STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Iowa Medicaid
Review of State Fair Hearing Appeals

January 1, 2022 – June 30, 2022

IOWA HHS

Executive Summary

The purpose of this report is to provide analysis of Medicaid Managed Care Organization (MCO) member appeals from January 1, 2022, to June 30, 2022. This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the provider or MCO, or overturned by an administrative law judge (ALJ).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, 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 January 1, 2022, to June 30, 2022, 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, 449 appeal requests were submitted for review. Of these, 56 were dismissed by the MCO, 24 were withdrawn by the member, and 32 were overturned by an ALJ and are the primary focus of this report.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. This may also increase the appeals originating from this population.

MCO	Number of Members	Number of LTSS Members
AGP	455,273	21,436
ITC	340,234	14,669

KEY FINDINGS

For this reporting period, there were 8,808,555 unique, appealable services provided to members by the MCOs. Members appealed 449, or 0.0051 percent, of the total appealable services. Moreover, of the total appealable services, only 0.00036 percent of those ultimately resulted in an overturned decision by an ALJ.

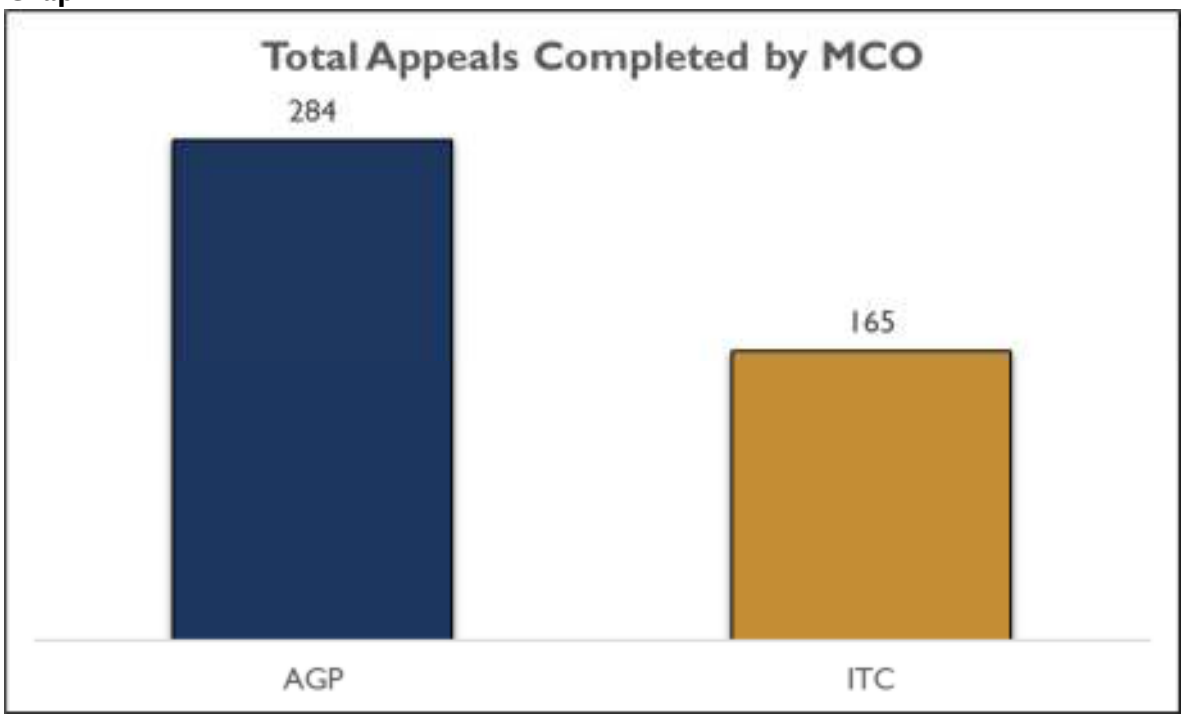
Table 1 and Graph 1 depict the number and percentage distribution of appeal requests completed, categorized by MCO. Of the total requests filed, 63 percent involved AGP enrolled members, 37 percent involved ITC members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	284	63%
ITC	165	37%
Total	449	100%

