STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Iowa Medicaid
Review of State Fair Hearing Appeals

January 1, 2023 to June 30, 2023

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HHS

Executive Summary

The purpose of this report is to provide analysis of Medicaid Managed Care Organization (MCO) member appeals from January 1, 2023, to June 30, 2023. This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Health and Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the provider or MCO, or overturned by an administrative law judge (ALJ).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, 2023, to June 30, 2023, 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, 590 appeal requests were submitted for review. Of these, 37 were dismissed by the MCO, 28 were withdrawn by the member, and 13 were overturned by an ALJ; and are the primary focus of this report.

Managed care was implemented in Iowa on April 1, 2016. During the reporting period, the MCOs serving Iowa Medicaid included Amerigroup Iowa, Inc. (AGP) and Iowa Total Care (ITC). The table on the following page outlines the membership of the two MCOs during the 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	430,406	20,293
ITC	368,864	15,810

KEY FINDINGS

For this reporting period, there were 8,704,463 unique, appealable services provided to members by the MCOs. Members appealed 590, or 0.00678 percent, of the total appealable services. Moreover, of the total appealable services, only 0.00015 percent of those ultimately resulted in an overturned decision by an ALJ.

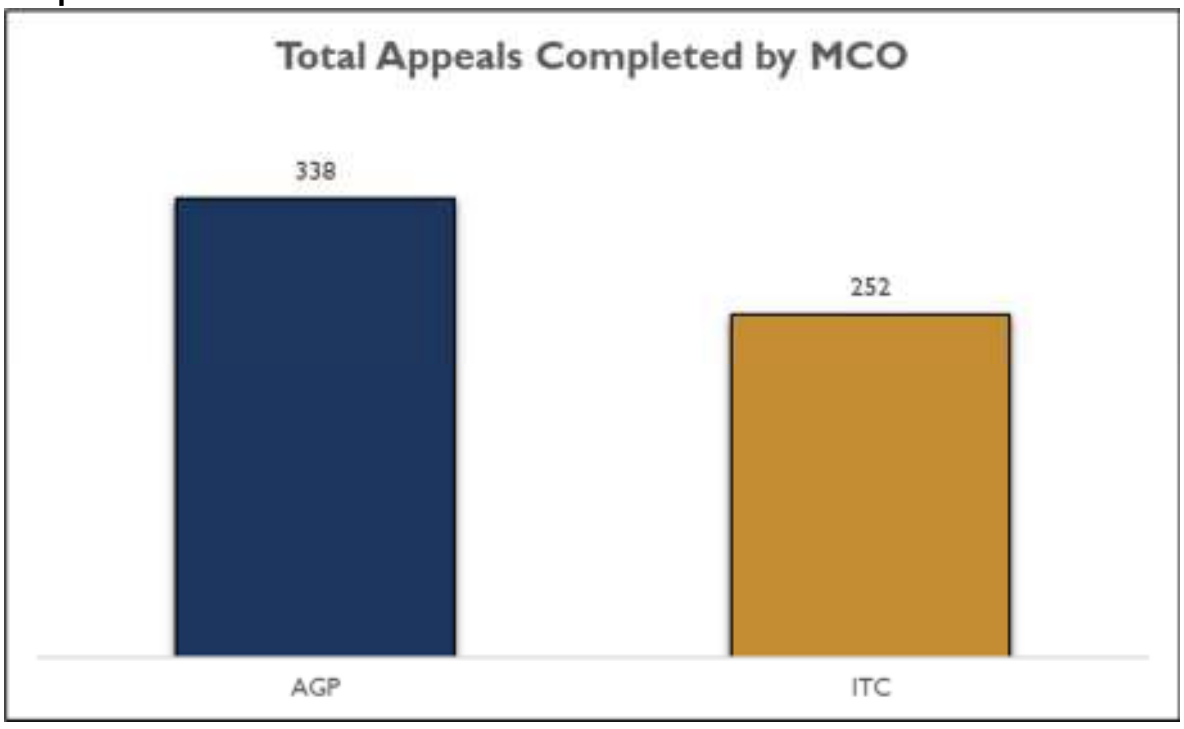
Table 1 and Graph 1 depict the number and percentage distribution of appeal requests completed, categorized by MCO. Of the total requests filed, 57 percent involved AGP enrolled members, 43 percent involved ITC members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	338	57%
ITC	252	43%
Total	590	100%

