STATE OF IOWA DEPARTMENT OF

Health AND Human SERVICES

Iowa Medicaid
Review of State Fair Hearing Appeals

July 1, 2023 to December 31, 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 July 1, 2023, to December 31, 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 This includes appeals that have been withdrawn, dismissed, or overturned.

In this report, the Iowa Department of Health and Human Services (Department) analyzed MCO appeals that were withdrawn by a Medicaid member, dismissed by the provider or MCO, or overturned by an administrative law judge (ALJ).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 July 1, 2023, to December 31, 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, 560 appeal requests were submitted for review. Of these, 44 were dismissed by the MCO, 61 were withdrawn by the member, and 23 were overturned by an ALJ and are the primary focus of this report.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), Iowa Total Care (ITC) and Molina Healthcare (MHC), which was implemented July 1, 2023.

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 through their plan of care. The table on the following page outlines the membership of the three MCOs during this reporting period.

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MCO	Number of Members	Number of LTSS Members
AGP	257,380	20,555
ITC	243,918	16,390
MHC	174,828	5,428

KEY FINDINGS

For this reporting period, there were 14,641,743 unique, appealable services provided to members by the MCOs. Members appealed 560, or 0.004 percent, of the total appealable services. Moreover, of the total appealable services, only 0.00016 percent of those ultimately resulted in an overturned decision by an ALJ.

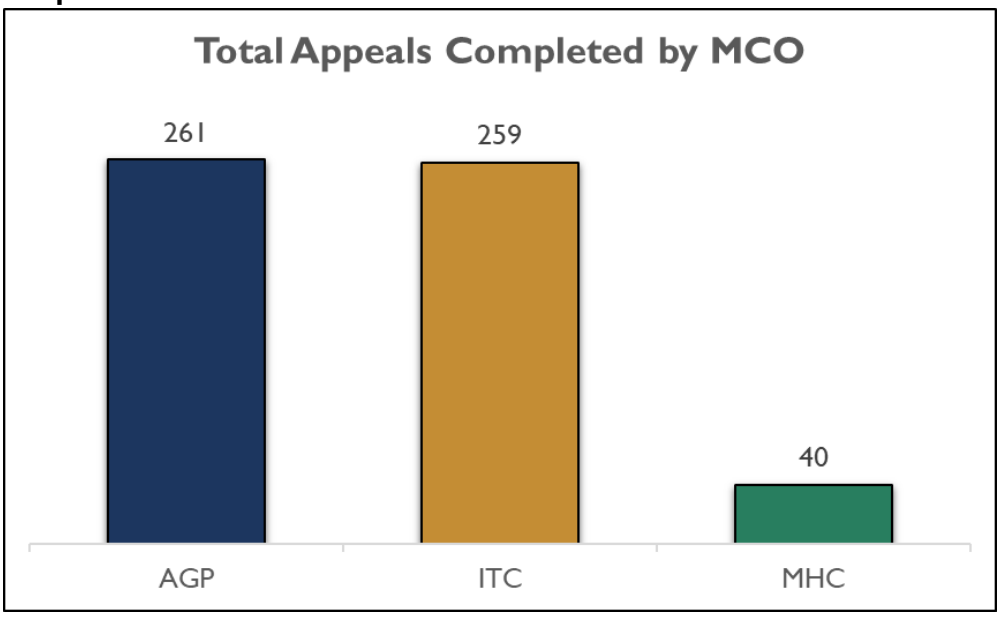
Table 1 and Graph 1 depict the number and percentage distribution of appeal requests completed, categorized by MCO. Of the total requests filed, 47 percent involved AGP enrolled members, 46 percent involved ITC members and 7 percent involved MHC members.

