Iowa Medicaid Enterprise
Review of State Fair Hearing Appeals
July 1, 2021 – December 31, 2021

Executive Summary

The purpose of this report is to provide analysis of Medicaid Managed Care Organization (MCO) member appeals from July 1, 2021, to December 31, 2021. This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the MCO, or overturned by an administrative law judge (ALJ).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 then 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 like 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, 2021, to December 31, 2021, 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, 434 appeal requests were submitted for review. Of these, 72 were dismissed by the MCO, 16 were withdrawn by the member, and 26 were overturned by an ALJ and are the primary focus of this report.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 the other 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 through their plan of care.

MCO	Number of Members	Number of LTSS Members
AGP	447,581	22,214
ITC	327,926	14,988

Key Findings

For this reporting period, there were 783,520 unique, appealable services provided to members by the MCOs. **Members appealed 434, or 0.055 percent, of the total appealable services. Moreover, of the total appealable services, only 0.003 percent of those ultimately resulted in an overturned decision by an ALJ.**

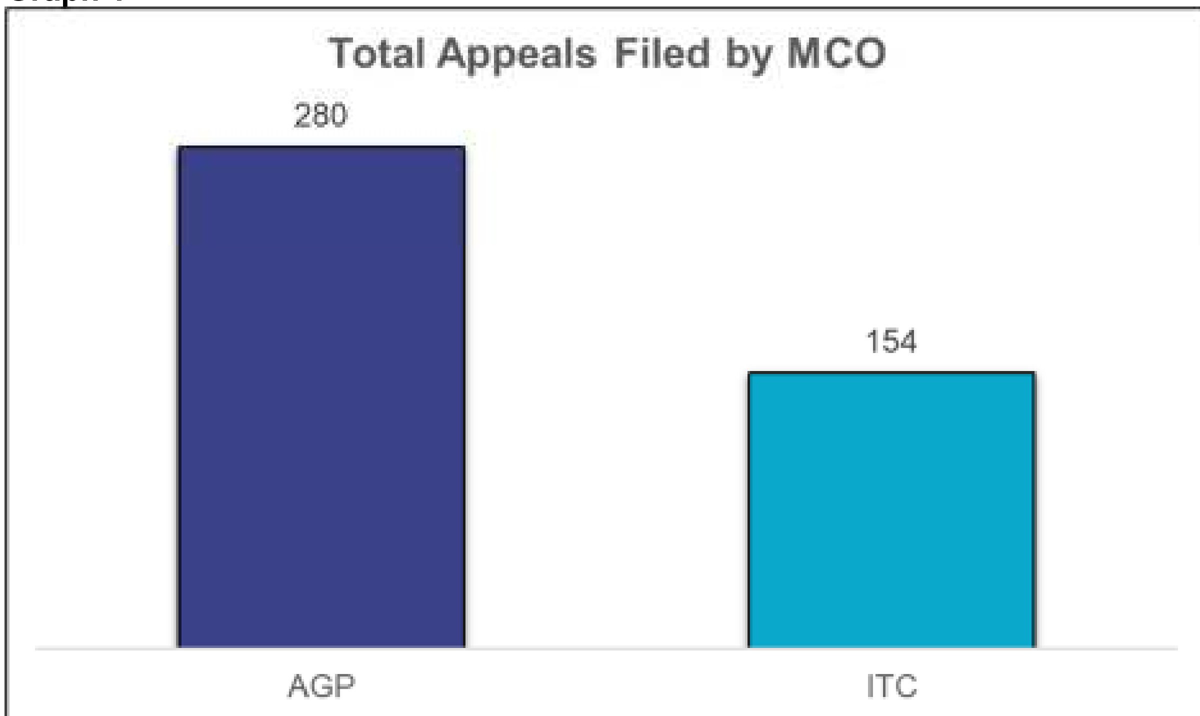
Table 1 and Graph 1 depict the number and percentage distribution of appeal requests received, categorized by MCO. Of the total requests filed, 65 percent involved AGP enrolled members, 35 percent involved ITC members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	280	65%
ITC	154	35%
Total	434	100%