Number and percentage of appeal requests completed by MCO

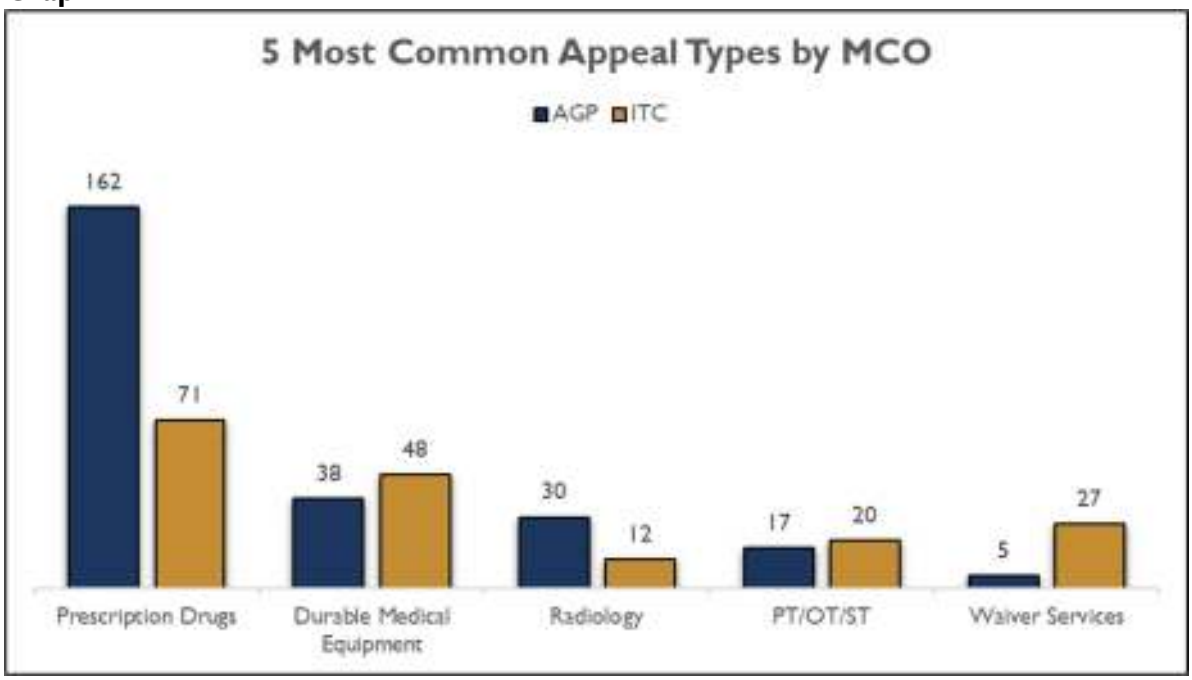
Graph 1



Total number of appeal requests completed

Graph 2 depicts the five most common appeal types by MCO

Graph 2



Top five appeal types by MCO – all outcomes.

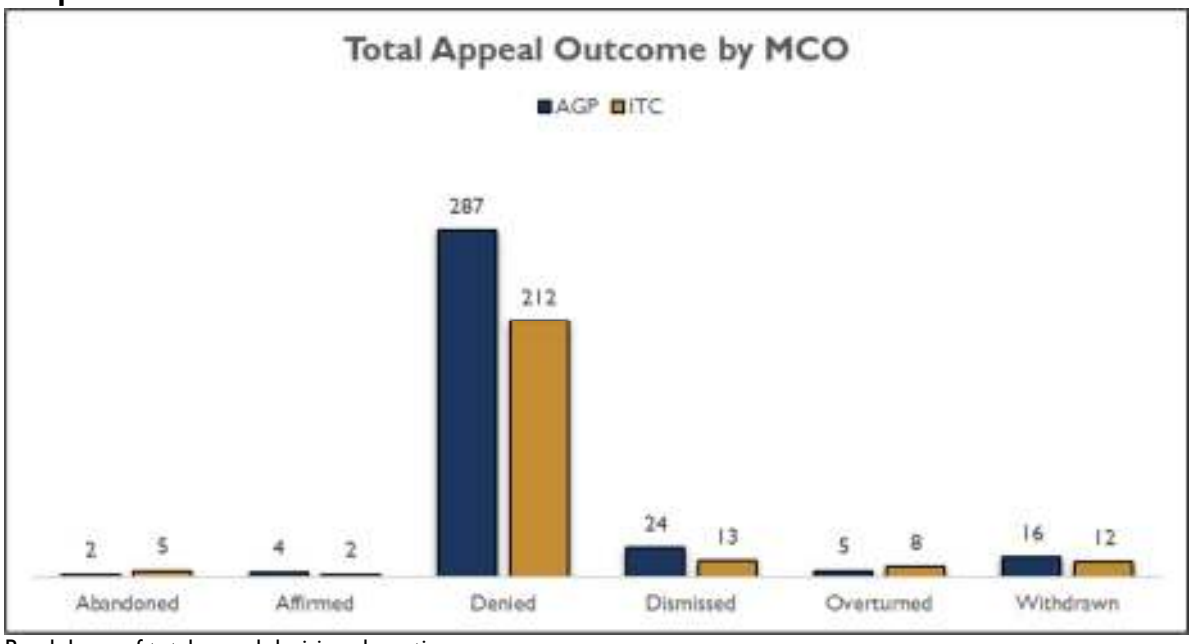
Requests for appeals during the reporting period were categorized by the type of action taken. These actions were:

- 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 not appeal eligible.

