Department of
HUMAN SERVICES

Iowa Medicaid
Review of State Fair Hearing Appeals
July 1, 2020 – December 31, 2020

Executive Summary

The purpose of this report is to provide analysis of Medicaid Managed Care Organization (MCO) member appeals from July 1, 2020, to December 31, 2020. This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the MCO, or overturned by an administrative law judge (ALJ).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, reduce, or limit items or services. Following the adverse action by the MCO, the member receives a letter explaining the reason for the denial, reduction, 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 Department through the state fair hearing (SFH) appeals process within 120 days of the MCO's decision. The SFH 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.

The Department's Quality Improvement Organization (QIO) reviewed SFH appeals filed during July 1, 2020, to December 31, 2020, to determine if the MCO's initial decision to deny, reduce, or limit 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 Medicaid services and supports.

During the reporting period, 426 appeal requests were submitted for review. Of these, 47 were dismissed by the MCO, 12 were withdrawn by the member, and 20 were overturned by an ALJ, and are the primary focus of this report.

During the reporting period, the MCOs serving Iowa Medicaid included Amerigroup Iowa, Inc. (AGP) and Iowa Total Care (ITC). (Managed care started in Iowa on April 1, 2016.) 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 or more members in a specific population. 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	423,312	23,356
ITC	299,899	15,370

Key Findings

For this reporting period, there were 800,680 unique, appealable services provided to members by the MCOs. **Members appealed 426, or 0.05 percent, of the total appealable services. Moreover, of the total appealable services, only 0.0025 percent of those ultimately resulted in an overturned decision by an ALJ.**

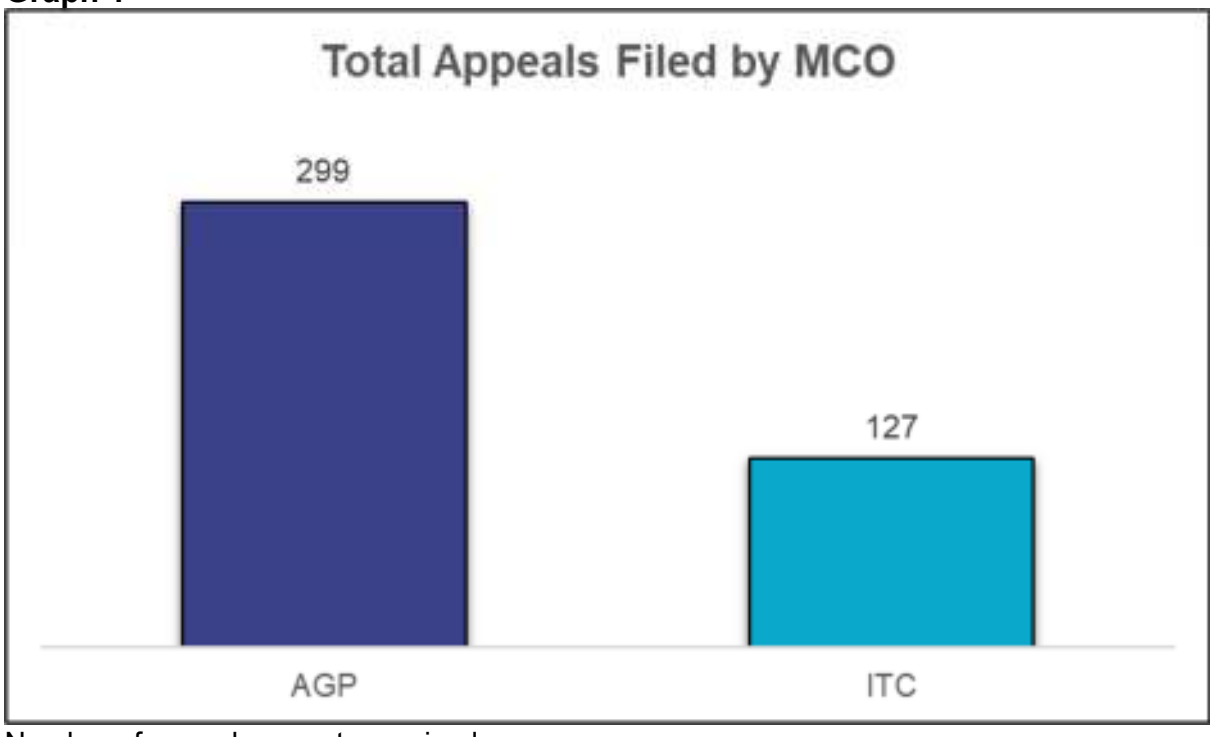
Table 1 and Graph 1 depict the number and percentage distribution of appeal requests received, categorized by MCO. Of the total requests filed, 70 percent involved AGP enrolled members, 30 percent involved ITC members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	299	70%
ITC	127	30%
Total	426	100%