Number and percentage of appeal requests received by MCO

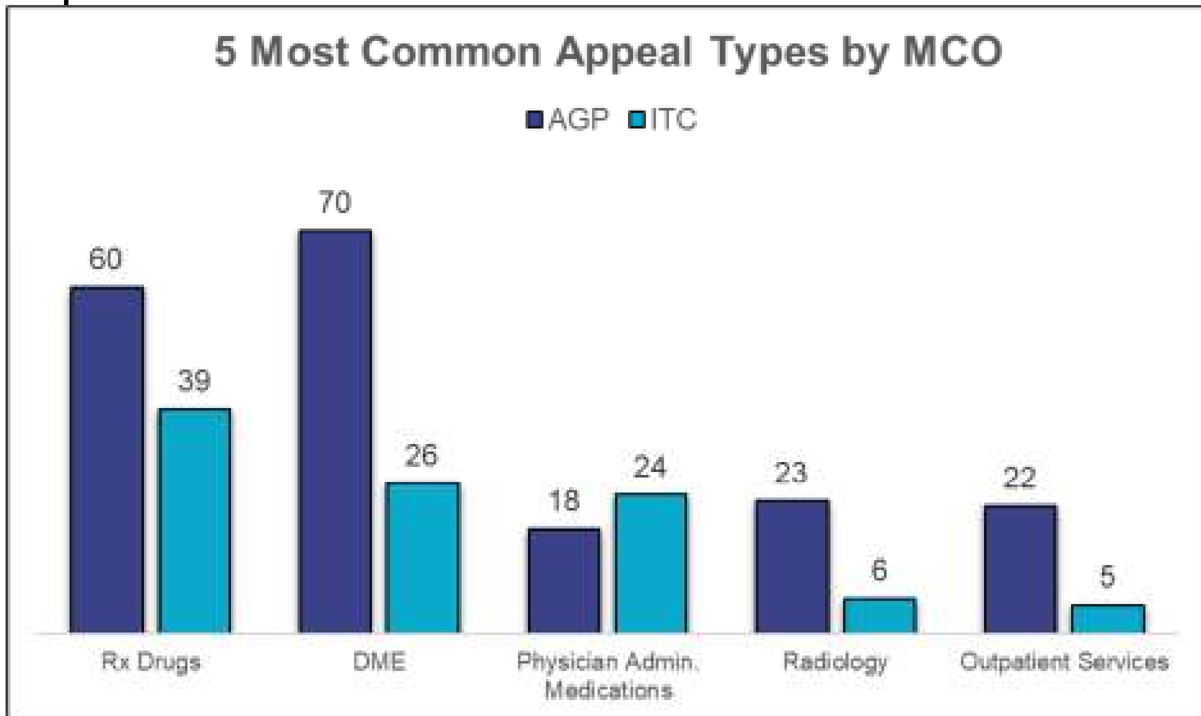
Graph 1



Total number of appeal requests received

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

Graph 2



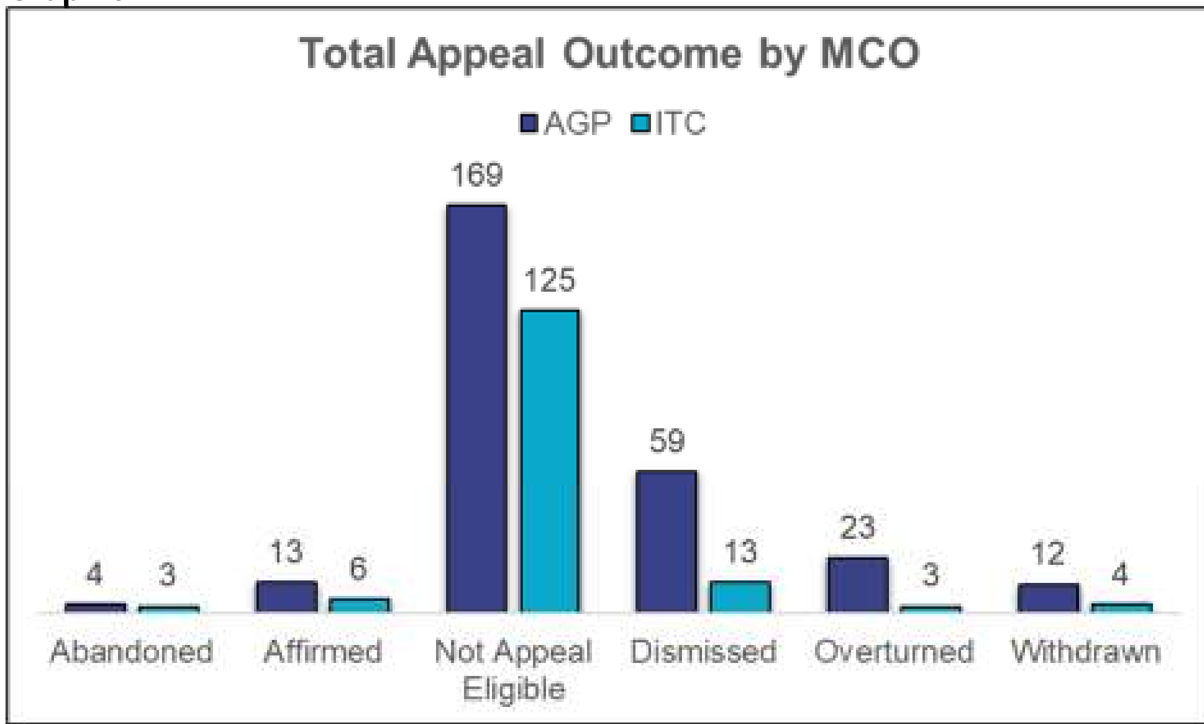
Top five appeal types by MCO – all outcomes

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 by the member or representative prior to the appeal hearing.
- Dismissed by the MCO 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, 2021 to December 31, 2021.