*See glossary

Graph 3 shows the breakdown of the total appeals filed for the period of January 1, 2023, to June 30, 2023.

Graph 3



Breakdown of total appeal decisions by action

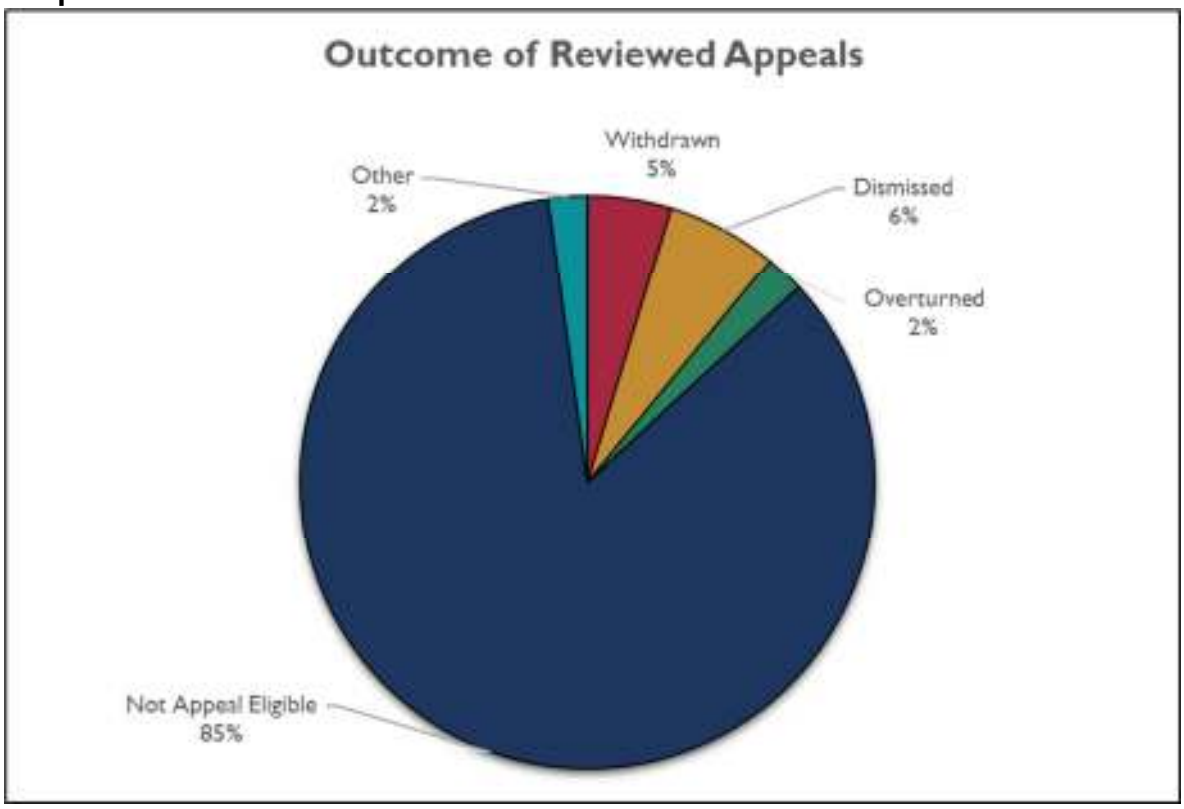
Table 2 and Graph 4 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only two percent resulted in overturned decisions by an ALJ, and 85 percent of the requests were determined not appeal eligible.

Table 2

Action	Appeals Filed	
Withdrawn	28	5%
Dismissed	37	6%
Overturned	13	2%
Not Appeal Eligible	499	85%
Other	13	2%
Total	590	100%

Breakdown of reviewed appeal decisions by action ("Other" is all Abandoned (7) and Affirmed (6) 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, 28 were withdrawn. AGP had the highest percentage of appeals withdrawn at three percent compared to the total number of appeals filed.

