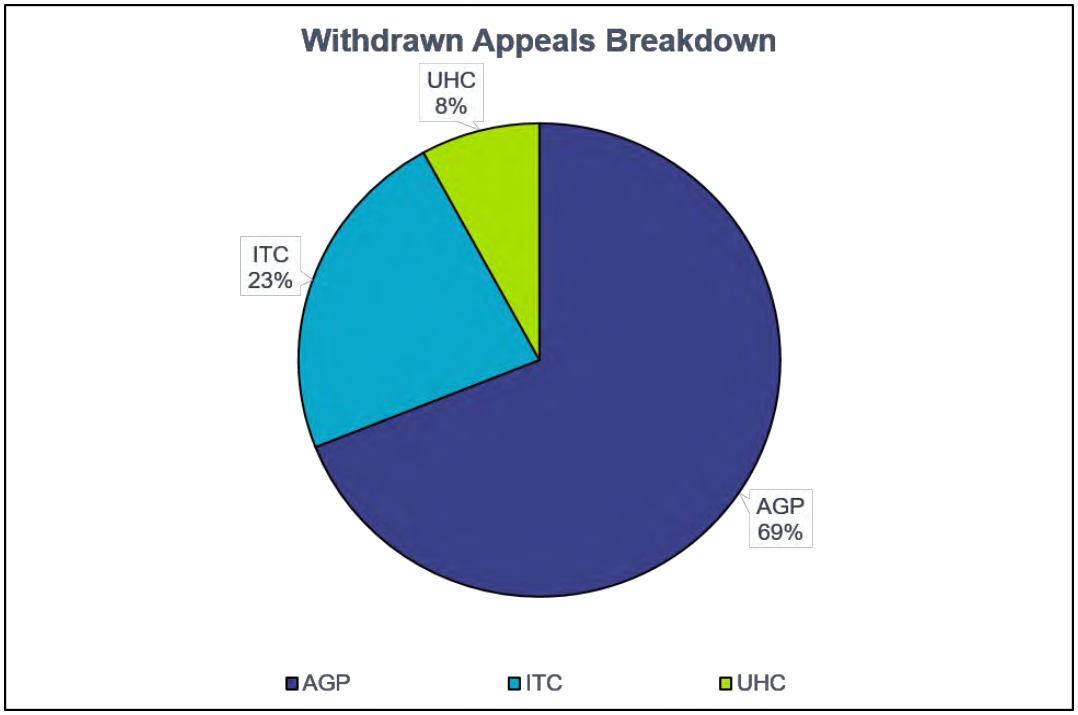
Table 3 and Graph 3 display the appeal volume breakdown for withdrawn appeal requests. Of the 13 appeal requests withdrawn, 69 percent were AGP member requests, 23 percent were ITC member requests, and eight percent were UHC member requests. The percentage of withdrawn appeals as compared to the total number of appeals completed for each MCO includes AGP with 3 percent of 265, ITC with five percent of 63, and UHC at two percent of 41.

Table 3

MCO	Number of Appeals	Number of Withdrawals	Percent of Withdrawals	Percent of Appeals
AGP	265	9	69%	3%
ITC	63	3	23%	5%
UHC	41	1	8%	2%
TOTAL	369	13	100%	11%

Breakdown of withdrawn appeals by MCO.

Graph 3



Breakdown of withdrawn appeals by MCO.

Appeals Dismissed

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

Of the total appeal requests received, 31 were dismissed. The percentage of appeals dismissed compared to the number of appeals filed for each MCO showed that ITC had the highest percentage of appeals withdrawn at 17 percent.