Graph 3



Breakdown of total appeal decisions by action

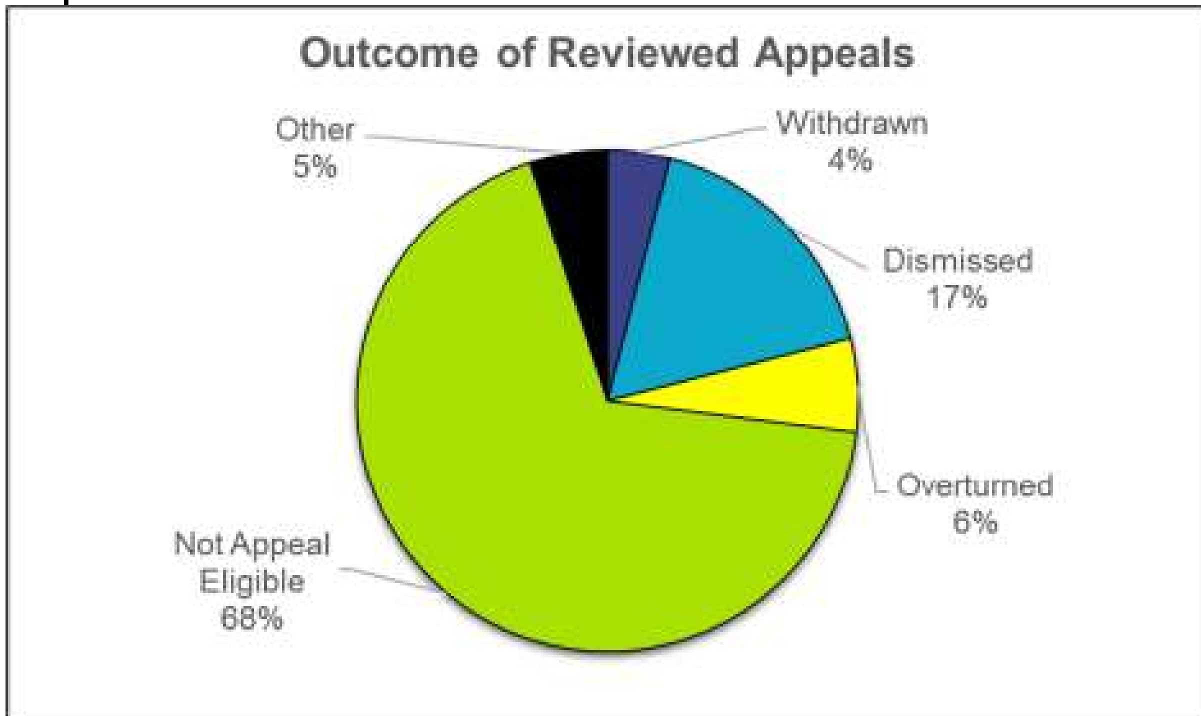
Table 2 and Graph 4 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only six percent resulted in overturned decisions by an ALJ, and 68 percent of the requests were determined to be not eligible for an appeal.

Table 2

Action	Appeals Filed	
Withdrawn	16	4%
Dismissed	72	17%
Overturned	26	6%
Not Appeal Eligible	294	68%
Other	26	5%
TOTAL	434	100%

Breakdown of reviewed appeal decisions by action ("Other" is all Abandoned (7) and Affirmed (19) appeals)

Graph 4



Breakdown of appeal decisions by reviewed appeals (Other = Abandoned & Affirmed)

Appeals Withdrawn

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

Of the total appeal requests received, 16 were withdrawn. AGP had the highest percentage of their appeals withdrawn at three percent compared to the total number of appeals filed.

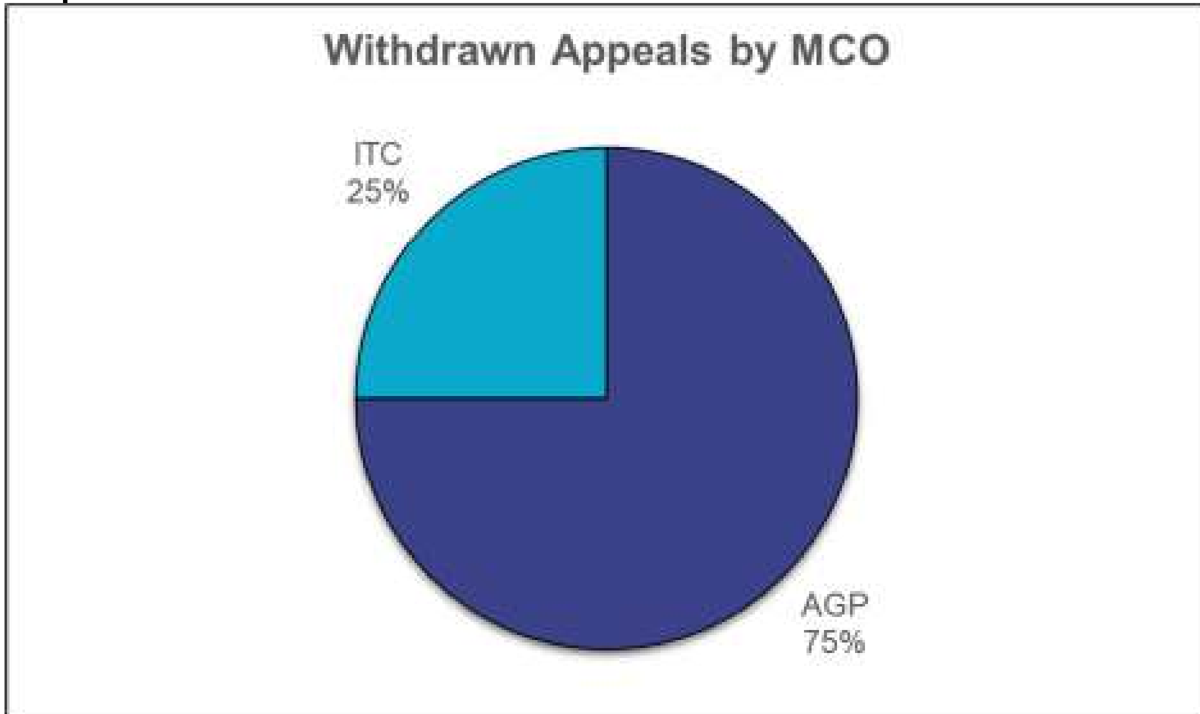
Table 3 and Graph 5 display the appeal volume breakdown for withdrawn appeal requests. Of the 16 appeal requests withdrawn, 75 percent were AGP member appeal requests and 25 percent were ITC. In total, only four percent of the 434 appeals filed were withdrawn.