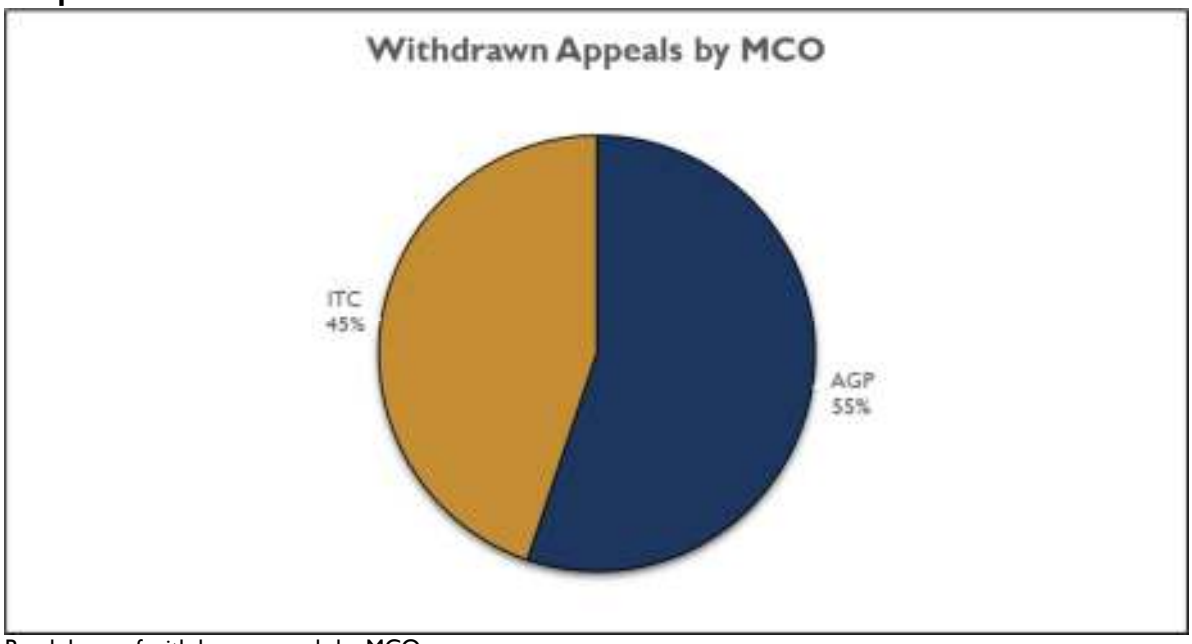
Table 3 and Graph 5 display the appeal volume breakdown for withdrawn appeal requests. Of the 28 appeal requests withdrawn, 55 percent were AGP member appeal requests and 45 percent were ITC. In total, only five percent of the 590 appeals filed were withdrawn.

Table 3

MCO	Number of Withdrawals	Percent of Withdrawals	Percent of Total Appeals
AGP	16	55%	3%
ITC	12	45%	2%
Total	28	100%	5%

Breakdown of appeal decisions by action.

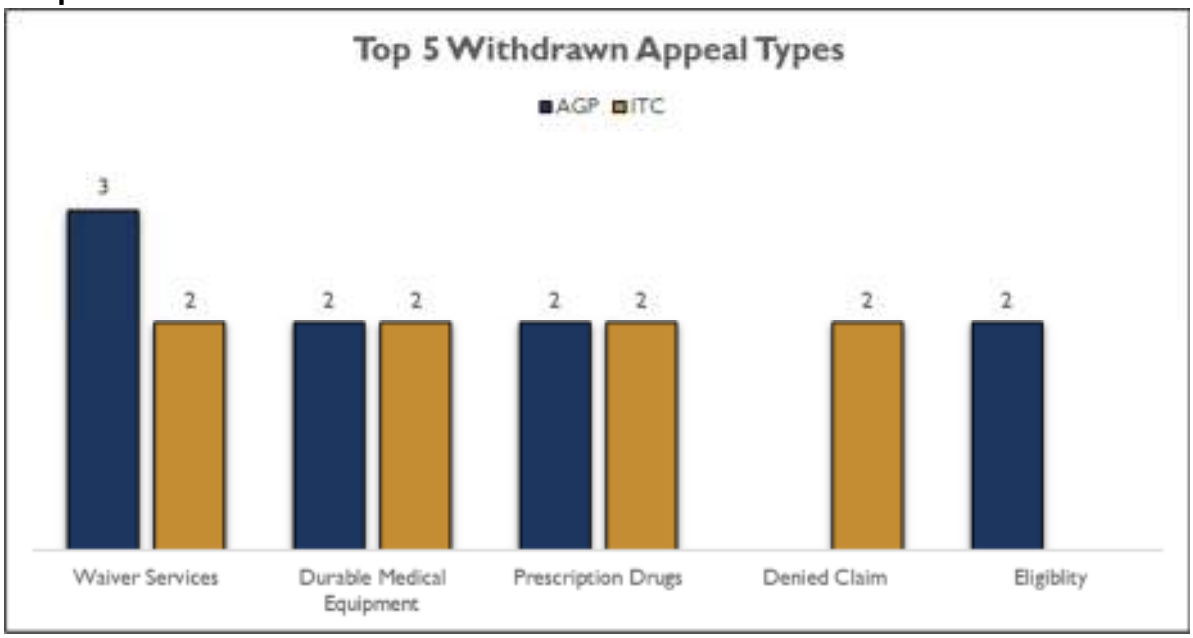
Graph 5



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.

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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 37 dismissed appeals, 65% were AGP member appeal requests and 35% were ITC member appeal requests.