Number and percentage of appeal requests received by MCO

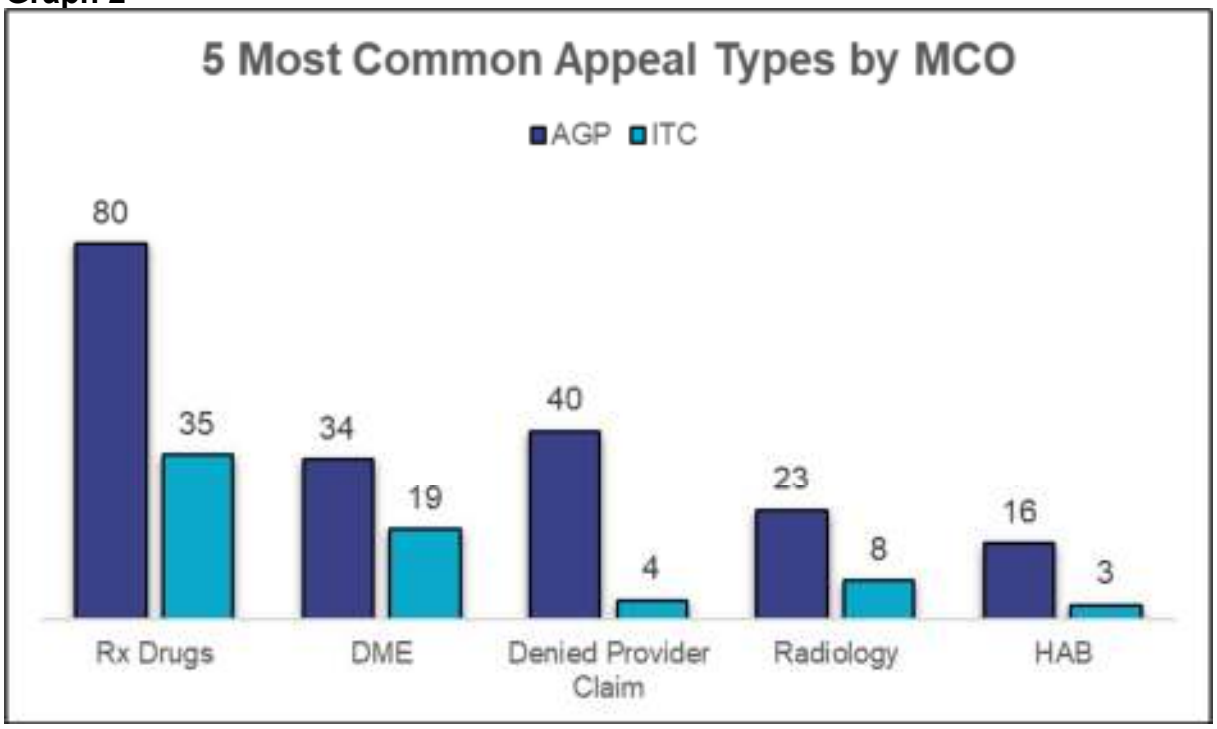
Graph 1



Number of appeal requests received

Graph 2 depicts the five most common appeal types by MCO.

Graph 2



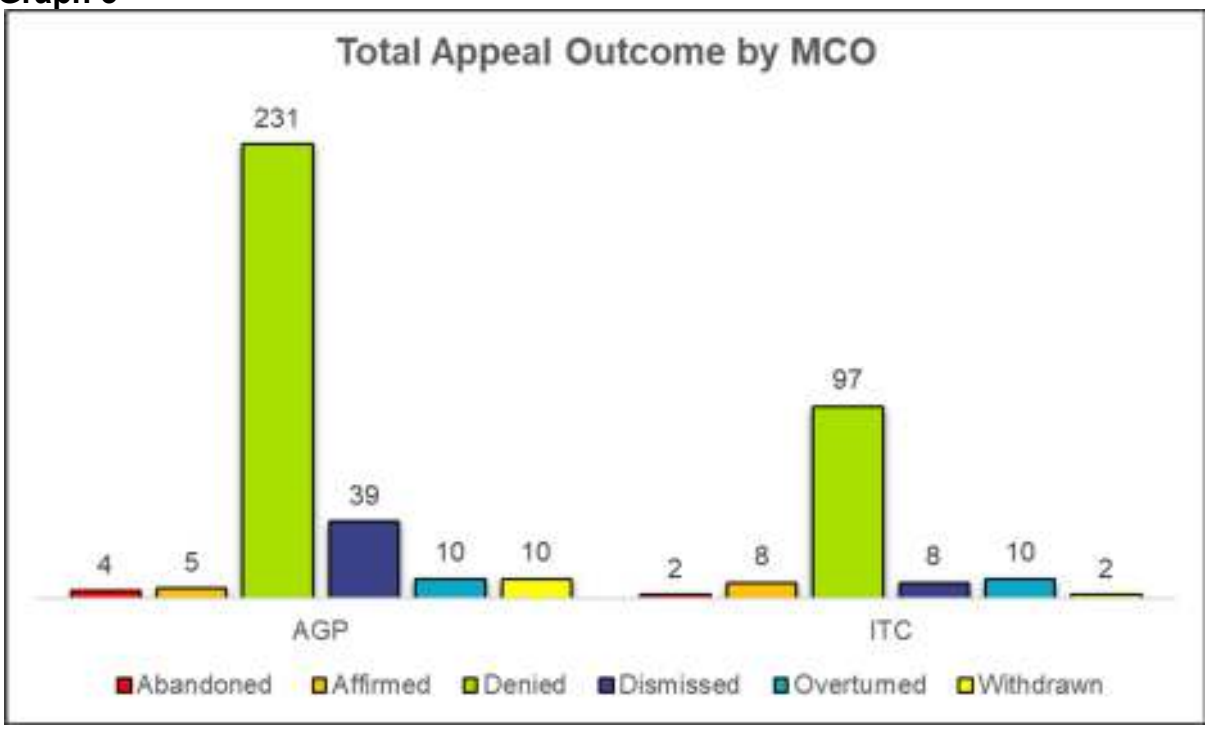
Most common appeal types

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

- Abandoned by the appellant. This means the member did not attend the hearing.
- Affirmed by the ALJ after the appeal hearing
- Withdrawn prior to the appeal hearing.
- Dismissed prior to or during the appeal hearing.
- Overturned by the ALJ after the appeal hearing.
- Case was determined to not be appeal eligible (see glossary).

Graph 3 below shows the breakdown of the total appeals filed for the period of July 1, 2020 to December 31, 2020.