Table 3

MCO	Number of Withdrawals	Percent of Withdrawals	Percent of Total Appeals
AGP	12	75%	3%
ITC	4	25%	1%
TOTAL	16	100%	4%

Breakdown of withdrawn appeals by MCO

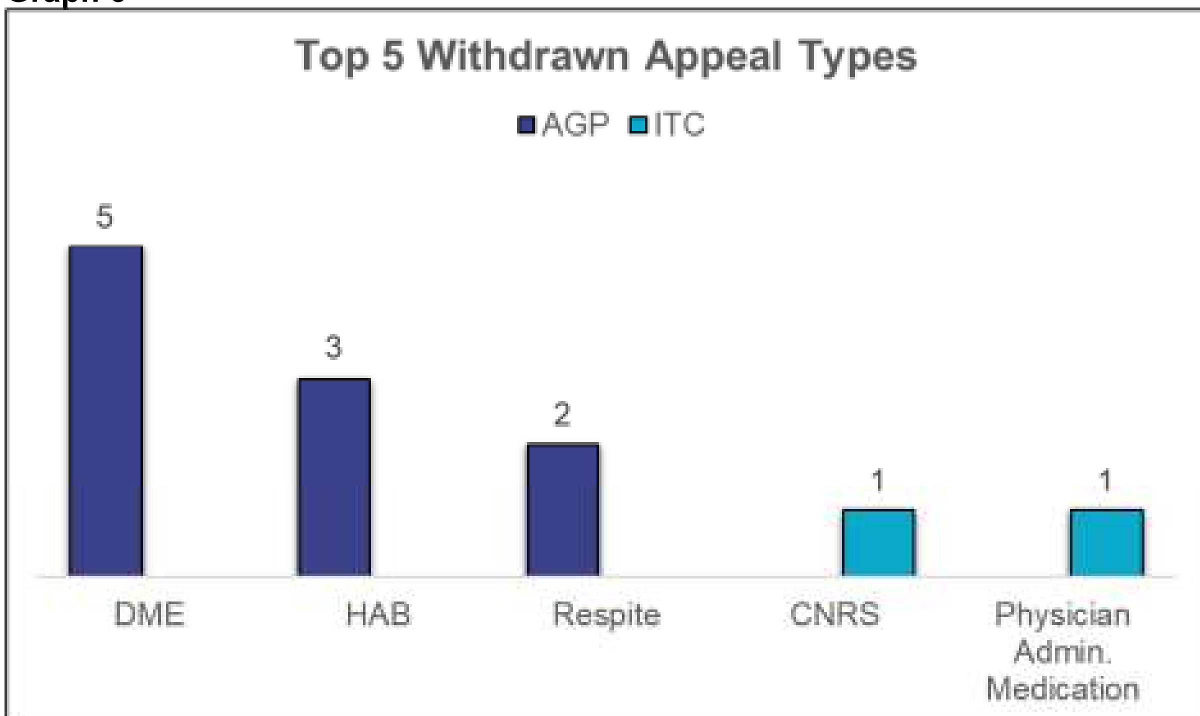
Graph 5



Breakdown of withdrawn appeals by MCO

Graph 6 shows the five most common appeal types that were withdrawn.

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. This can be done before or during the appeal hearing.

Table 4 and Graph 7 show the appeal volume breakdown for appeal requests that were dismissed. Of the 72 dismissed appeals, 82 percent were AGP member appeal requests and 18 percent were ITC member appeal requests.

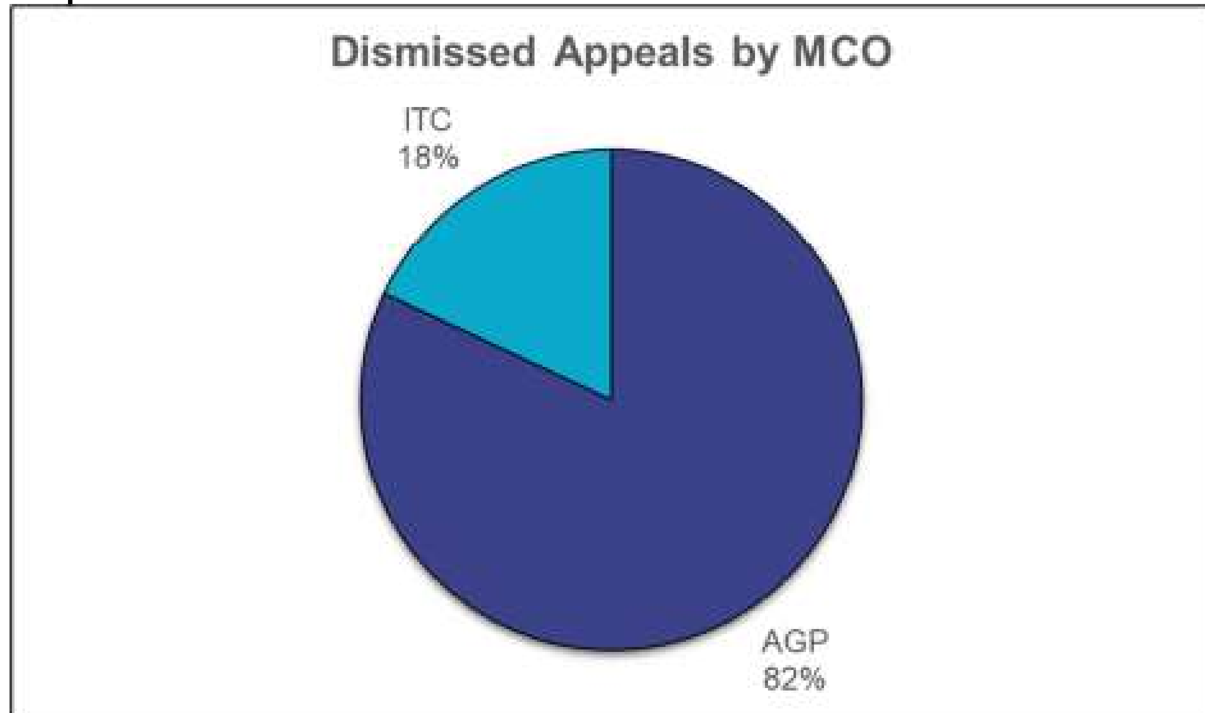
Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals filed. AGP dismissed 14 percent and ITC dismissed three percent. In total, 17 percent of the 434 appeals filed were dismissed.