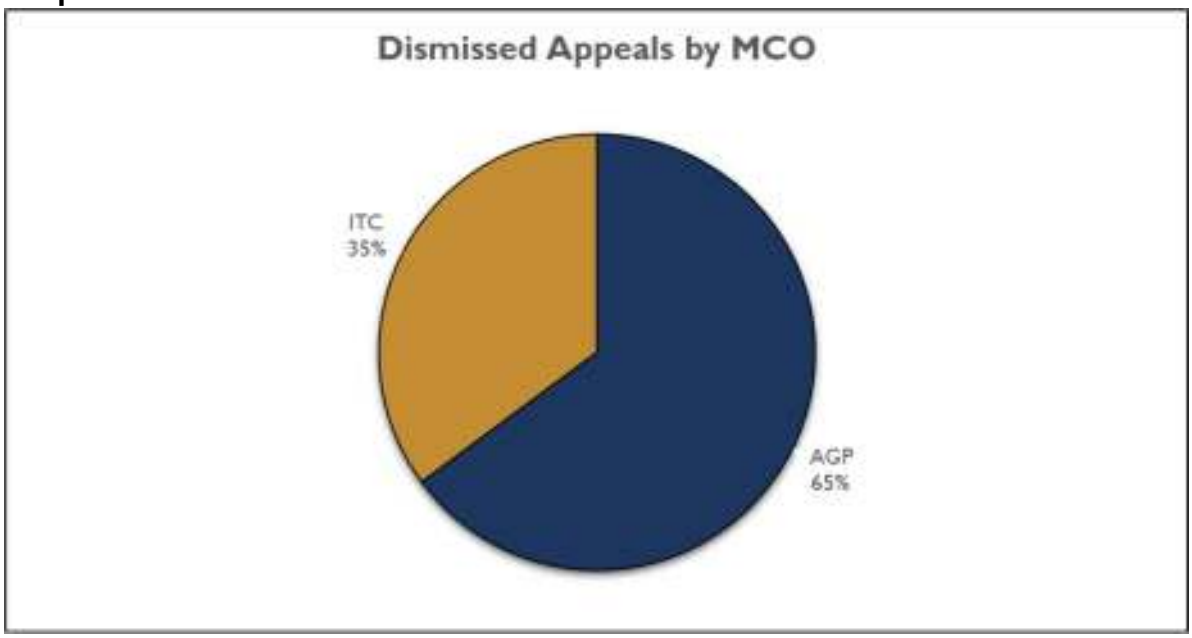
Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals filed. AGP dismissed four percent and ITC dismissed two percent. In total, six percent of the 590 appeals filed were dismissed.

Table 4

MCO	Number of Dismissals	Percent of Dismissals	Percent of Total Appeals
AGP	24	65%	4%
ITC	13	35%	2%
Total	37	100%	6%

Breakdown of dismissed appeals by MCO.

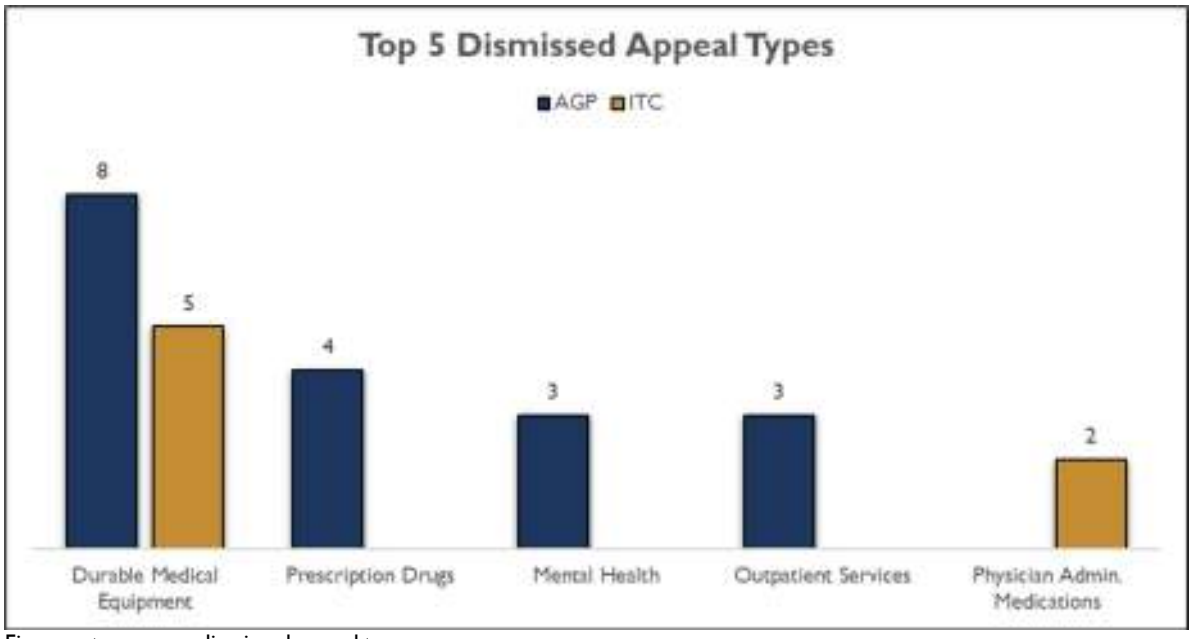
Graph 7



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.