Graph 3



Breakdown of all appeal decisions by action

For this report, Tables 2-7 and Graphs 4-13 reflect only those appeals reviewed by the clinical review team, which were withdrawn, dismissed, overturned, or appeals determined to not be appeal eligible (407 total appeals).

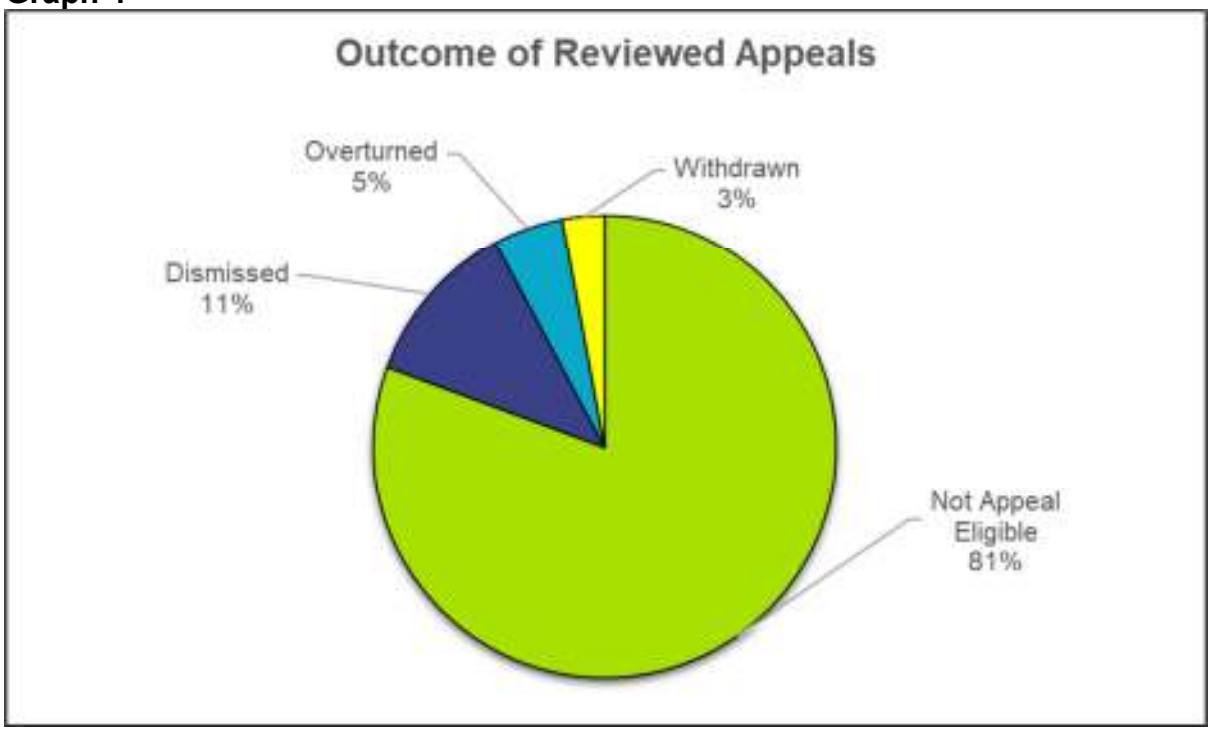
Table 2 and Graph 4 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the 426 appeal requests completed, only five percent resulted in overturned decisions by an ALJ, and 77 percent of the requests were determined to be not eligible for an appeal.

Table 2

Action	Appeals Filed	
Withdrawn	12	3%
Dismissed	47	11%
Overturned	20	5%
Not Appeal Eligible	328	77%
TOTAL	407	96%

Breakdown of reviewed appeal decisions by action

Graph 4



Breakdown of appeal decisions by reviewed appeals (n=407)

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, 12 were withdrawn. AGP had the highest percentage of their appeals withdrawn at three percent compared to the number of appeals reviewed for each MCO.

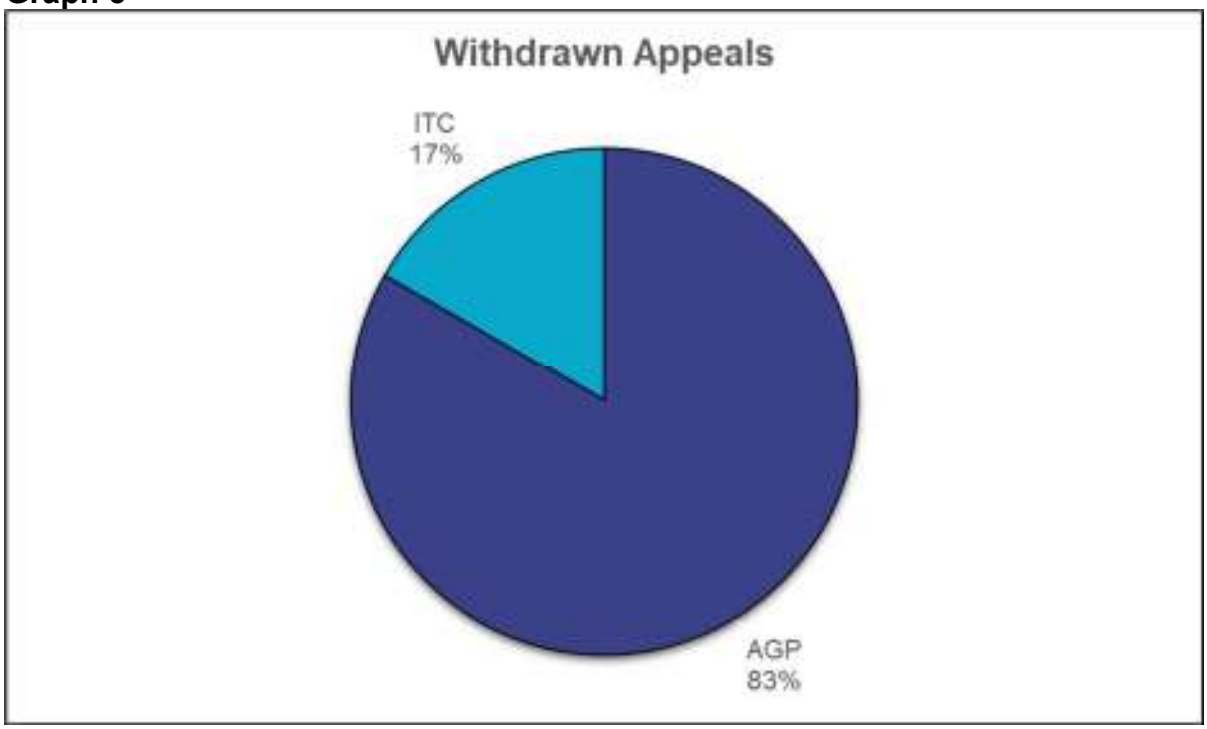
Table 3 and Graph 5 display the appeal volume breakdown for withdrawn appeal requests. Of the 12 appeal requests withdrawn, 83 percent were AGP member appeal requests and 17 percent were for ITC. Compared to the total number of appeals completed for each MCO, the percentage of withdrawn appeals for each MCO included AGP with three percent of 299 and ITC at two percent of 127 appeals filed. In total, three percent of the 426 appeals filed were withdrawn.