Table 4

MCO	Number of Dismissals	Percent of Dismissals	Percent of Appeals
AGP	59	82%	14%
ITC	13	18%	3%
TOTAL	72	100%	17%

Breakdown of dismissed appeals by MCO

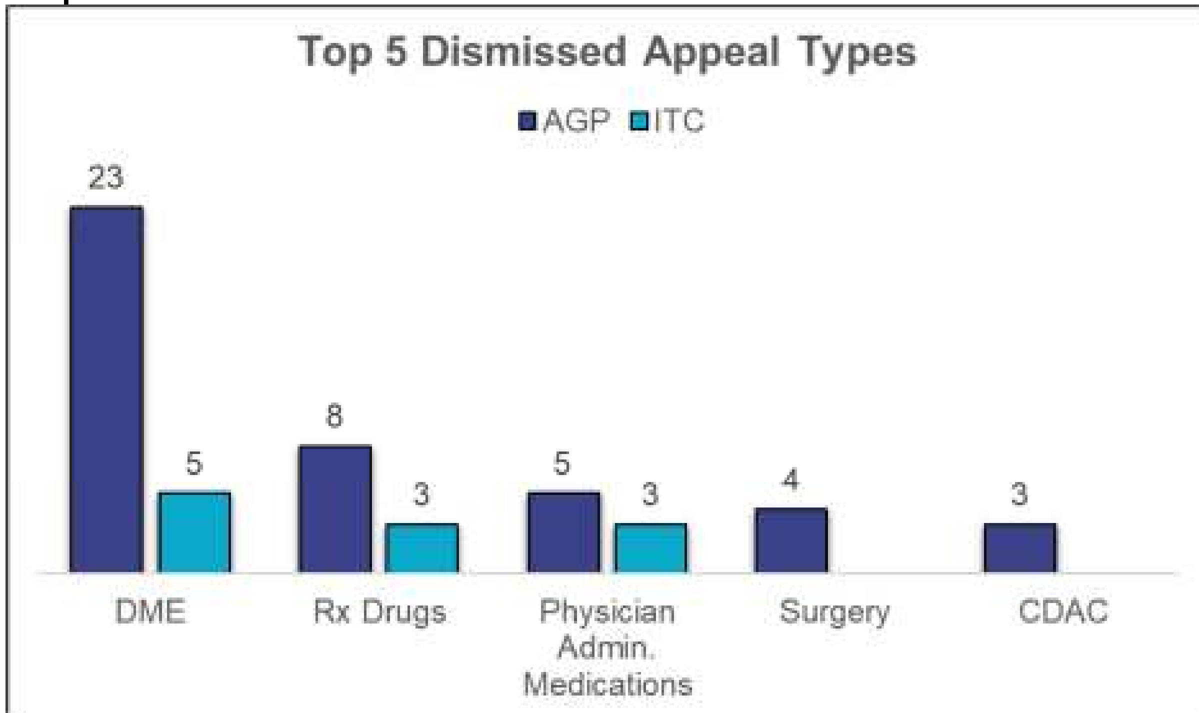
Graph 7



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 not consistent with state and/or federal criteria.

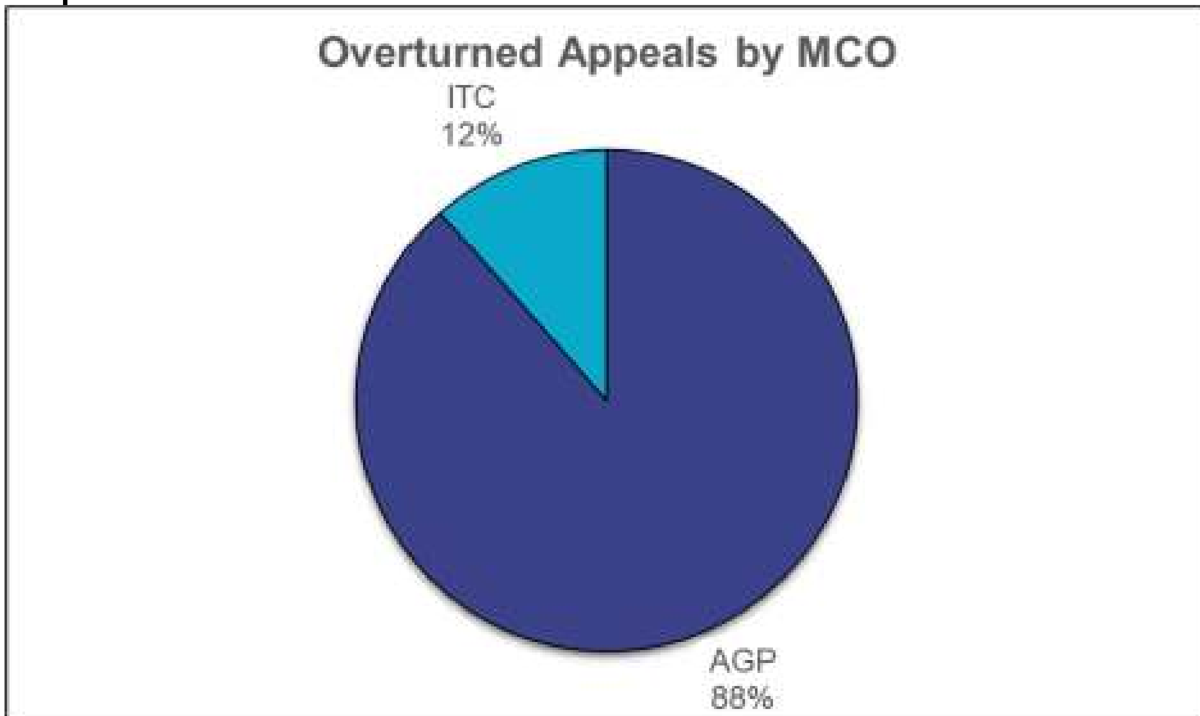
Table 5 and Graph 9 show that, of the 26 overturned appeals, AGP had the highest number at 88 percent. Further breakdown shows that of the 434 appeals filed, six percent were overturned.