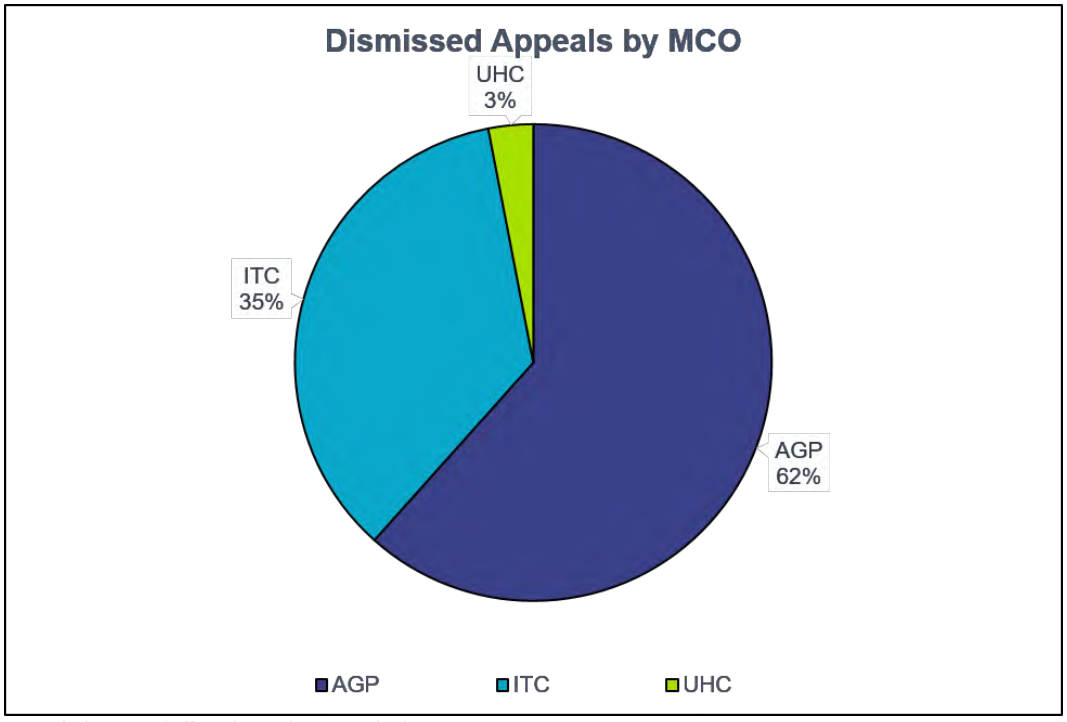
Table 4 and Graph 4 show the appeal volume breakdown for appeal requests that were dismissed. Of the 369 total appeals, seven percent of AGP member appeal requests were dismissed, 17 percent of ITC member appeal requests were dismissed, and two percent of UHC member appeal requests were dismissed. Further breakdown indicates the percentage of dismissed appeals as compared to the total number of dismissed appeals completed for each MCO. Of the 31 dismissed appeals, AGP had 62 percent, ITC had 35 percent, and UHC had three percent of their appeals dismissed.

Table 4

MCO	Number of Appeals	Number of Dismissals	Percent of Dismissals	Percent of Appeals
AGP	265	19	62%	7%
ITC	63	11	35%	17%
UHC	41	1	3%	2%
TOTAL	369	31	100%	27%

Breakdown of dismissed appeals by MCO. Percentages are rounded to the nearest tenth.

Graph 4



Breakdown of dismissed appeals by MCO.

Table 5 and Graph 5 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 IME and/or state and federal review criteria. For example, of the 31 dismissals, the clinical review team concluded that 55 percent of the time, or 17 of the 31 MCO dismissals, were considered inconsistent with how the clinical review team would have evaluated the cases using state and federal criteria along with IAC.