Table 1

MCO	Number of Appeals	Percent of Appeals
AGP	261	47%
ITC	259	46%
MHC	40	7%
Total	560	100%

Number and percentage of appeal requests completed by MCO

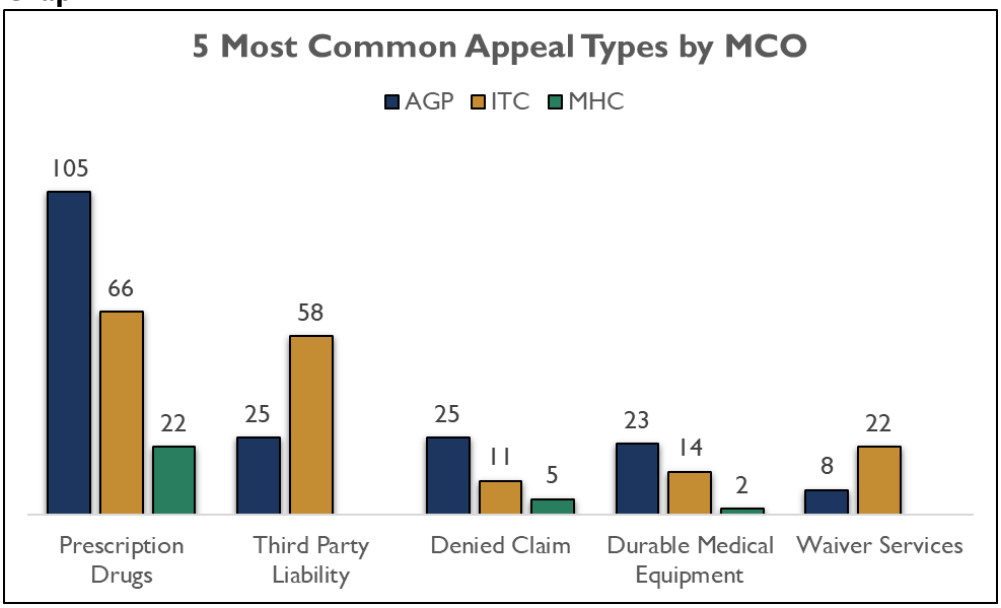
Graph 1



Total number of appeal requests completed

Graph 2 depicts the five most common appeal types by MCO

Graph 2



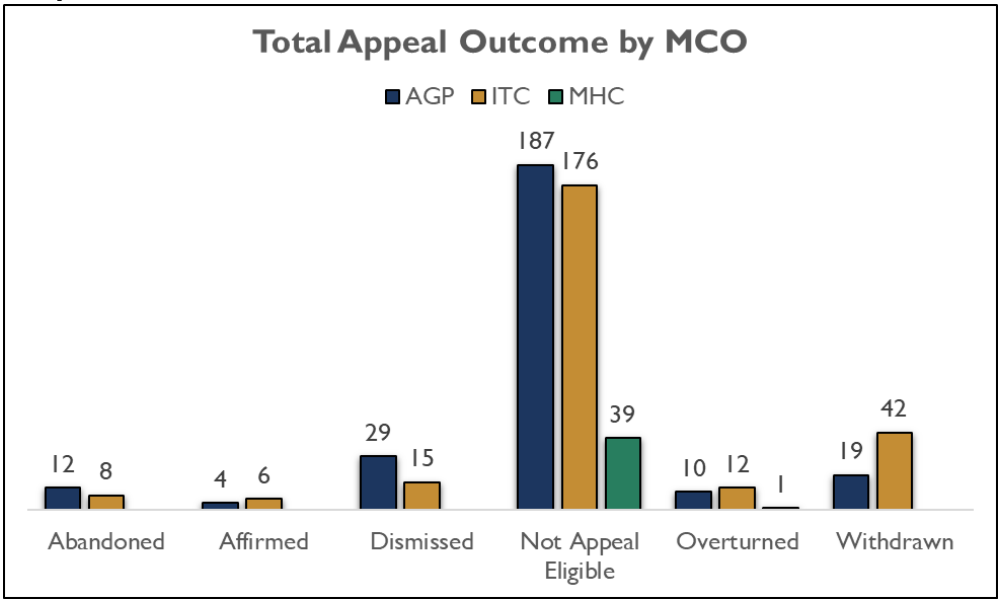
Top five appeal types by MCO – all outcomes

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 to not be appeal eligible (see glossary).

Graph 3 shows the breakdown of the total appeals filed for the period of July 1, 2023 to December 31, 2023.