Table 5

MCO	Number of Overturned	Percent of Overturned	Percent of Appeals
AGP	23	88%	5%
ITC	3	12%	1%
TOTAL	26	100%	6%

Number of overturned appeals by MCO

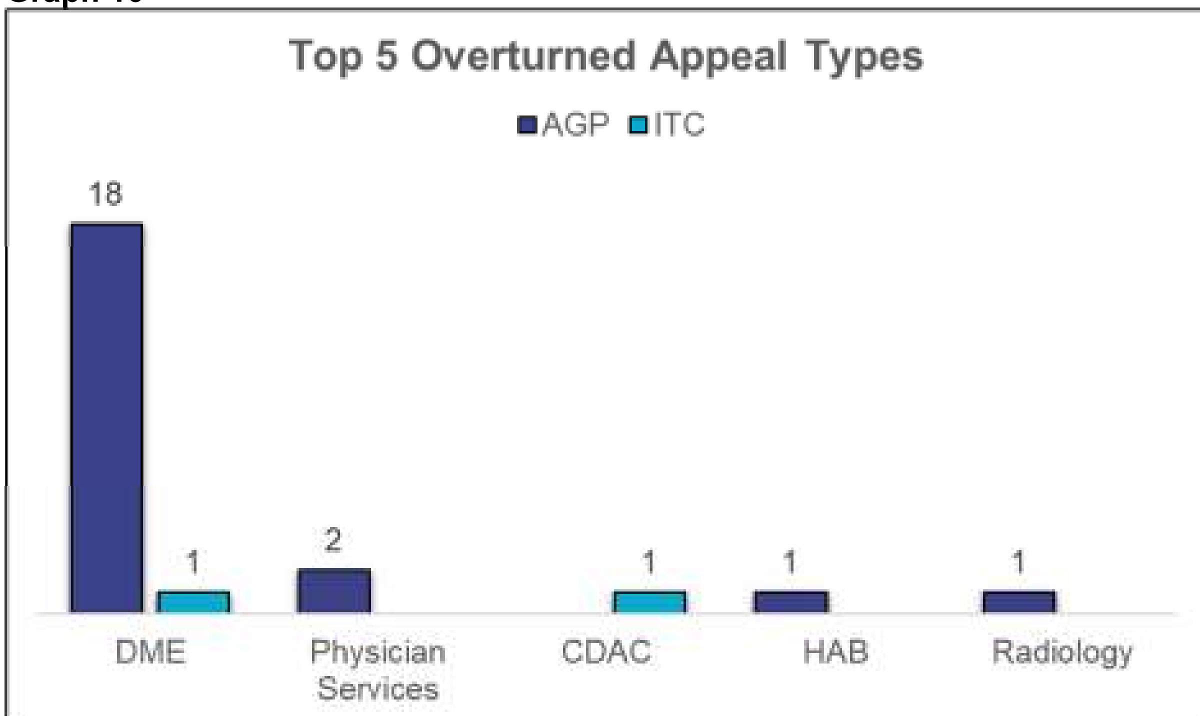
Graph 9



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 attempting to appeal a claim dispute

There were 294 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.