Number and percentage of appeal requests completed by MCO

Graph 1



Total number of appeal requests completed

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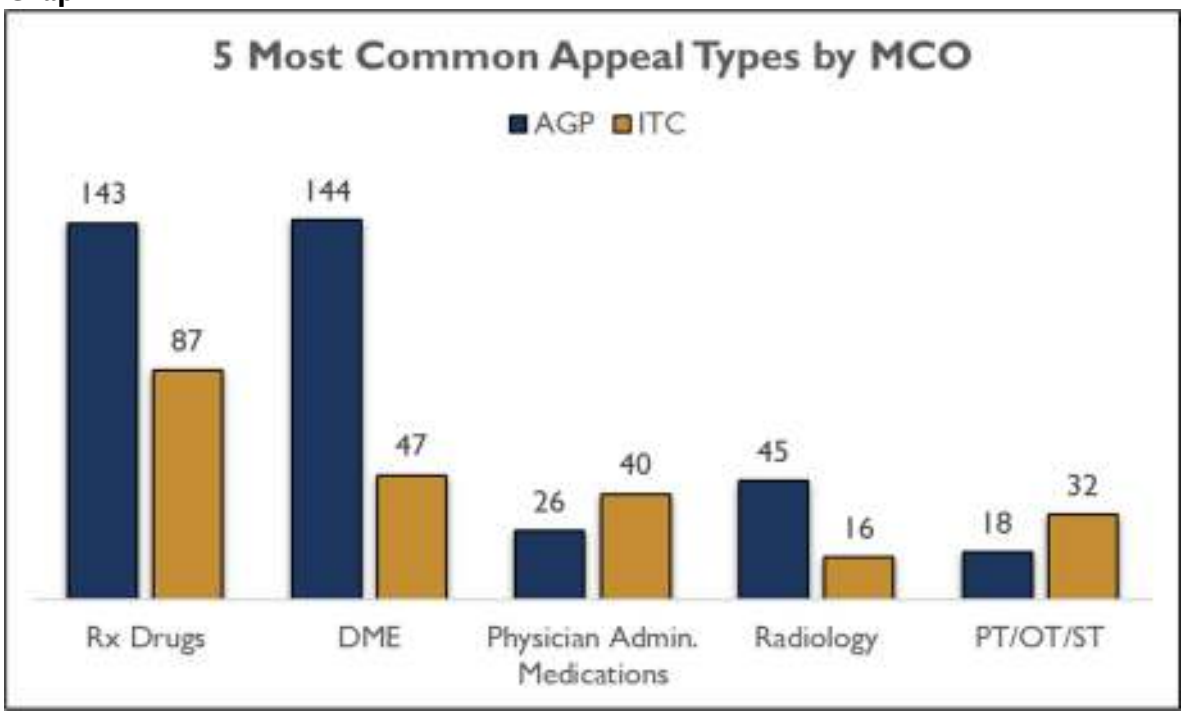
Graph 2 depicts the five most common appeal types by MCO

Graph 2



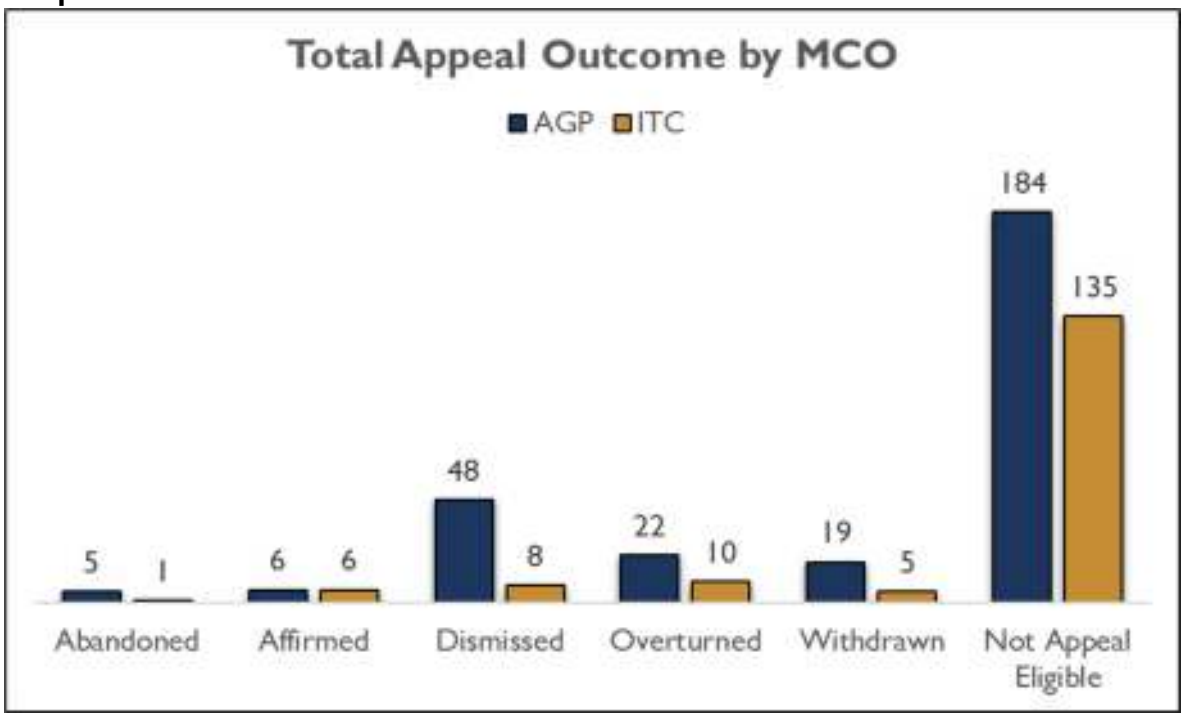
Top five appeal types by MCO – all outcomes

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
- Dismissed by the MCO prior to or during the appeal hearing.
- Overturned by the ALJ after the appeal hearing.
- Withdrawn by the member or representative prior to the appeal hearing.
- Case was determined to not be appeal eligible (see glossary).

Graph 3 shows the breakdown of the total appeals filed for the period of January 1, 2022 to June 30, 2022.