Table 3

MCO	Number of Withdrawals	Percent of Withdrawals	Percent of Appeals
AGP	10	83%	3%
ITC	2	17%	2%
TOTAL	12	100%	3%

Breakdown of withdrawn appeals by MCO

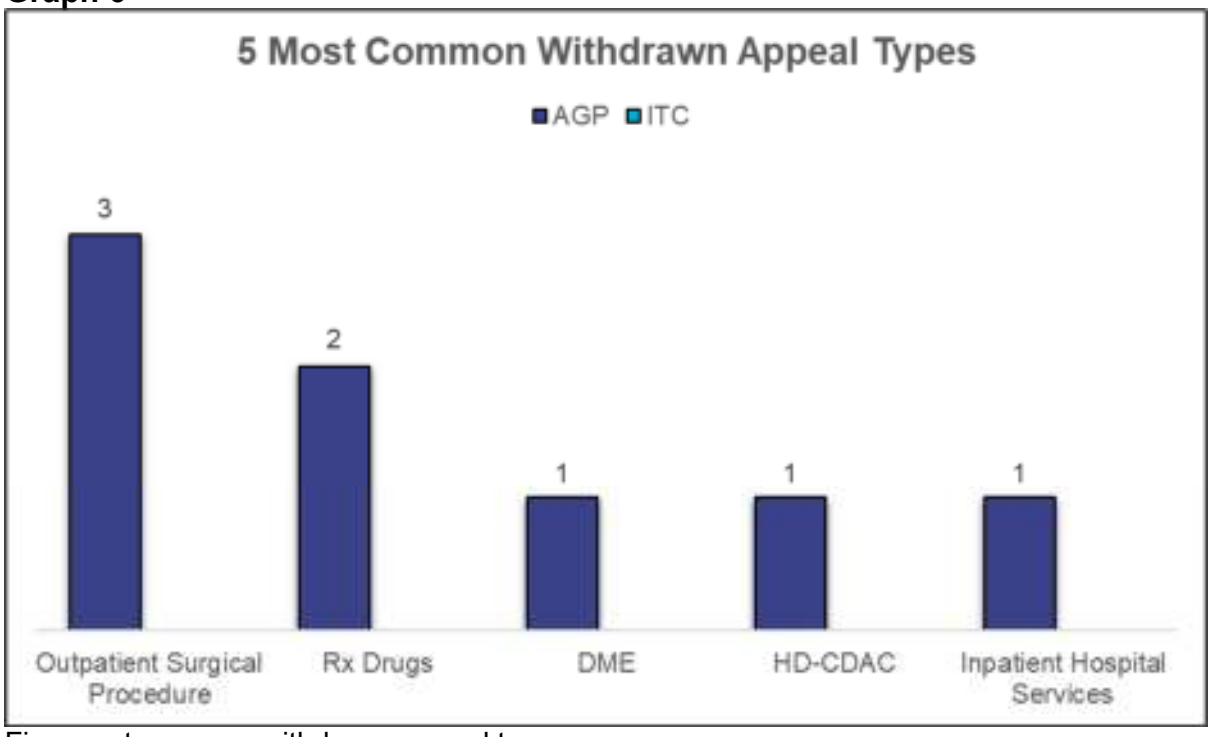
Graph 5



Breakdown of withdrawn appeals by MCO

Graph 6 shows the five most common appeal types that were withdrawn. ITC only had two appeals withdrawn for this period and neither of them were one of the five most common types.

Graph 6



Five most common withdrawn appeal types

Appeals Dismissed

An appeal is dismissed when the MCO reverses their original decision to deny, reduce, or limit a service, and an appeal hearing is no longer necessary.

Table 4 and Graph 7 show the appeal volume breakdown for appeal requests that were dismissed. Of the 47 dismissed appeals, 83 percent were AGP member appeal requests and 17 percent were ITC member appeal requests.