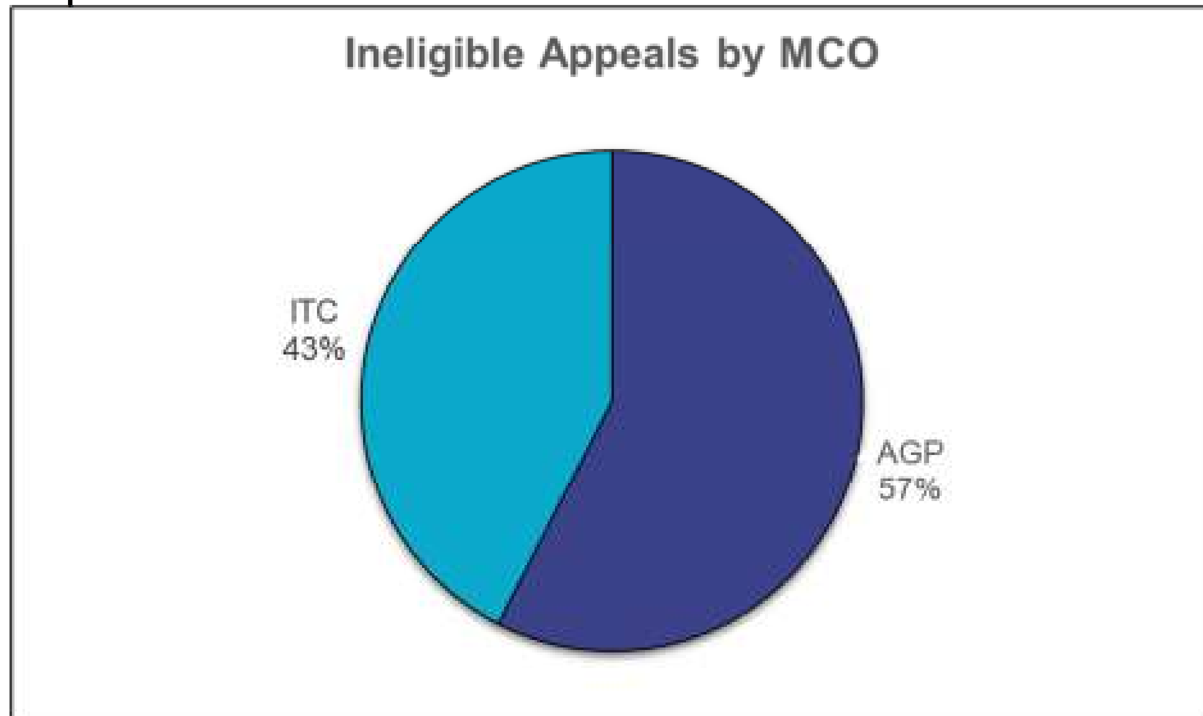
Table 6 and Graph 11 show the distribution of ineligible appeals by MCO. Of the 294 ineligible appeals, AGP had 57 percent and ITC had 43 percent. Of the total 434 appeals filed, AGP had 39 percent of their appeals deemed ineligible, and ITC had 29 percent. In total, more than half of all MCO appeals filed for the reporting period were determined to not be appeal eligible (68 percent).

Table 6

MCO	Number of Ineligible	Percent of Ineligible	Percent of Total Appeals
AGP	169	57%	39%
ITC	125	43%	29%
TOTAL	294	100%	68%

Number of appeals determined to be ineligible

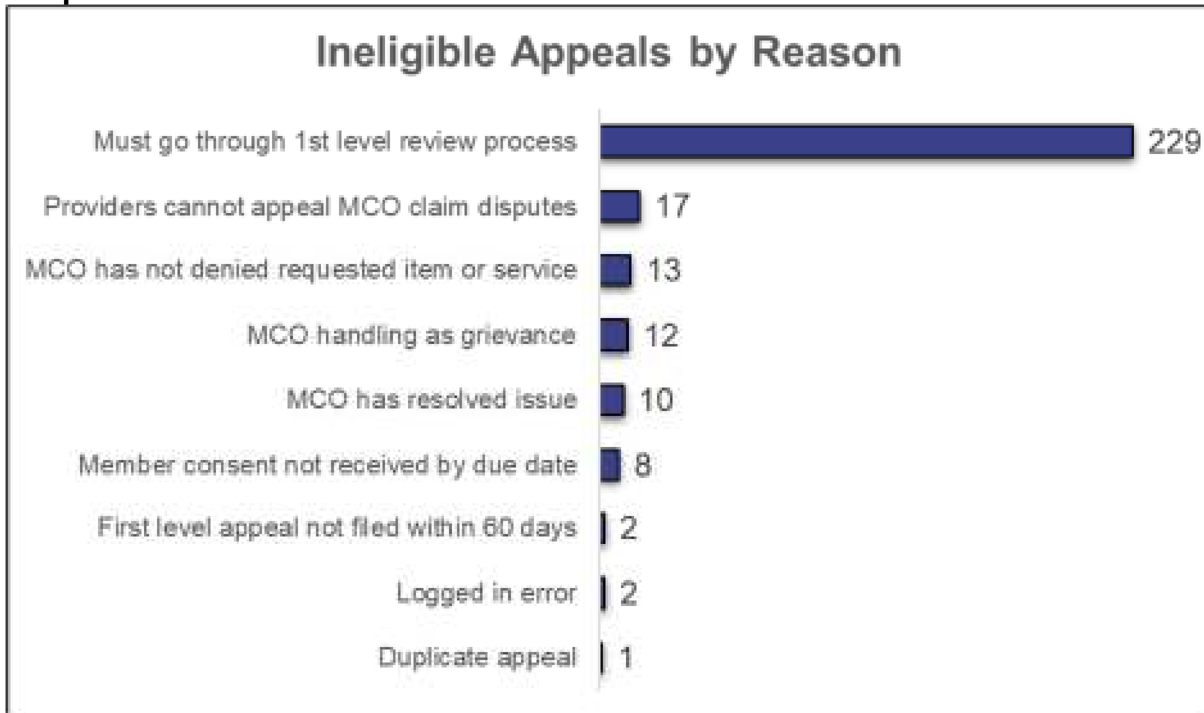
Graph 11



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.