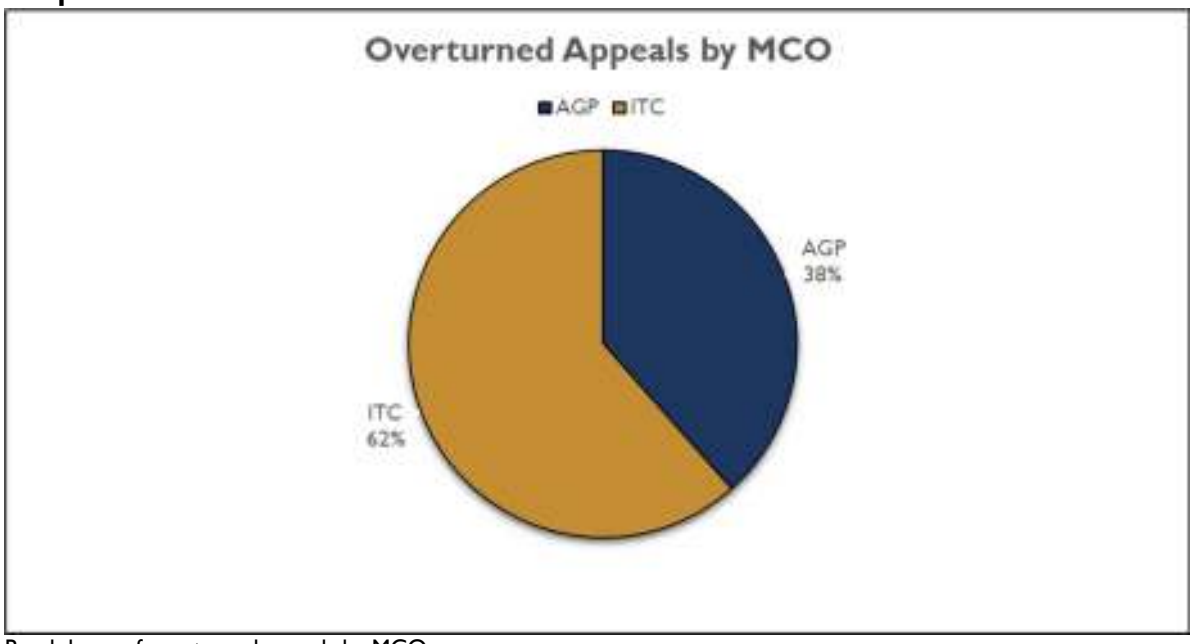
Table 5 and Graph 9 show that, of the 13 overturned appeals, ITC had the highest number at 62 percent. Further breakdown shows that of the 590 appeals filed, two percent were overturned.

Table 5

MCO	Number of Overturned	Percent of Overturned	Percent of Total Appeals
AGP	5	38%	1%
ITC	8	62%	1%
Total	13	100%	2%

Number of overturned appeals by MCO.