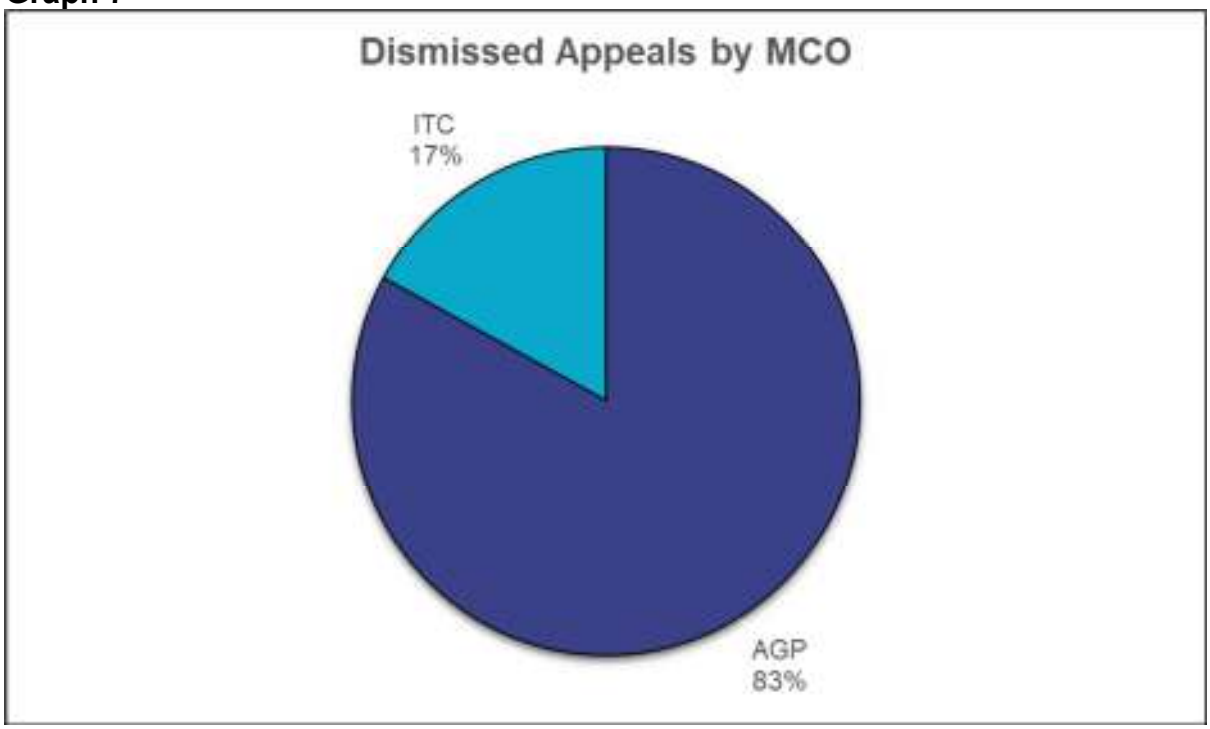
Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals completed for each MCO. AGP dismissed 13 percent of 299 appeals and ITC dismissed six percent of 127 appeals. In total,11 percent of the 426 appeals filed were dismissed.

Table 4

MCO	Number of Dismissals	Percent of Dismissals	Percent of Appeals
AGP	39	83%	13%
ITC	8	17%	6%
TOTAL	47	100%	11%

Breakdown of dismissed appeals by MCO

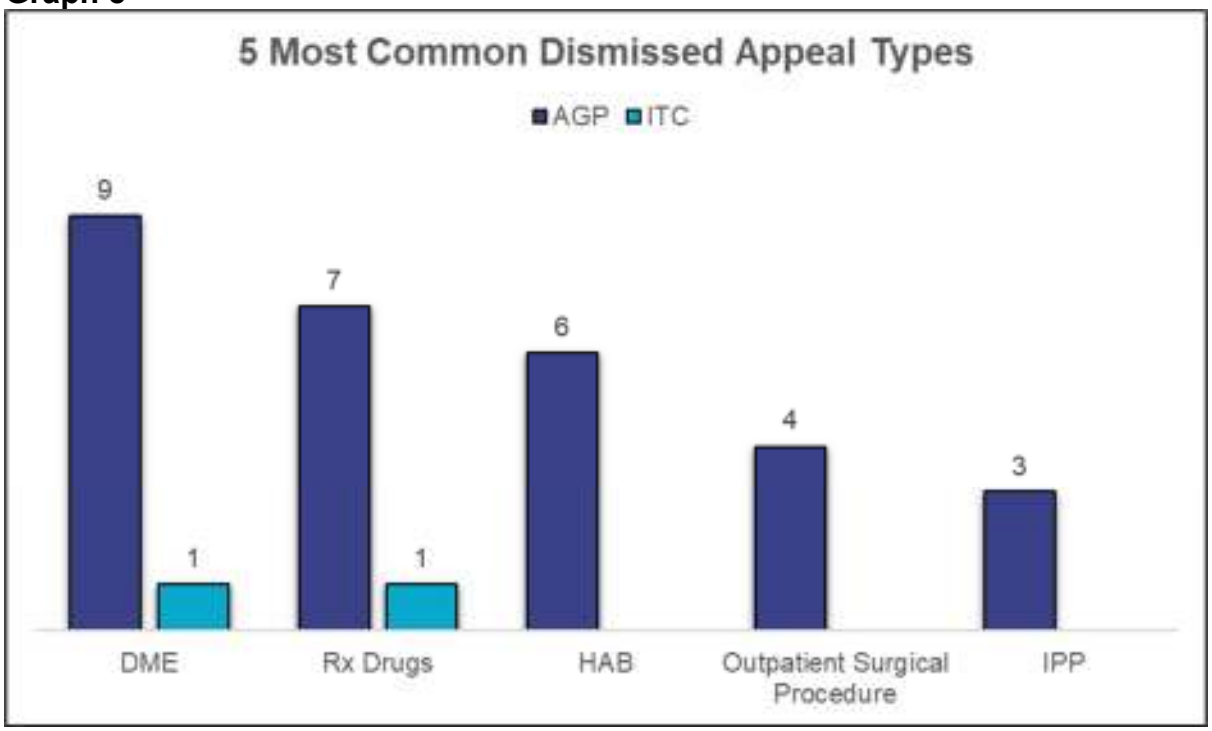
Graph 7



Breakdown of dismissed appeals by MCO

Graph 8 shows the five most common appeal types that were dismissed.