Graph 3



Breakdown of total appeal decisions by action

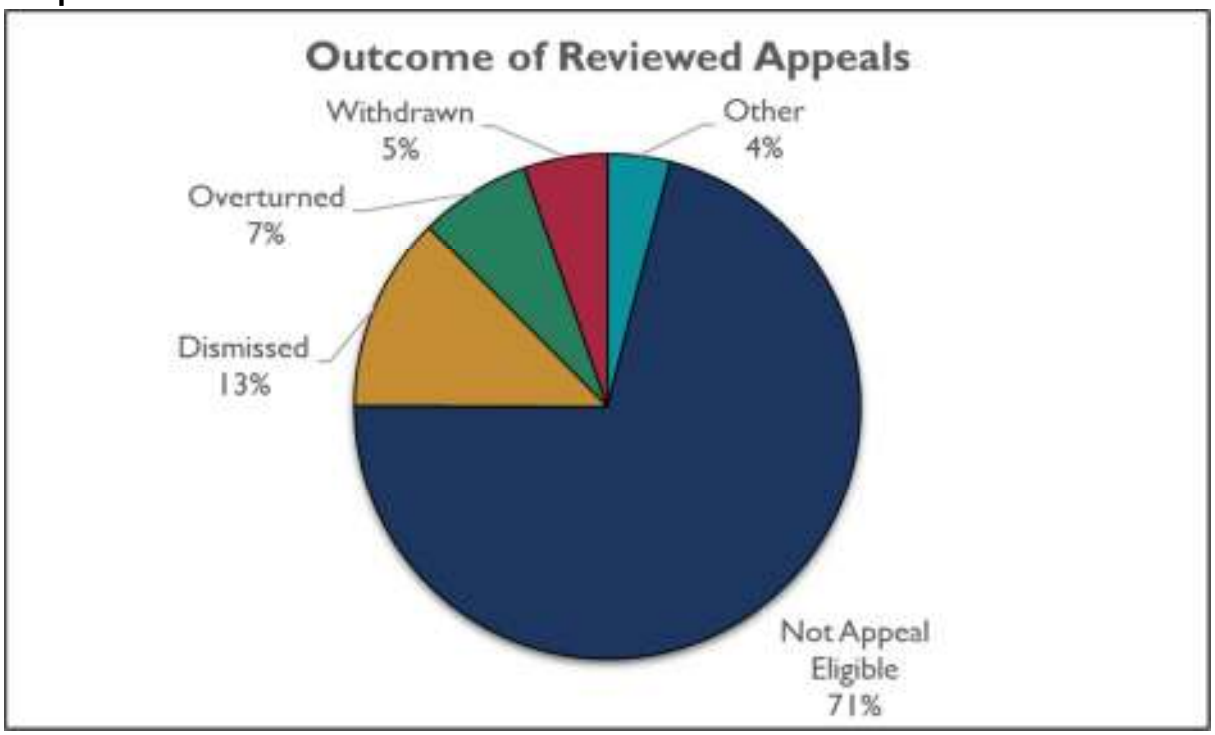
Table 2 and Graph 4 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only seven percent resulted in overturned decisions by an ALJ, and 71 percent of the requests were determined to be not eligible for an appeal.

Table 2

Action	Appeals Filed	
Withdrawn	24	5%
Dismissed	56	13%
Overturned	32	7%
Not Appeal Eligible	319	71%
Other	18	4%
Total	449	100%

Breakdown of reviewed appeal decisions by action ("Other" is all Abandoned (6) and Affirmed (12) appeals)

Graph 4



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

APPEALS WITHDRAWN

An appeal request is withdrawn when the member has decided they no longer wish to proceed with the appeals process.

Of the total appeal requests received, 24 were withdrawn. AGP had the highest percentage of appeals withdrawn at four percent compared to the total number of appeals filed.

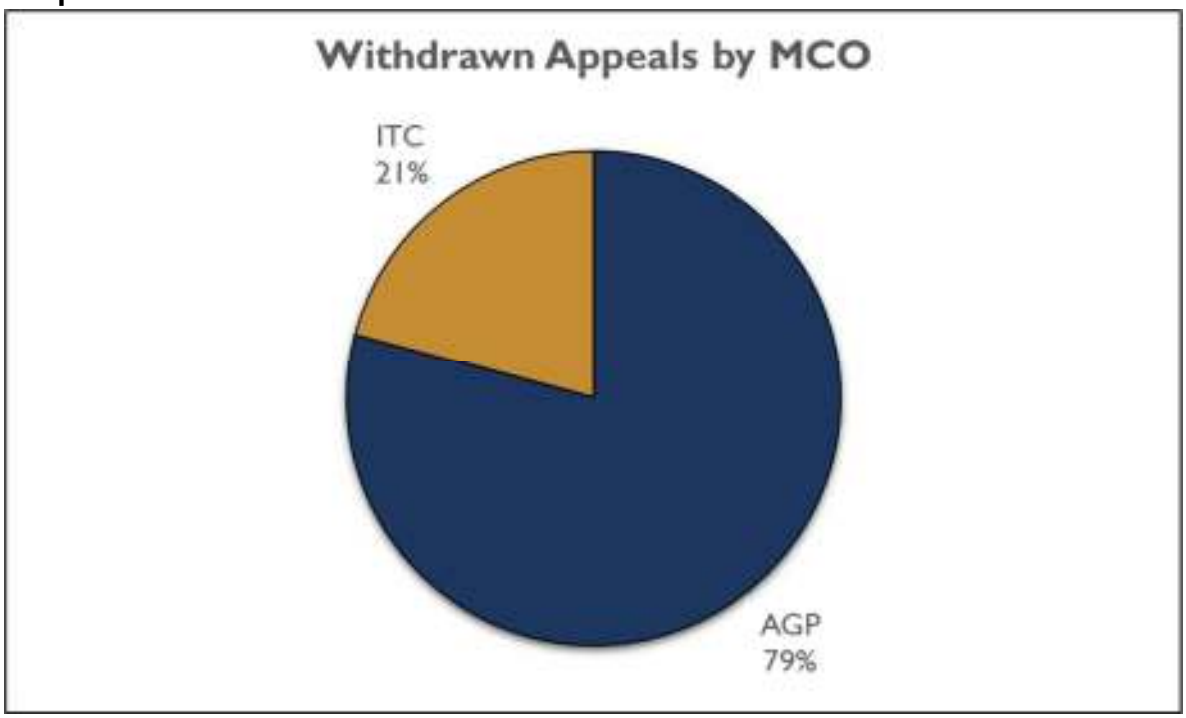
Table 3 and Graph 5 display the appeal volume breakdown for withdrawn appeal requests. Of the 24 appeal requests withdrawn, 79 percent were AGP member appeal requests and 21 percent were ITC. In total, only 5 percent of the 449 appeals filed were withdrawn.