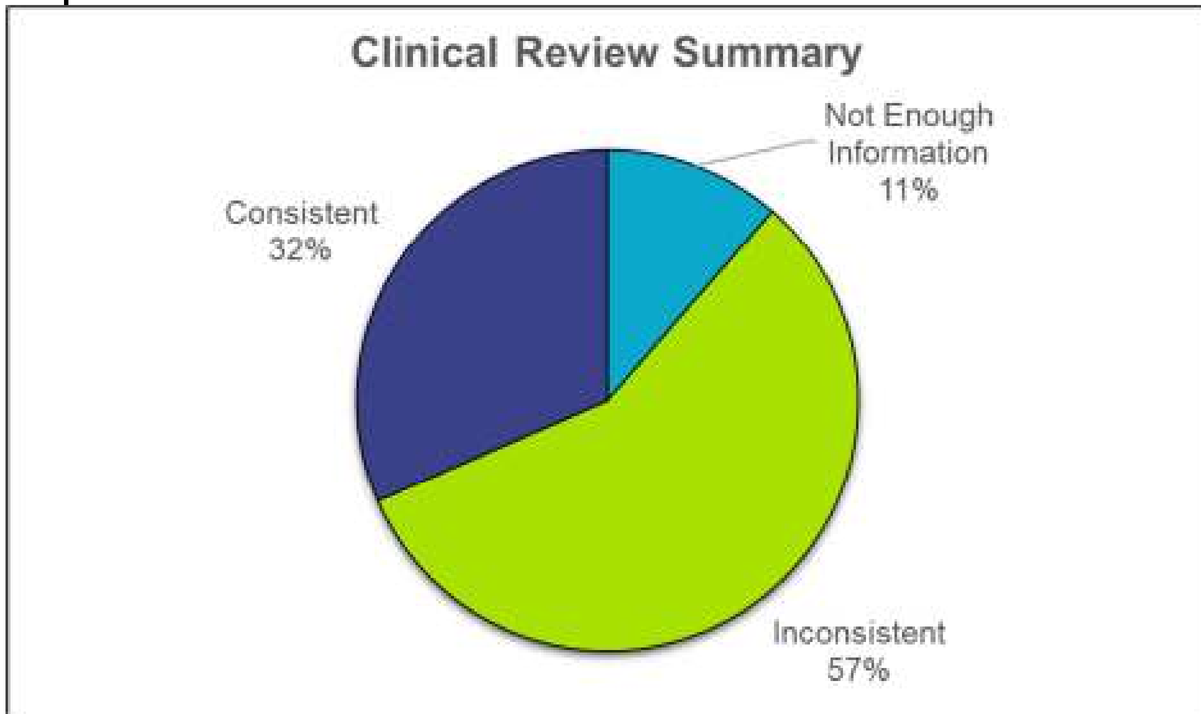
Table 7 and Graph 13 show the breakdown, by MCO, whether the denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate that of the 114 appeals reviewed, 32 percent of the time, the MCOs were consistent with state and federal criteria; 57 percent of the time, the MCOs were inconsistent with state and federal criteria; and 11 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	27	24%	58	51%	9	8%	94
ITC	9	8%	7	6%	4	4%	20
TOTAL	36	32%	65	57%	13	11%	114

Percentages are calculated using the total appeals reviewed (114: 16 Withdrawn, 72 Dismissed, 26 Overturned)

Graph 13



Clinical review outcome by MCO

Progress Report

Listed below is an update on the improvement opportunities identified in the previous report (January 1, 2021 – June 30, 2021 Executive Summary):

Action Item: 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 has begun work on a process to evaluate overturned appeals in real time (month after finalization), which will eventually include a feedback loop involving the MCOs. A tool has also been built to watch for any trends and address them which will allow the Department to identify and address issues in a more time sensitive manner.

Action Item: 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.

- The Department will begin a review of the first level appeal process with the MCOs with the goal of identifying barriers and opportunities to ensure that members can take full advantage of this process and ensure state fair hearing eligibility.
- The Department will identify opportunities to provide education on the appeals process within its communication vehicles and with its partners.

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. In 15 percent of the clinical reviews, it was mentioned that additional information would have been helpful in making the determination.
- The MCOs should specify which criteria the member did not meet for any given request. This could assist providers in understanding what is needed for future requests. 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. There were seven clinical reviews that indicated the MCO did not specify which criteria the member failed to meet.
- 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. In 5 of the clinical reviews, it was noted that the IAC was not interpreted correctly by the MCO.
- If a member is requesting a service out of the normal parameters, an ETP could help get the member the services they need. The clinical review found that in four instances, FFS members had received similar services through the ETP process.

Conclusion/Next Steps

This analysis identified opportunities for improvement. The following action steps will be completed by the end of SFY23:

- The Department will collaborate with the MCOs to determine ways that more information can be obtained prior to a determination of coverage being made in order to decrease dismissed and overturned appeals.
- The Department will collaborate with the MCOs around the clarification, alignment to criteria, and interpretation of Iowa Administrative Code on services frequently overturned in appeal. DME will be a focus in the coming months as it was identified as an outlier for both dismissed and overturned appeals. This work has already begun with some DME items that were identified including wheelchairs and speech generating devices.

In addition, an analysis of all reporting periods to date was performed. The results show:

- Since July 1, 2019, the total appealable services have averaged around 873,000, and approximately 430 appeals have been filed per reporting period.
- Appeals deemed ineligible for state fair hearing appear to be on the decline for Amerigroup for CY 2022. The highest number of ineligible appeals occurred in

2020 with Amerigroup at 454 but has declined for 2021 with 383. Iowa Total Care started off 2020 with 145 ineligible appeals, however that number has grown in CY 2021 to 235.

MCOs must provide coverage for all Medicaid covered services and abide by IAC when deciding 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
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) OR 4- A provider is attempting to appeal a claim dispute
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