Graph 3



Breakdown of total appeal decisions by action

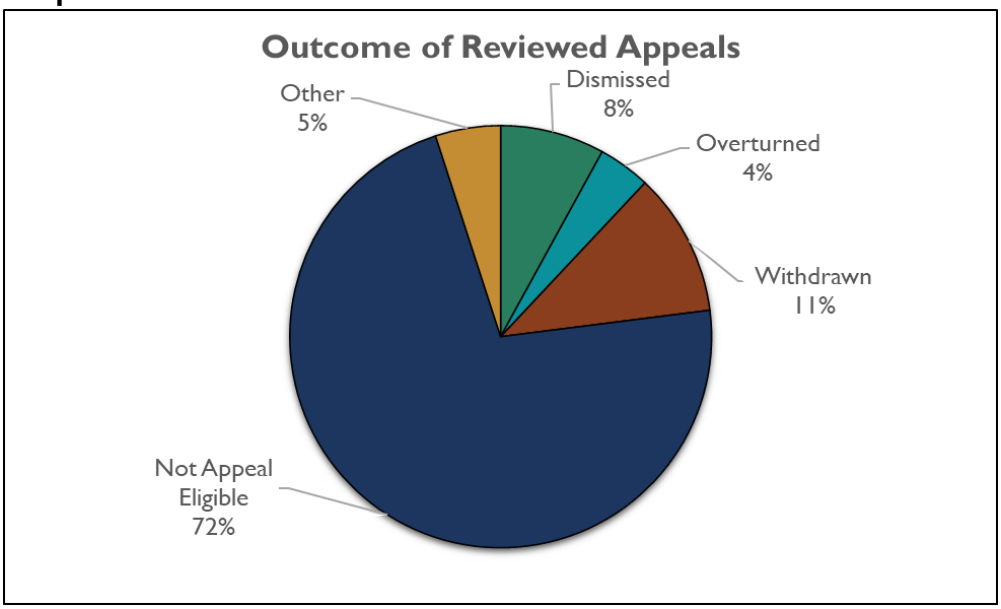
Table 2 and Graph 4 show the breakdown of withdrawn, dismissed, overturned, and not appeal eligible categories. As shown, of the total appeal requests completed, only four percent resulted in overturned decisions by an ALJ, and 72 percent of the requests were determined not appeal eligible.

Table 2

Action	Appeals Filed	
Withdrawn	61	11%
Dismissed	44	8%
Overturned	23	4%
Not Appeal Eligible	402	72%
Other	30	5%
Total	560	100%

Breakdown of reviewed appeal decisions by action ("Other" is all Abandoned (20) and Affirmed (10) appeals)

Graph 4



Breakdown of appeal decisions by reviewed appeals (Other = Abandoned [20] & Affirmed [10])

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, 61 were withdrawn, ITC had the highest percentage of appeals withdrawn at eight percent compared to the total number of appeals filed.

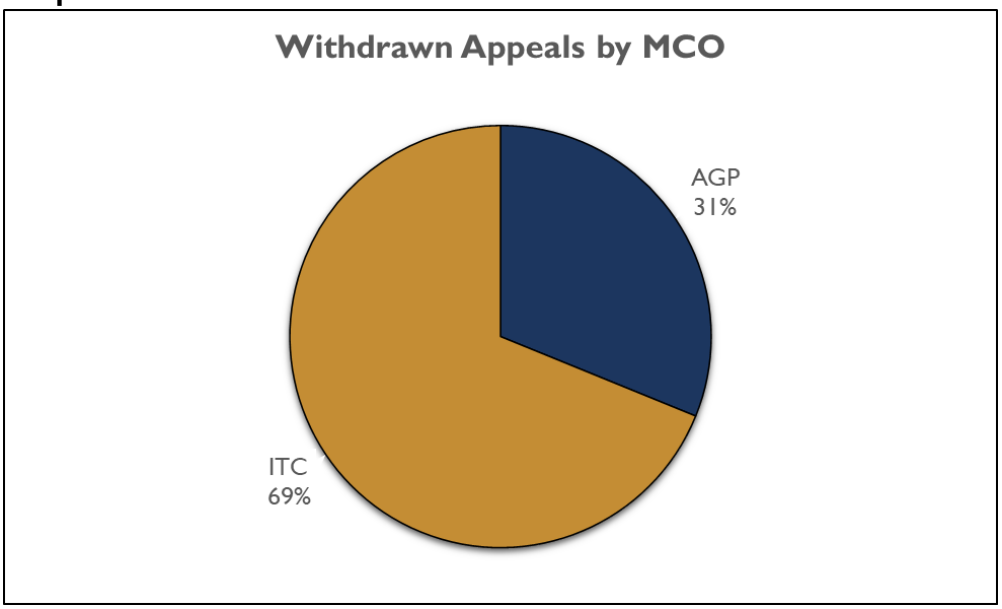
Table 3 and Graph 5 display the appeal volume breakdown for withdrawn appeal requests. Of the 61 appeal requests withdrawn, 31 percent were AGP member appeal requests and 69 percent were ITC. In total, only 11 percent of the 560 appeals filed were withdrawn.