Table 3

MCO	Number of Withdrawals	Percent of Withdrawals	Percent of Total Appeals
AGP	19	79%	4%
ITC	5	21%	1%
Total	24	100%	5%

Breakdown of withdrawn appeals by MCO

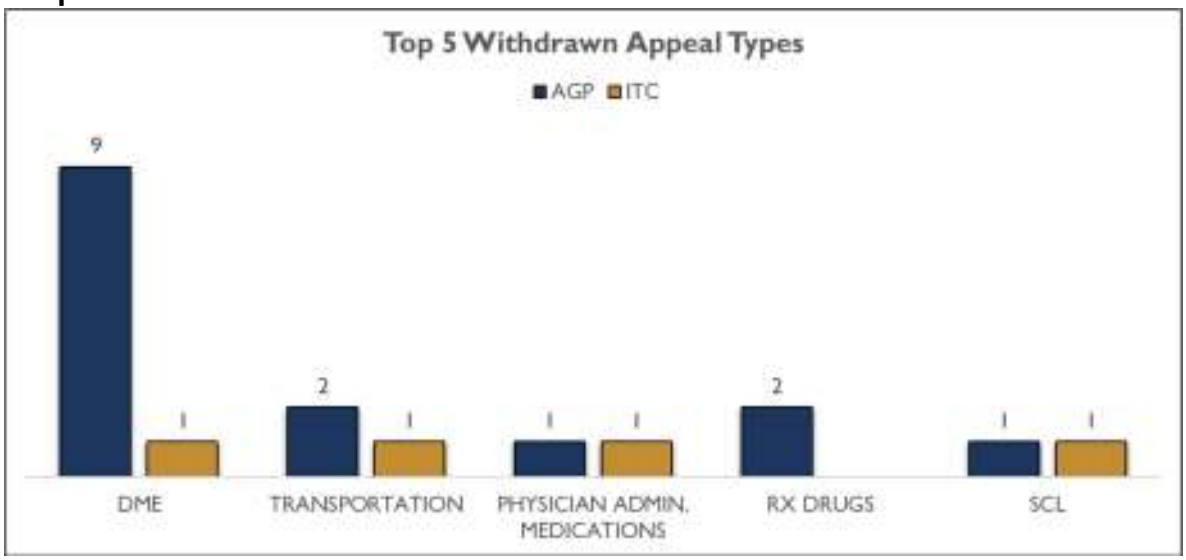
Graph 5



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 56 dismissed appeals, 86 percent were AGP member appeal requests and 14 percent were ITC member appeal requests.

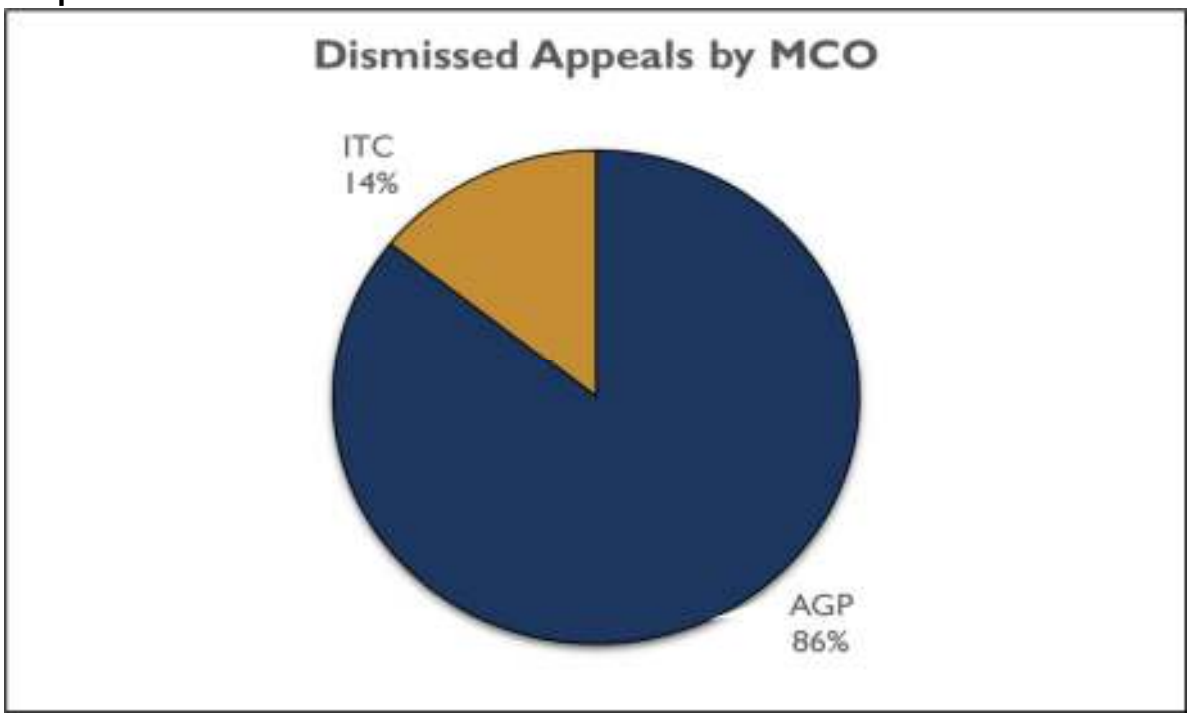
Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals filed. AGP dismissed 11 percent and ITC dismissed two percent. In total, 13 percent of the 449 appeals filed were dismissed.