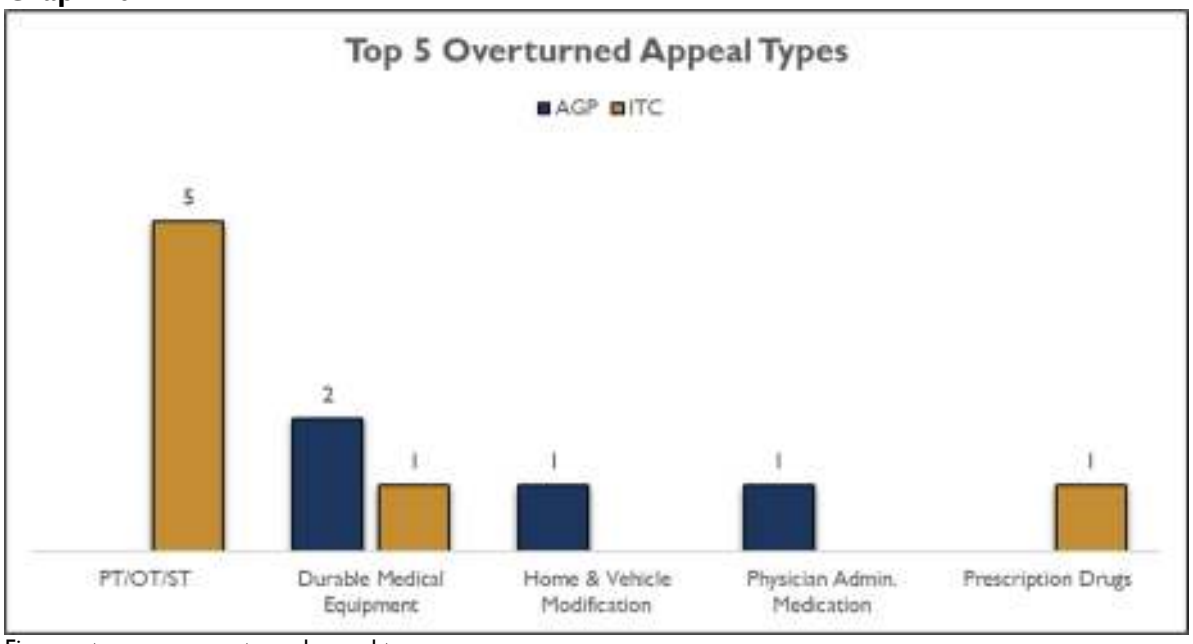
Graph 9



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

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NOT APPEALELIGIBLE

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 499 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.

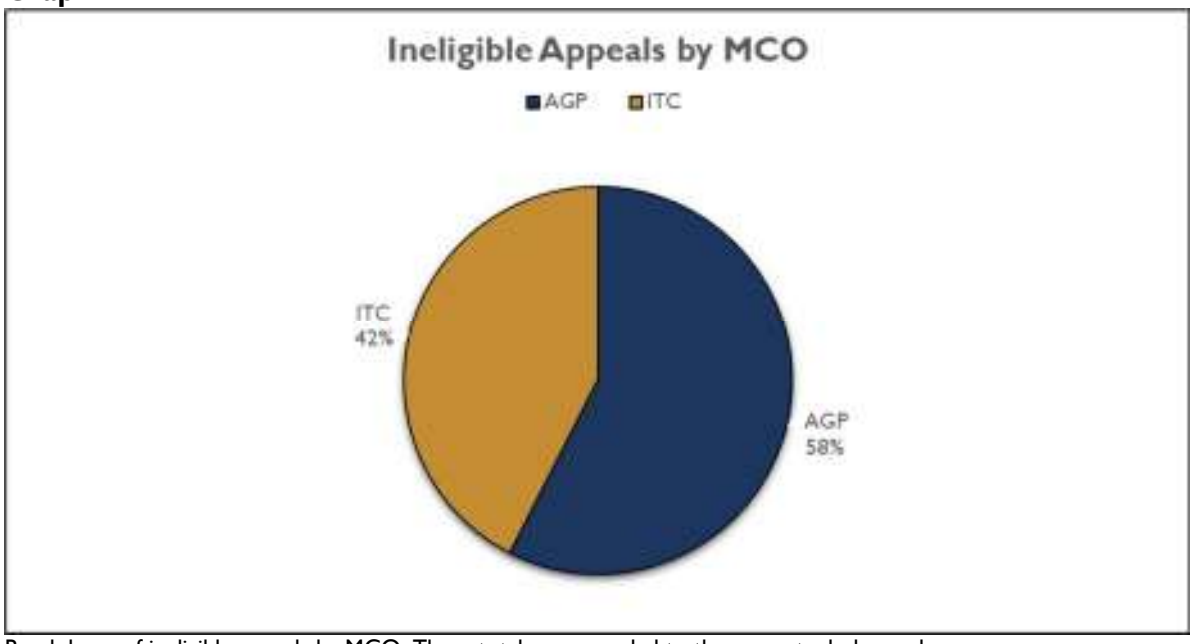
Table 6 and Graph 11 show the distribution of ineligible appeals by MCO. Of the 499 ineligible appeals, AGP had 58 percent and ITC had 42 percent. Of the total 590 appeals filed, AGP had 49 percent of their appeals deemed ineligible and ITC had 36 percent. In total, 85 percent of all MCO appeals filed for the reporting period were determined not appeal eligible.

Table 6

MCO	Number of Ineligible Appeals	Percent of Ineligible Appeals	Percent of Total Appeals
AGP	287	58%	49%
ITC	212	42%	36%
Total	499	100%	85%

Number of appeals determined to be ineligible.

Graph 11



Breakdown of ineligible appeals by MCO. These totals are rounded to the nearest whole number.

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.