Graph 8



Five most common dismissed appeal types

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.

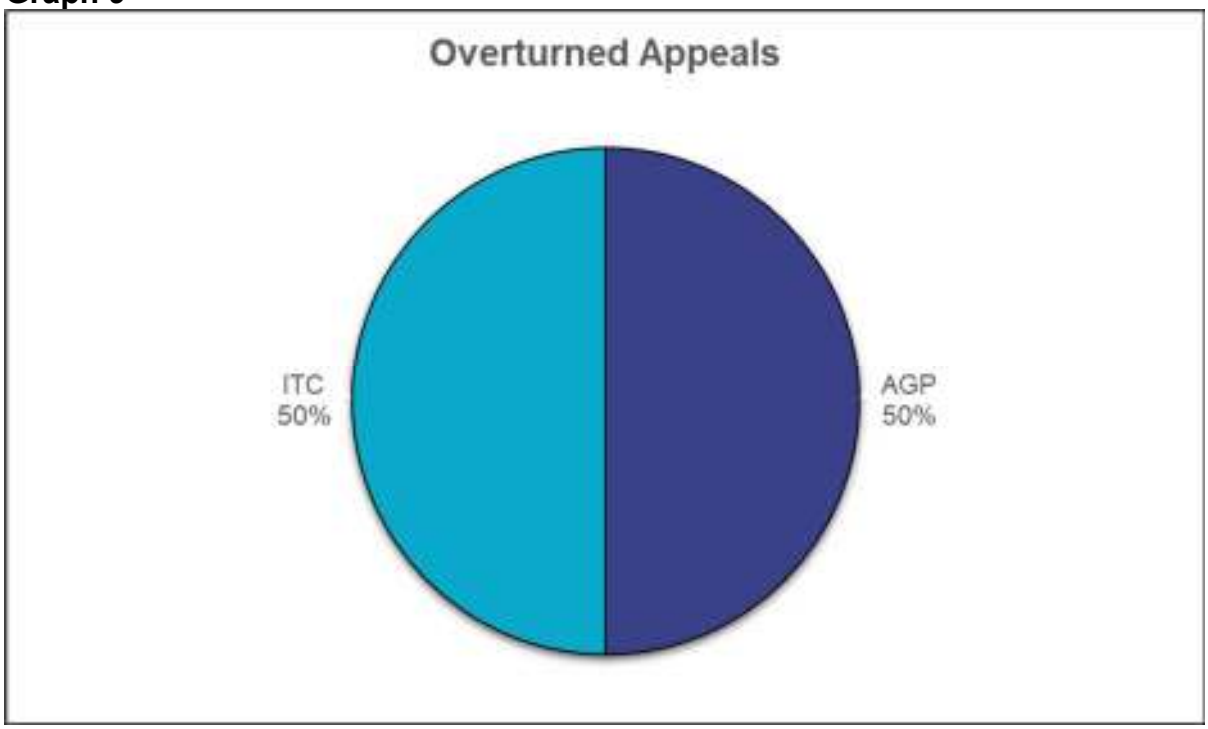
Table 5 and Graph 9 show that of the 20 overturned appeals, they were evenly split between MCOs at 10 each. Further breakdown shows that of the 299 AGP appeals, three percent were overturned, and eight percent of ITC's 127 appeals were overturned. In total, only 5 percent of the 426 appeals filed were overturned.

Table 5

MCO	Number of Overturned	Percent of Overturned	Percent of Appeals
AGP	10	50%	3%
ITC	10	50%	8%
TOTAL	20	100%	5%