Table 4

MCO	Number of Dismissals	Percent of Dismissals	Percent of Total Appeals
AGP	48	86%	11%
ITC	8	14%	2%
Total	56	100%	13%

Breakdown of dismissed appeals by MCO

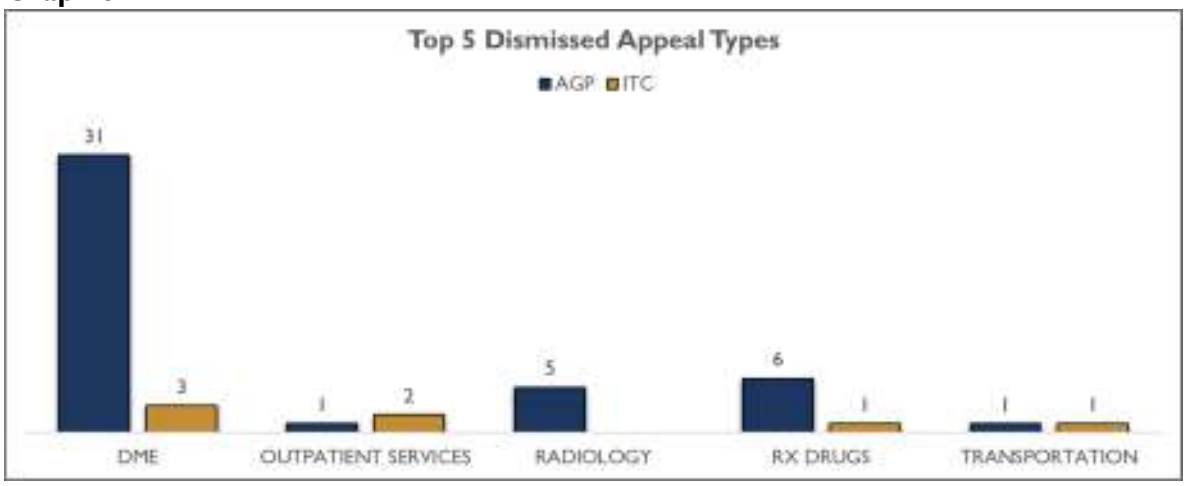
Graph 7



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.

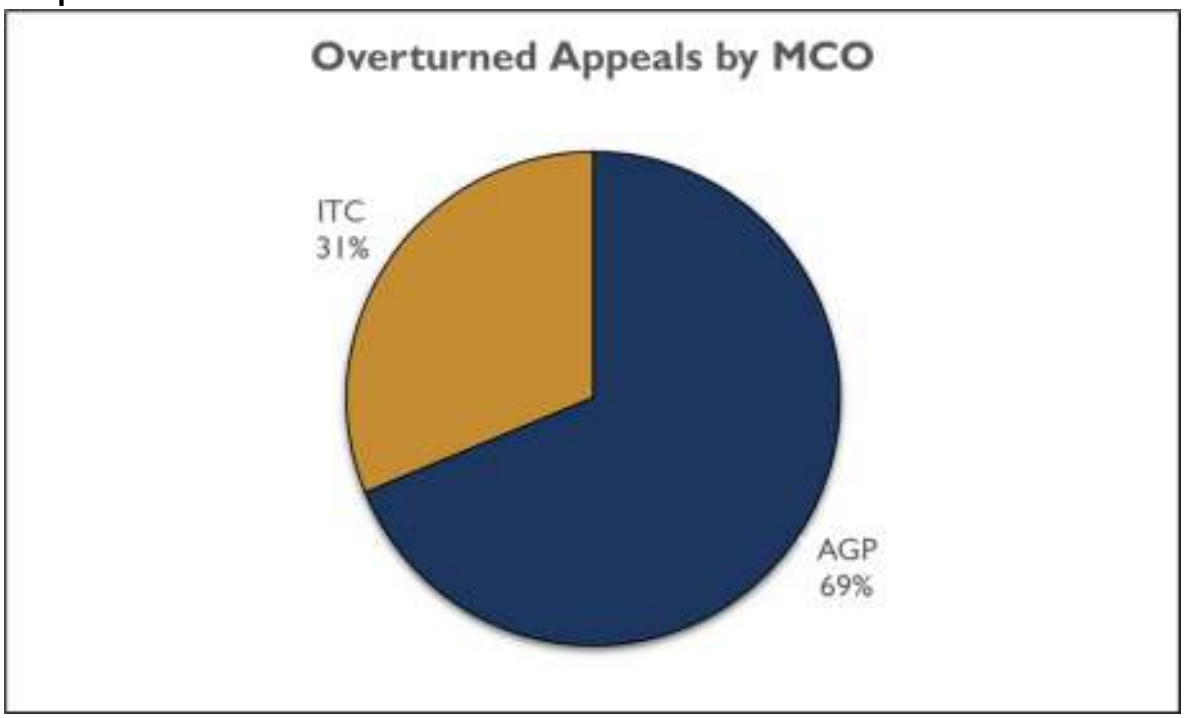
Table 5 and Graph 9 show that, of the 32 overturned appeals, AGP had the highest number at 69 percent. Further breakdown shows that of the 449 appeals filed, seven percent were overturned.