Table 3

MCO	Number of Withdrawals	Percent of Withdrawals	Percent of Total Appeals
AGP	19	31%	3%
ITC	42	69%	8%
MHC	0	0%	0%
Total	61	100%	11%

Breakdown of appeal decisions by action

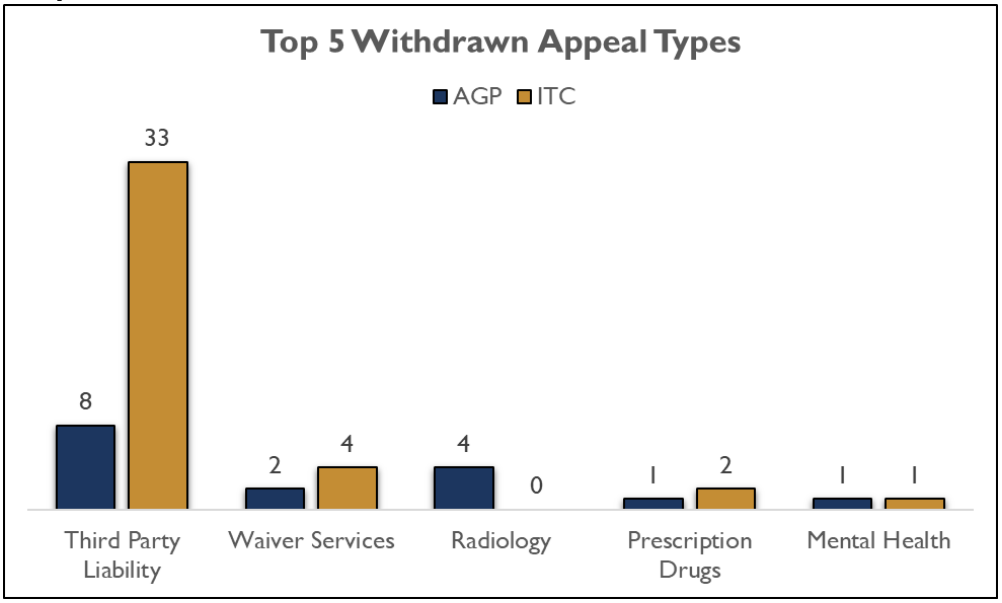
Graph 5



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 44 dismissed appeals, 66 percent were AGP member appeal requests and 34 percent were ITC member appeal requests.