Number of overturned appeals by MCO

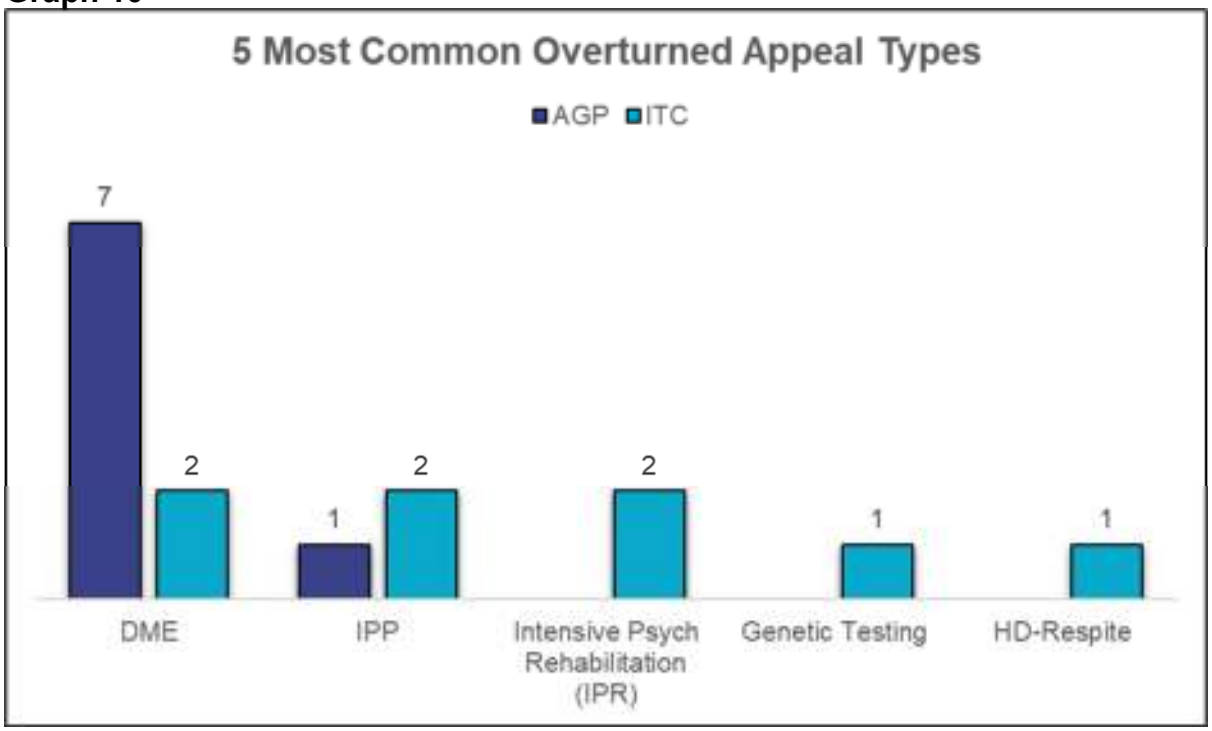
Graph 9



Breakdown of overturned appeals by MCO

Graph 10 shows the five most common appeal types that were overturned.

Graph 10



Five most common overturned appeal types

Not Appeal Eligible

An appeal is deemed ineligible for the State Fair Hearing Appeal process if:

- The internal MCO first level review process has not been completed, OR
- If the appeal is not filed within the expected time frame, OR
- There is an absence of an adverse Notice of Decision to the member or legal representative(s), OR
- A provider is disputing the outcome of a claim.

There were 328 appeals filed during the reporting period that were determined to be ineligible. While the clinical review team did not review these appeals there are some data points that can be identified.

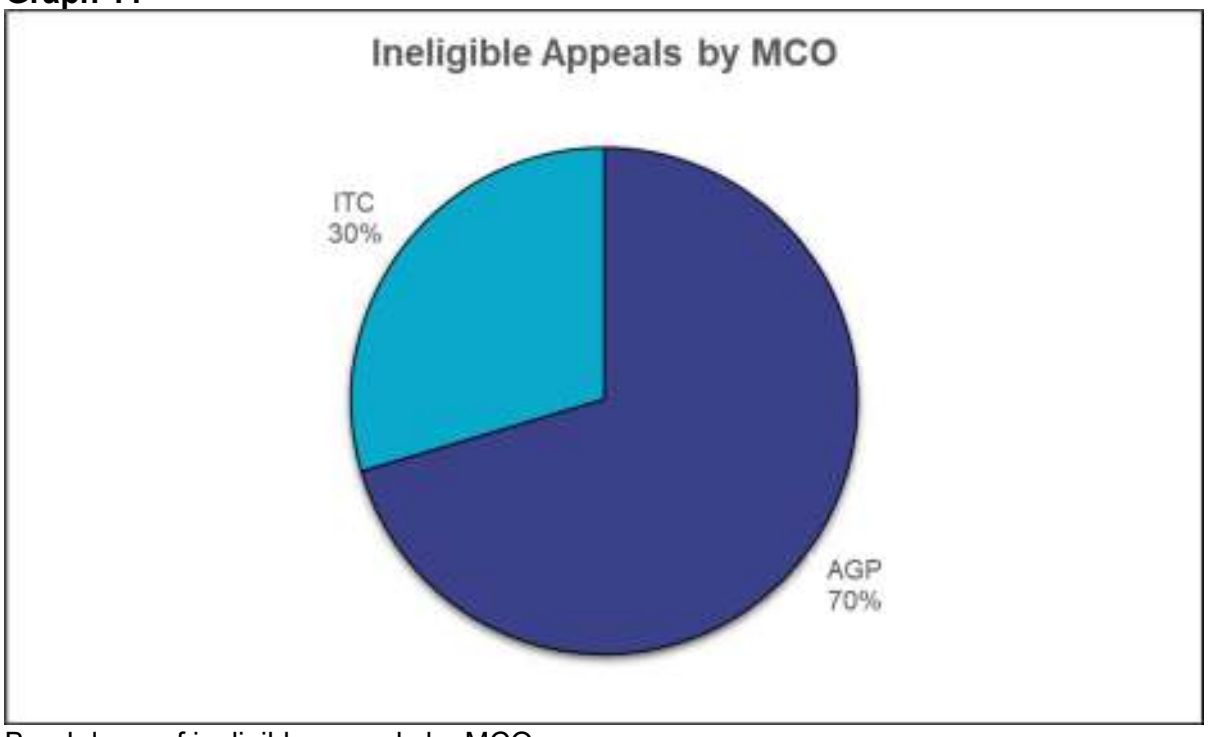
Table 6 and Graph 11 show the distribution of ineligible appeals by MCO. Of the 328 ineligible appeals, AGP had 70 percent and ITC had 30 percent. Of the total 426 appeals filed, AGP had over half of their appeals deemed ineligible (54 percent), and ITC had 23 percent of their appeals deemed ineligible. In total, 77 percent of all MCO appeals filed for the reporting period were determined to not be appeal eligible.