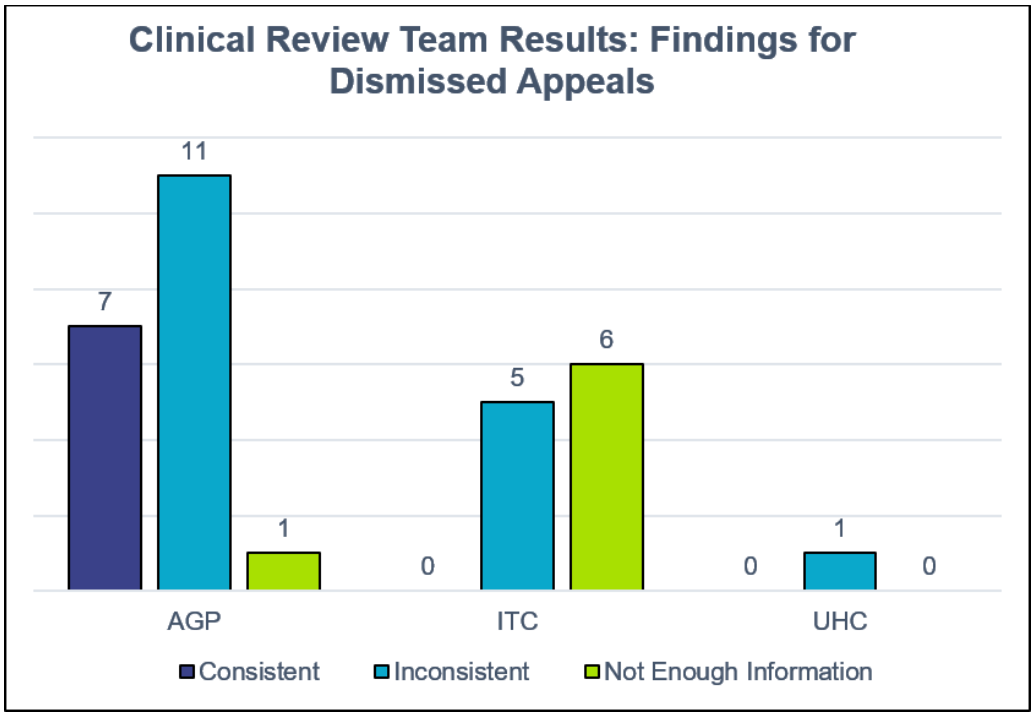
When looking at each MCO, the clinical review team concluded that their decision would be different from the original MCO decision 35 percent of the time for AGP, 16 percent for ITC, and three percent for UHC. The clinical review team was unable to come to a conclusive decision on seven dismissals, or 23 percent of the total 31 dismissed appeals due to lack of information.

Table 5

MCO	Consistent		Inconsistent		Not Enough Information		Total Dismissed Appeals
AGP	7	23%	11	35%	1	3%	19
ITC	0	0%	5	16%	6	19%	11
UHC	0	0%	1	3%	0	0%	1
TOTAL	7	23%	17	55%	7	23%	31

Dismissed appeals clinical review outcomes. Percentages are rounded to the nearest tenth.

Graph 5



Dismissed appeals clinical review outcomes.

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.

Of the total appeal requests received, six were overturned. The percentage of appeals overturned compared to the number of appeals filed for each MCO concluded that ITC had the highest percentage of appeals overturned at three percent.

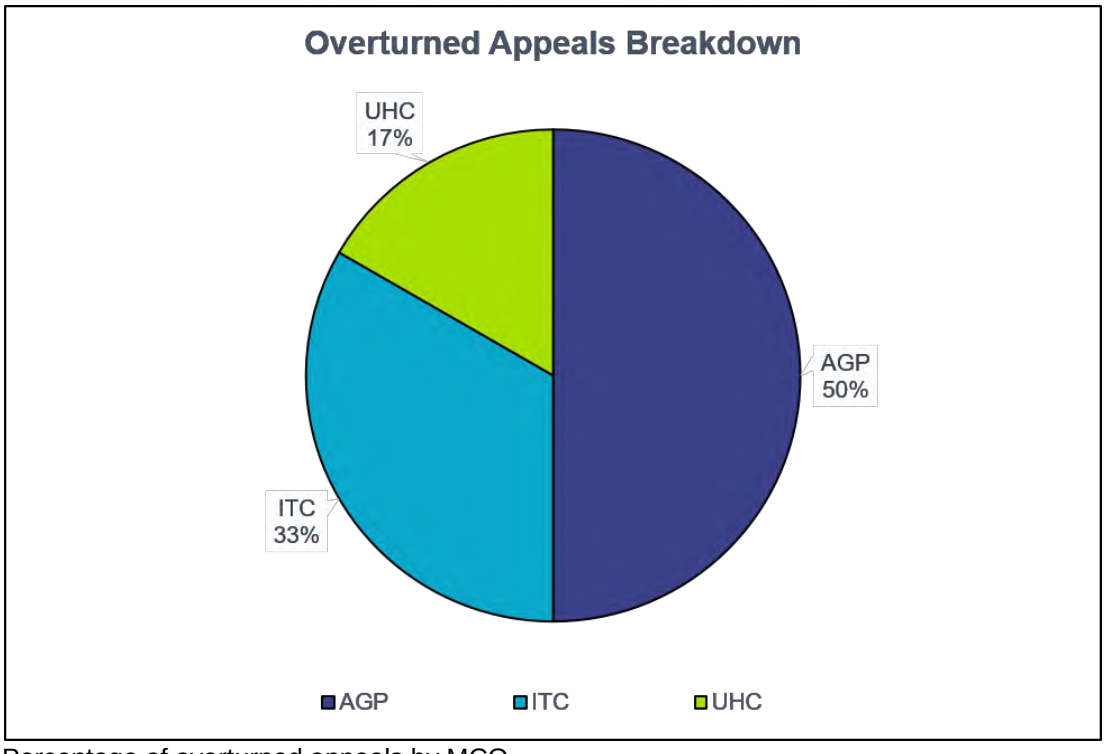
Table 6 and Graph 6 display the overturned volume breakdown. Of the six overturned appeals, 50 percent belonged to AGP, 33 percent belonged to ITC, and 17 percent belonged to UHC. Additionally, AGP had one percent of their 265 appeals overturned, ITC had three percent of their 63 appeals overturned, and UHC had two percent of their 41 appeals overturned.