Table 5

MCO	Number of Overturned	Percent of Overturned	Percent of Total Appeals
AGP	22	69%	5%
ITC	10	31%	2%
Total	32	100%	7%

Number of overturned appeals by MCO

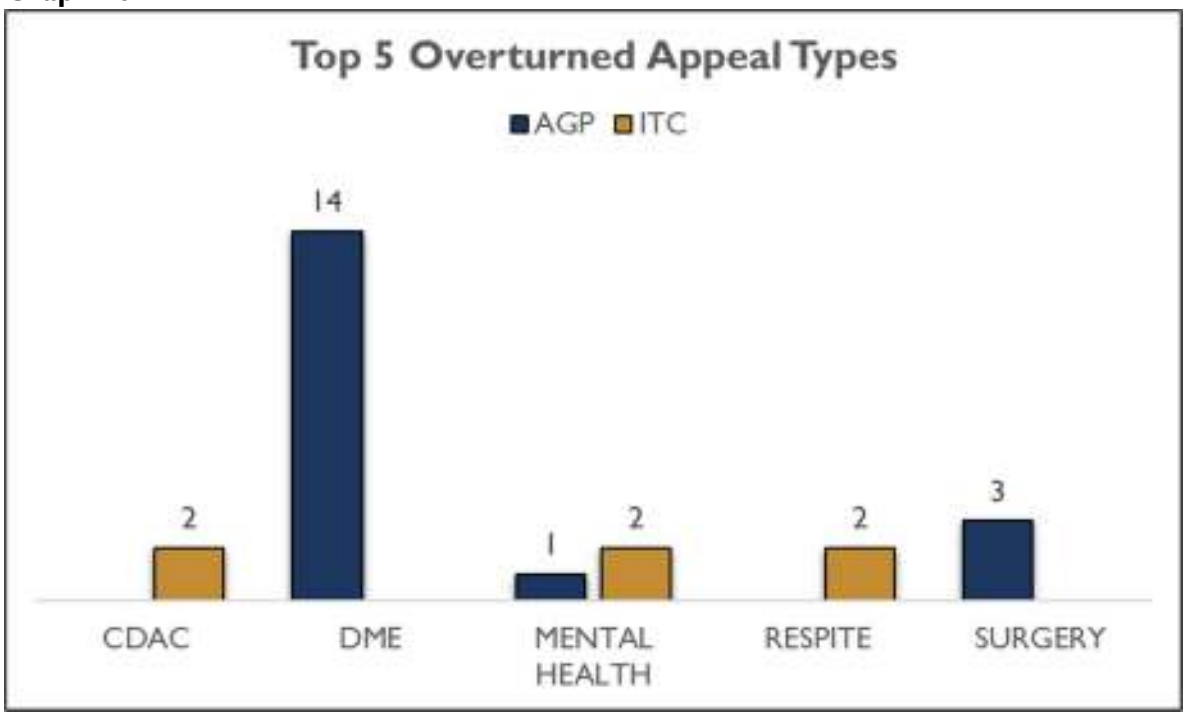
Graph 9



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 319 appeals filed during the reporting period that were determined to be ineligible for a State Fair Hearing. While the clinical review team did not review these appeals, there are some data points that can be identified.

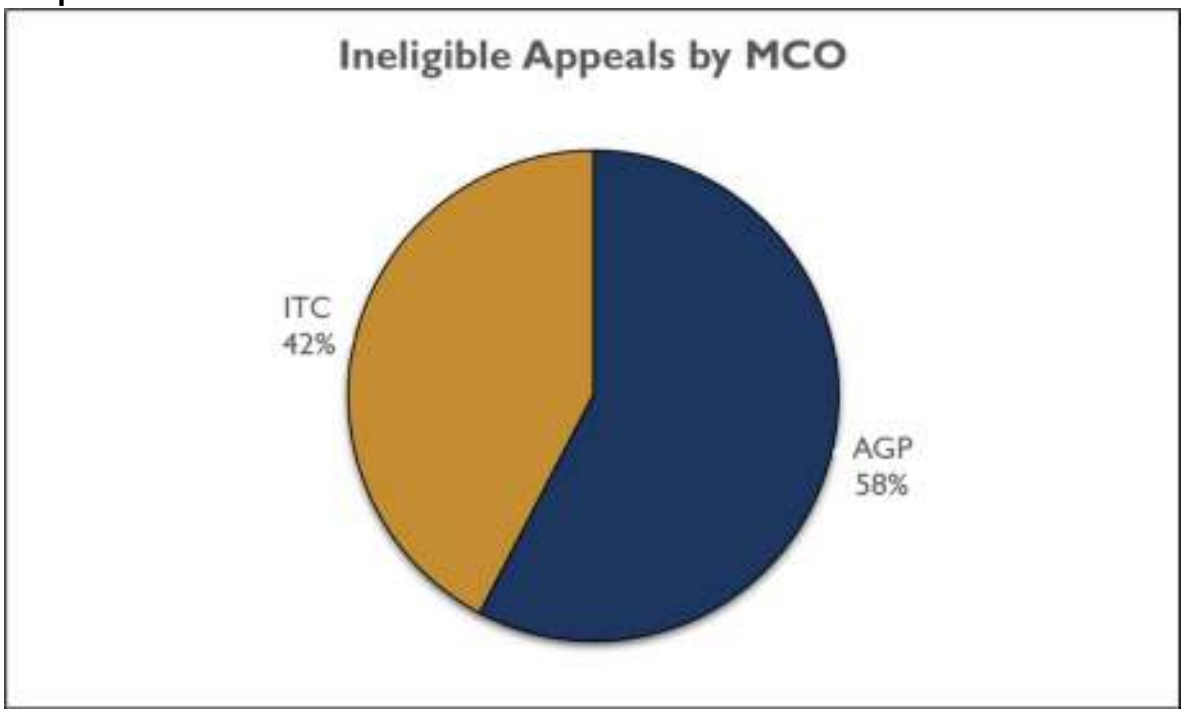
Table 6 and Graph 11 show the distribution of ineligible appeals by MCO. Of the 319 ineligible appeals, AGP had 58 percent and ITC had 42 percent. Of the total 449 appeals filed, AGP had 41 percent of their appeals deemed ineligible, and ITC had 30 percent. In total, nearly 3 out of every 4 MCO appeals filed for the reporting period were determined to not be appeal eligible (71 percent).