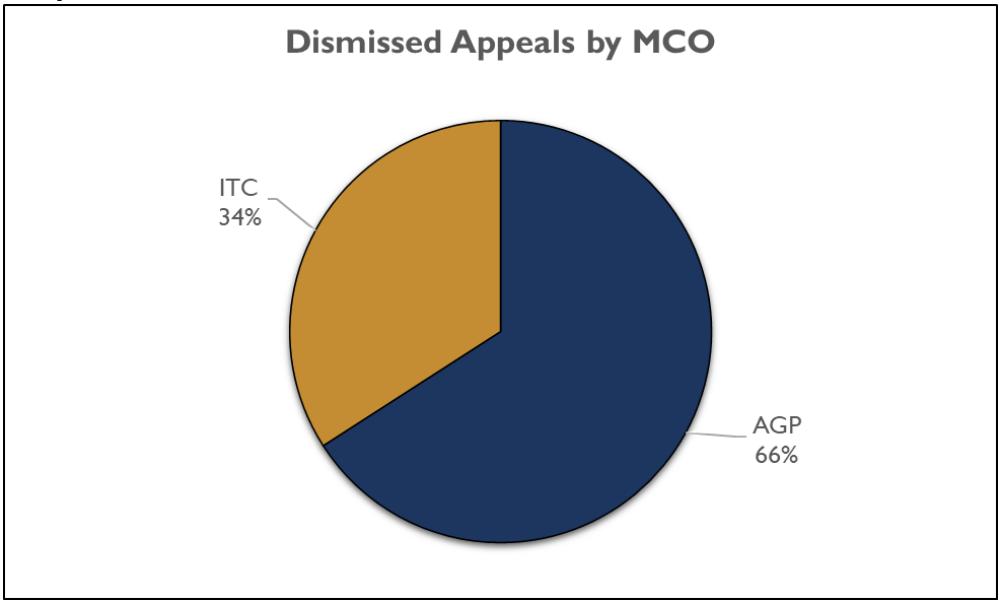
Further breakdown indicates the percentage of dismissed appeals as compared to the total number of appeals filed. AGP dismissed five percent and ITC dismissed three percent. In total, eight percent of the 560 appeals filed were dismissed.

Table 4

MCO	Number of Dismissals	Percent of Dismissals	Percent of Total Appeals
AGP	29	66%	5%
ITC	15	34%	3%
MHC	0	0%	0%
Total	44	100%	8%

Breakdown of dismissed appeals by MCO

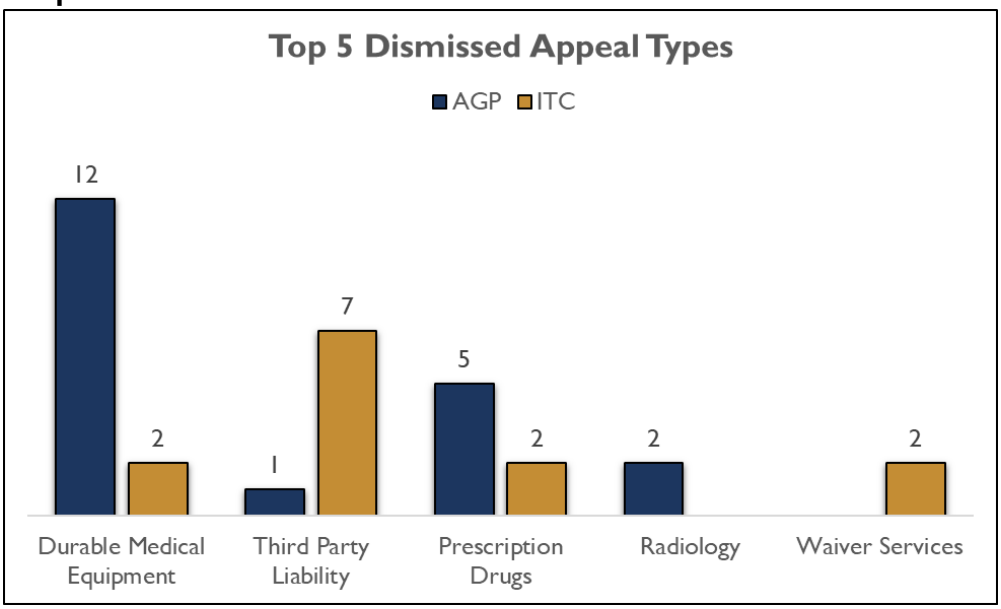
Graph 7



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.