Table 6

MCO	Number of Appeals	Number Overturned	Percent Overturned	Percent of Appeals
AGP	265	3	50%	1%
ITC	63	2	33%	3%
UHC	41	1	17%	2%
TOTAL	369	6	100%	6%

Number of overturned appeals by MCO.

Graph 6



Percentage of overturned appeals by MCO.

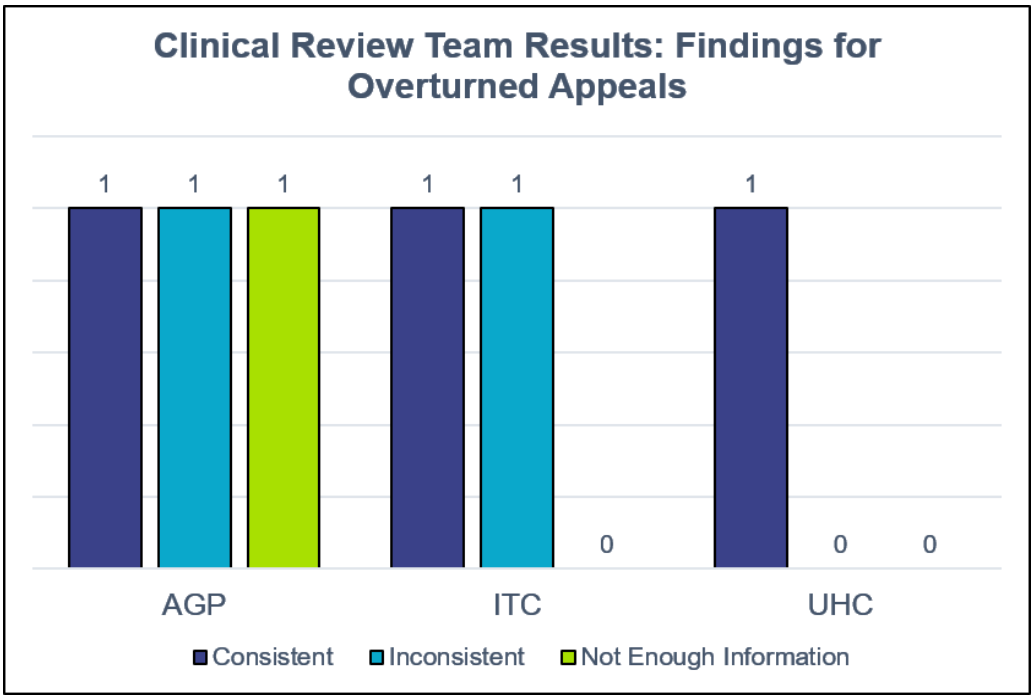
Table 7 and Graph 7 display by MCO the number of cases where the clinical review team determined whether the original decision to deny was consistent or inconsistent with state and federal criteria as well as IAC. The clinical review team reached these decisions by reviewing the reversal utilizing state and federal criteria in accordance with IAC. Of the six ALJ reversals, the clinical review team concluded that 33 percent of the time, or two of the six 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 clinical review team concluded that their decision would be different from the original denial decision 17 percent of the time for AGP, 17 percent for ITC, and none of the time for UHC.