Table 6

MCO	Number of Ineligible Appeals	Percent of Ineligible Appeals	Percent of Total Appeals
AGP	184	58%	41%
ITC	135	42%	30%
Total	319	100%	71%

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.

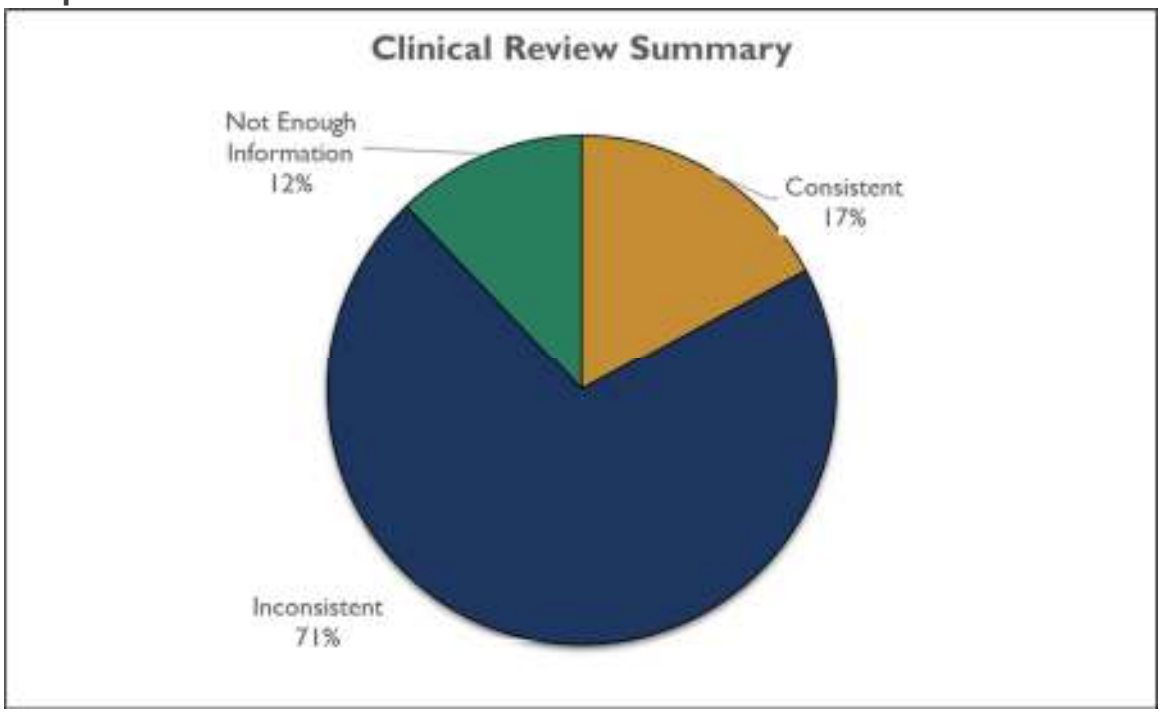
Table 7 and Graph 13 show the breakdown, by MCO, whether the original denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate that of the 99 appeals reviewed, 17 percent of the time the clinical review team determined the MCOs were consistent with state and federal criteria. Seventy percent of the time, the clinical review team found the MCOs were inconsistent with state and federal criteria, and 12 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	12	12%	59	60%	8	8%	79
ITC	5	5%	11	11%	4	4%	20
Total	17	17%	70	71%	12	12%	99

Percentages are calculated using the total appeals reviewed (99: 24 Withdrawn, 56 Dismissed, 32 Overturned)

Graph 13



Clinical review outcome

Progress Report

Listed below is an update on the improvement opportunities identified in the previous report (July 1, 2021 – December 31, 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 a real time process for evaluating overturned appeals monthly. An internal report has been produced each month for calendar year 2022, and sample months have been shared with Iowa Medicaid leadership with the goal of fine tuning the report and creating a monthly cadence and eventual feedback loop for the MCOs.
    - Work has been done in specific areas of concern such as speech generating devices and wheelchairs.
    - A prior authorization work group has been formed with the MCOs to assess where improvements or alignment can be made. The work group is entering its second phase and moving to more of a targeted resolution process.
    - The Department has been working with the MCO medical directors to create more alignment in policies to reduce unnecessary denials and provider/member abrasion.

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 has begun to look at 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 evaluate with the MCOs ways that they can better communicate with providers that providers cannot appeal claim disputes.

- The QIO presented its finding to the MCO bureau and the Policy team and initial suggestions for better communicating the process were solicited.