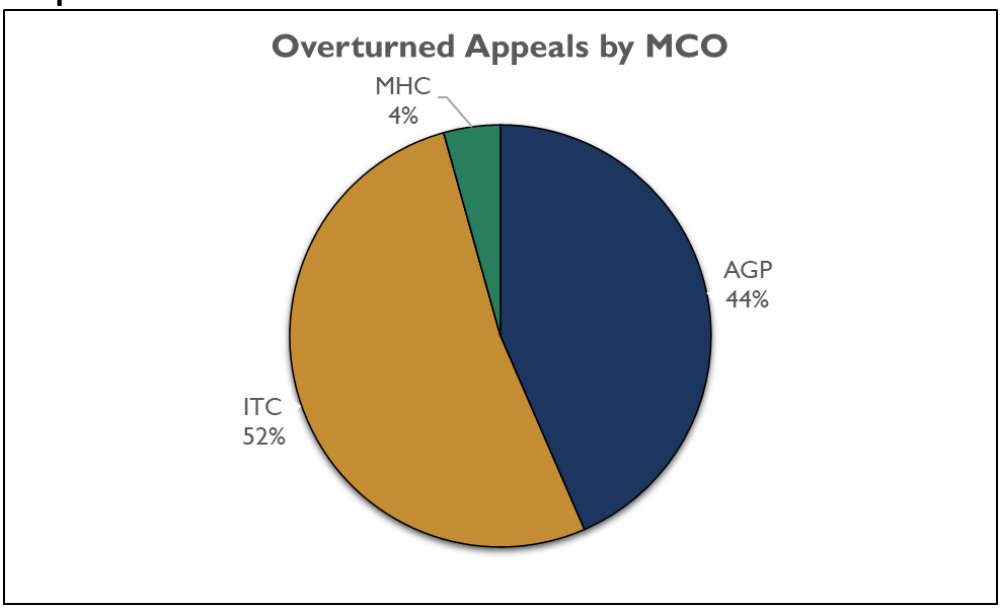
Table 5 and Graph 9 show that, of the 23 overturned appeals, ITC had the highest number at 52 percent. Further breakdown shows that of the 560 appeals filed, four percent were overturned.

Table 5

MCO	Number of Overturned	Percent of Overturned	Percent of Total Appeals
AGP	10	44%	1.8%
ITC	12	52%	2.1%
MHC	1	4%	0.2%
Total	23	100%	4.1%

Number of overturned appeals by MCO

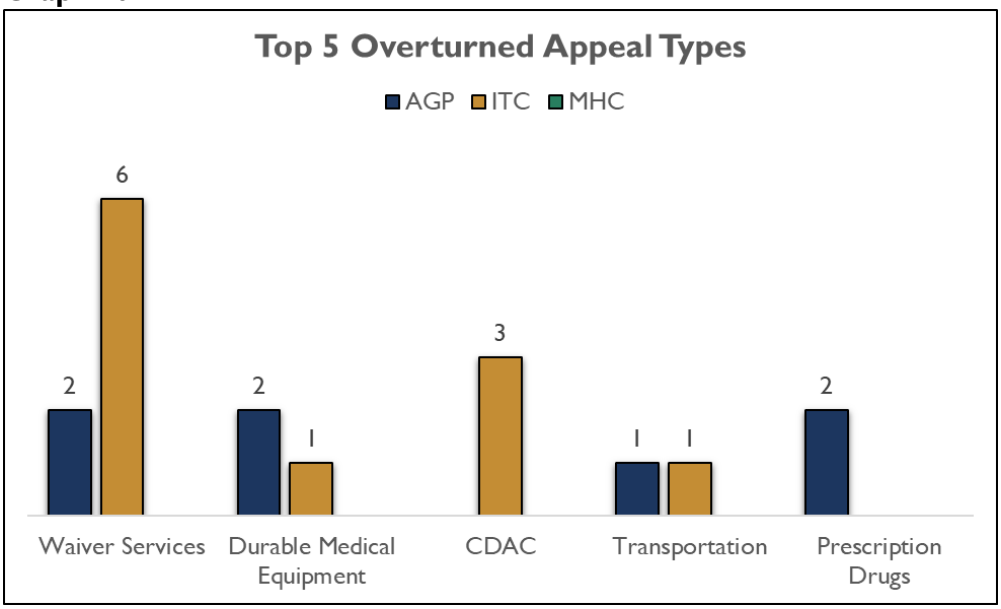
Graph 9



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 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 402 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.