Table 6

MCO	Number of Ineligible	Percent of Ineligible	Percent of Total Appeals
AGP	231	70%	54%
ITC	97	30%	23%
TOTAL	328	100%	77%

Number of appeals determined to be ineligible

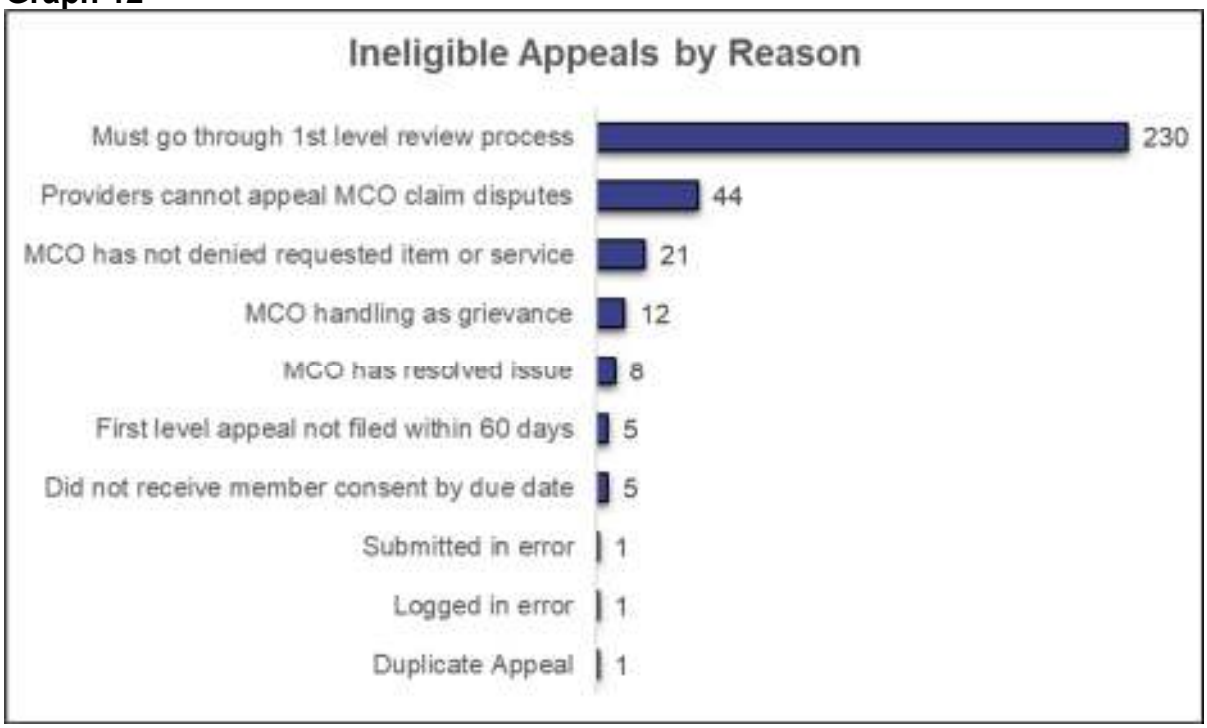
Graph 11



Breakdown of ineligible appeals by MCO

Graph 12 shows the reason these appeals were deemed ineligible.

Graph 12



Reasons appeals were deemed ineligible

Clinical Review

The clinical review team reviewed each dismissed, withdrawn, or overturned appeal to determine whether the MCO's original decision to deny, reduce, or limit services was based off state and federal criteria as well as IAC.

Table 7 and Graph 13 show the breakdown, by MCO, whether the denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate that of the 79 appeals reviewed, 39 percent of the time, the MCOs were consistent with state and federal criteria; 27 percent of the time, the MCOs were inconsistent with state and federal criteria; and 34 percent of the time there was not enough information to perform an objective review.

Table 7

MCO	Consistent		Not Consistent		Not Enough Information		Total Reviewed Appeals
AGP	19	24%	15	19%	25	31%	59
ITC	12	15%	6	8%	2	3%	20
TOTAL	31	39%	21	27%	27	34%	79

Percentages are calculated using the total appeals reviewed (79: 12 Withdrawn, 47 Dismissed, 20 Overturned)

Graph 13

Clinical review outcome by MCO

Analysis

This analysis identified several opportunities for improvement:

- 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 services that allow for a more informed, defendable decision.

- Insufficient information submitted to support a decision to deny a service request may have contributed to appeals being overturned by the ALJ and ensuring the necessary information is submitted could assist the MCO in supporting denials.

- The MCOs continue to 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.

- When a service is requested for continuation, the outcomes and rationales from the previous approval should be reviewed.

- If a service is considered "not allowed", the MCO should consider whether requesting an Exception to Policy (ETP) for the member is appropriate.

Progress Report

Listed below is an update on the improvement opportunities identified in the previous report (January 1, 2020 – June 30, 2020 Executive Summary):

Action Item: 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 continues to provide policy clarifications to the MCOs and continues to work with providers to review PA requirements.

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

- The Department is in the process of building a tool to identify trends.

Conclusion/Next Steps

This analysis identified opportunities for improvement. The following action steps will be completed by the end of SFY22:

- The Department will collaborate with the MCOs to target the top areas of overturned appeals to identify the need for alignment, policy clarifications, or education.

- The Department will collaborate with the MCOs to identify ways to support members and providers in their understanding of the steps in the appeals process and how to access a first level appeal.

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 timelier response to members' needs and ultimately a reduction for decisions resulting in the need for a State Fair Hearing.

Glossary of Terms

Term	Definition
Adverse Decision	A decision that results in a denial, reduction or limitation of services
AGP	Amerigroup Iowa, Inc.
ALJ	Administrative Law Judge
CCO	Consumer Choice Option
CDAC	Consumer Directed Attendant Care
Dismissed	The MCO has decided to grant the previously denied item or service and an appeal hearing is no longer necessary
DME	Durable Medical Equipment
ETP	Exception to Policy
FFS	Fee-for-Service
First Level Review	The first step in the member appeal process. The member appeals to their MCO.
HAB	Habilitation
IAC	Iowa Administrative Code
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
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, OR 2- If the appeal is not filed within the expected time frame, OR 3- The absence of an adverse Notice of Decision to the member or legal representative(s)
Overturned	The appeal was heard before an ALJ and the original denial, reduction, or limit of the requested item or service is found to be incorrect
SFH	State Fair Hearing
Withdrawn	The member has decided they no longer wish to proceed with the appeal process