Analysis

This analysis identified several opportunities for improvement:

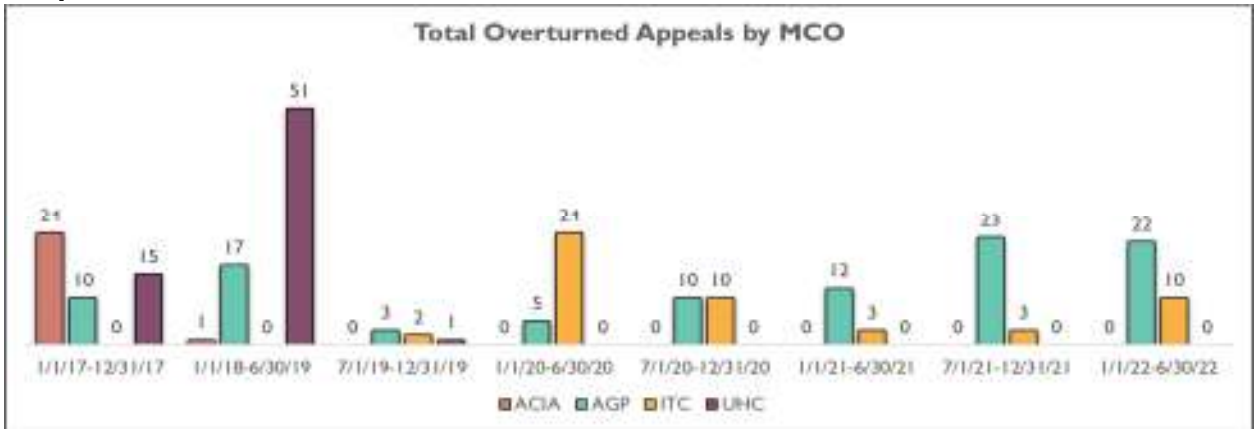
- The MCOs should seek additional information from providers, when necessary, prior to making a decision on a member's request for service. This information may provide additional insight into the reasons for a member's request for services that allow for a more informed, defendable decision. In nine 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 three clinical reviews that indicated the MCO did not specify which criteria the member failed to meet.
- In 44 percent of the clinical reviews, it was noted that the IAC was not interpreted correctly by the MCO. 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.
- 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.
- The MCOs should review the published FFS criteria on the Iowa Medicaid website for alignment to their own medical criteria and bring issues needing discussion to the MCO Medical Directors meeting with the Department.
- The MCOs should align their prior authorization requirements and criteria with the Preferred Drug List on the Iowa Medicaid website. Prior authorization requirements for specific drugs are clearly stated.

Trends

Graph 14

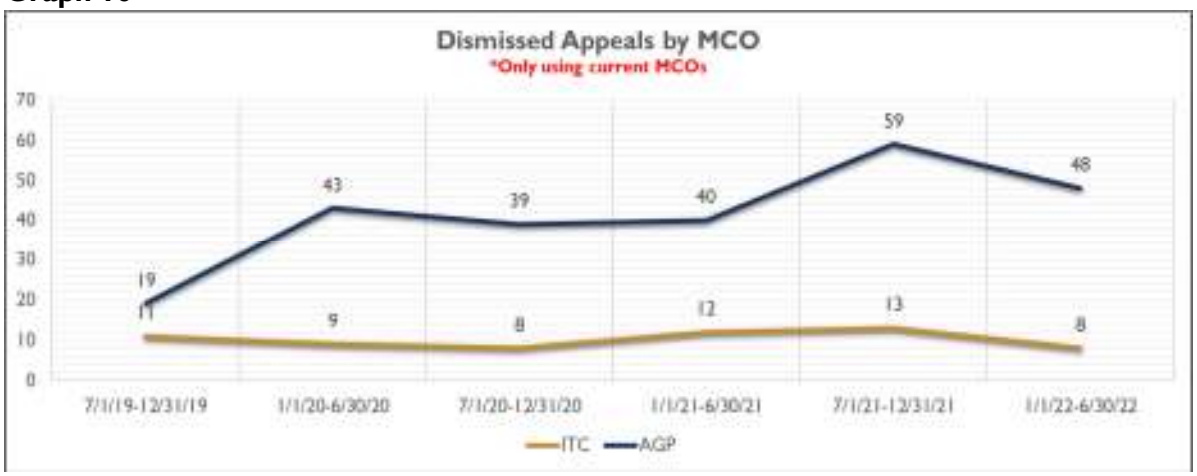
The percentage of overturned appeals had been trending downward after hitting a high point of 7.04% in the first six months of 2020. The downward trend began before the recent public health emergency (PHE) and therefore does not appear to be a contributing factor. However, overturned appeals as a percentage of the whole have been on an upward trend since the beginning of 2021 and reached their highest point yet at 7.13%. Focusing on some of the suggestions in the analysis section, may help reverse this trend.

Graph 15



Graph 15 details the total number of overturned appeals for a reporting period by MCO. Amerigroup has had the highest number of overturned appeals for the last three reporting periods. More analysis needs to be done to determine if there might be interventions that would reduce this trend or if there is any correlation between the higher waiver population and higher overturned appeals.

Graph 16



Dismissed appeals have begun to trend downward after climbing for the past two reporting periods. This could be indictive of the MCOs doing a better job obtaining additional information prior to the adverse decision going to appeal.

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.

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:
Overturned	1- The Internal MCO first level review process has not been completed, OR
SFH	2- If the appeal is not filed within the expected time frame, OR
Withdrawn	3- The absence of an adverse Notice of Decision to the member or legal representative(s) OR