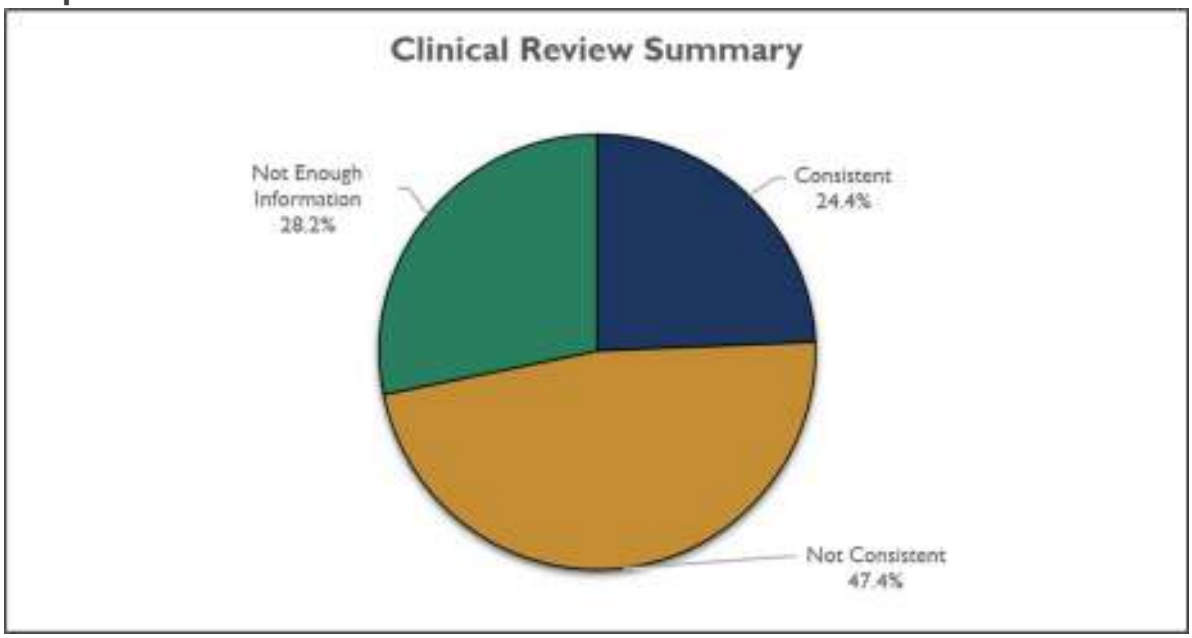
Table 7 and Graph 13 show the breakdown, by MCO, whether the original denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate that of the 78 appeals reviewed, 24 percent of the time, the MCOs were consistent with state and federal criteria; 47 percent of the time, the MCOs were inconsistent with state and federal criteria; and 28 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	11	14%	22	28%	12	15%	45
ITC	8	10%	15	19%	10	13%	33
Total	19	24%	37	47%	22	28%	78

Percentages are calculated using the total appeals reviewed (78: 28 Withdrawn, 37 Dismissed, 13 Overturned)

Graph 13



Clinical review outcome

PROGRESS REPORT

Listed below is an update on the improvement opportunities identified in the previous report (July 1, 2022 to December 31, 2022 Executive Summary)

Action Item: 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.

Progress Updates:

- A prior authorization workgroup was created in the first quarter of 2022 to work on global provider and member issues, with an emphasis on policy interpretation and alignment. The workgroup focus is to review prior authorization codes and processes to identify opportunities for alignment across the managed care organizations (MCO) and Fee-for-Service (FFS) and mechanisms to help reduce burden for providers. In April 2022, the workgroup began discussions surrounding mobility devices, specifically wheelchair repairs, which included a group of Durable Medical Equipment providers. Topics discussed included new wheelchairs, repairs, prior authorization and the review process, denials, and the providers provided some overall suggestions to the workgroup. The workgroup will continue research and discussion in the months to come.

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.

Progress Updates:

- The Department developed a process to evaluate overturned appeals in real time (month after finalization), which includes a feedback loop involving the MCOs. The Department

reviews appeals on a monthly basis and has presented the findings to the MCOs. A tracking tool was built to monitor trends and address issues in a timely manner.
- The Department has completed the first state fiscal year on the trending tool. Analysis for continued process improvements is underway.

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 is working to identify opportunities to provide education on the appeals process within its communication vehicles and with its partners.

Progress Updates:

- The Department completed a review of the first level appeal process for each MCO, documenting recommendations which identified potential barriers and opportunities, so members can take full advantage of the MCOs' first level review process and ensure state fair hearing eligibility.

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.
- A broader understanding of IAC may result in a reduction in the number of total appeals. In 44 percent of the clinical reviews, it was noted that the IAC was not interpreted correctly by the MCO.
- The MCOs should consider submitting an ETP for an item or service not otherwise covered to obtain medically necessary services for their members. The clinical review found that in four instances, the ETP process could have been used to meet the member's needs.
- The MCO criteria should not be more restrictive than Iowa Medicaid criteria.
- The MCOs should become familiar with the Preferred Drug List on the Iowa Medicaid website and the prior authorization requirements for specific drugs.

CONCLUSION/NEXT STEPS

This analysis identified opportunities for improvement. The following action steps will be completed by the end of SFY 2025:

- The Department will continue to collaborate with the MCOs around the clarification, alignment to criteria, and interpretation of Iowa Administrative Code on services frequently overturned in appeal.

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.

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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
ITC	Iowa Total Care
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 it was determined that the MCO incorrectly denied a request for an item or service.
SFH	State Fair Hearing
Withdrawn	An appeal is withdrawn when the member or their authorized representative decides they no longer wish to proceed with the appeal.