Table 7

MCO	Consistent		Inconsistent		Not Enough Information		Total Overturned Appeals
AGP	1	17%	1	17%	1	17%	3
ITC	1	17%	1	17%	0	0%	2
UHC	1	17%	0	0%	0	0%	1
TOTAL	3	50%	2	33%	1	17%	6

Number and percentage of overturned clinical review outcomes.

Graph 7



Clinical review outcomes for overturned appeals.

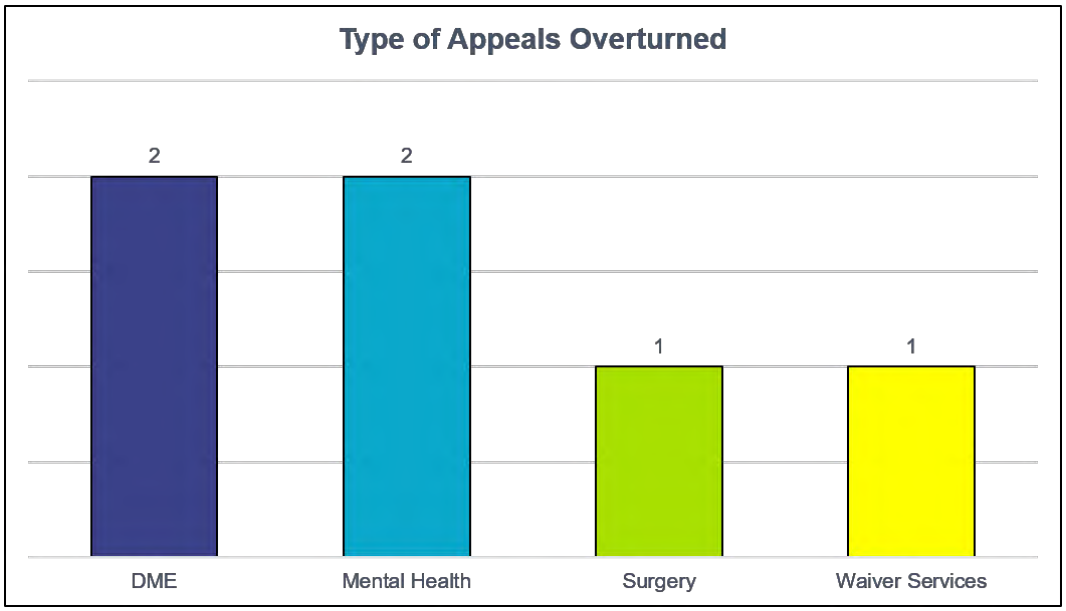
Table 8 and Graph 8 detail the number and percent of appeals overturned by the ALJ by category. As displayed, the services overturned most frequently include DME and Mental Health.

Table 8

Appeal Category	Number of Appeals Overturned	Percent of Appeals Overturned
Durable Medical Equipment (DME)	2	33%
Mental Health	2	33%
Surgery	1	17%
Waiver Services	1	17%

Number and percentage of overturned appeals by category.

Graph 8



Number of overturned appeals by category.

Next Steps

This analysis identified several opportunities for improvement. The following action steps will be completed by the end of SFY21:

- The Department will collaborate with the MCOs to develop clear and consistent information to providers regarding the documentation required for prior authorization requests and/or claim submissions.

- In conjunction with the Process Improvement Workgroup, continue to review codes requiring PA annually and codes that are identified as having unnecessary PA requirements will be removed.

- The Department will collaborate with the MCOs to identify ways to simplify the communication to the member regarding how an appeal can be filed.

- The Department will collaborate with the MCOs to engage in targeted outreach to providers that continue to file SFH appeals regarding claim denials.

- The Department will collaborate with the MCOs on any trends identified, to proactively address issues and opportunities for improvement.

Conclusion

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.

The benefit of actively addressing these opportunities will create a more timely response to members' needs and the reduction of decisions resulting in the need for a State Fair hearing.

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.
ITC	Iowa Total Care
UHC	UnitedHealthcare 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.