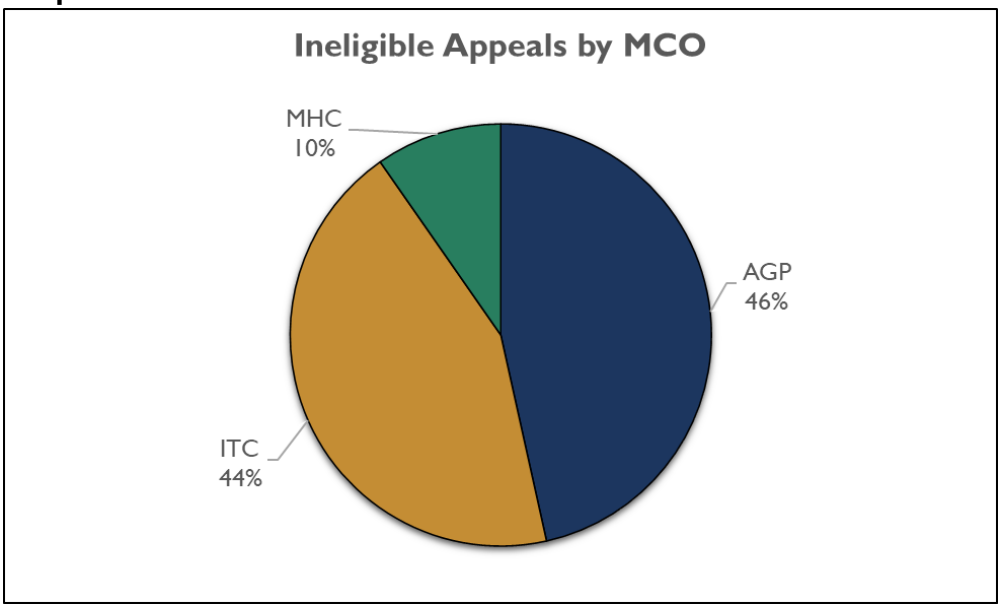
Table 6 and Graph 11 show the distribution of ineligible appeals by MCO. Of the 402 ineligible appeals, AGP had 47 percent, ITC had 43 percent and MHC had 10 percent. Of the total 560 appeals filed, AGP had 33 percent of their appeals deemed ineligible, ITC had 31 percent and MHC had 7 percent. In total, 71 percent of all MCO appeals filed for the reporting period were determined to not be appeal eligible.

Table 6

MCO	Number of Ineligible Appeals	Percent of Ineligible Appeals	Percent of Total Appeals
AGP	187	47%	33%
ITC	176	43%	31%
MHC	39	10%	7%
Total	402	100%	71%

Number of appeals determined to be ineligible

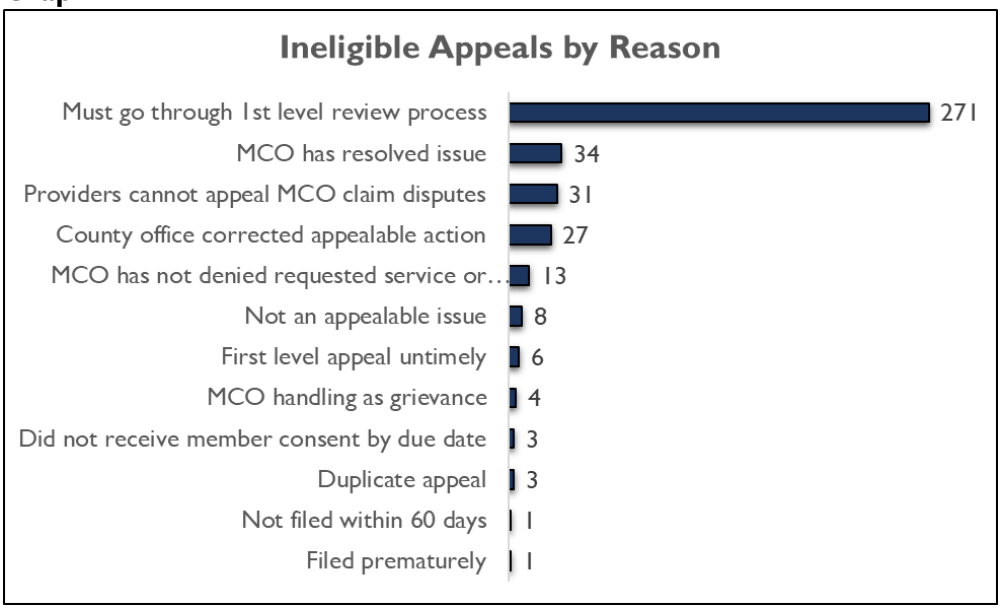
Graph 11



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.

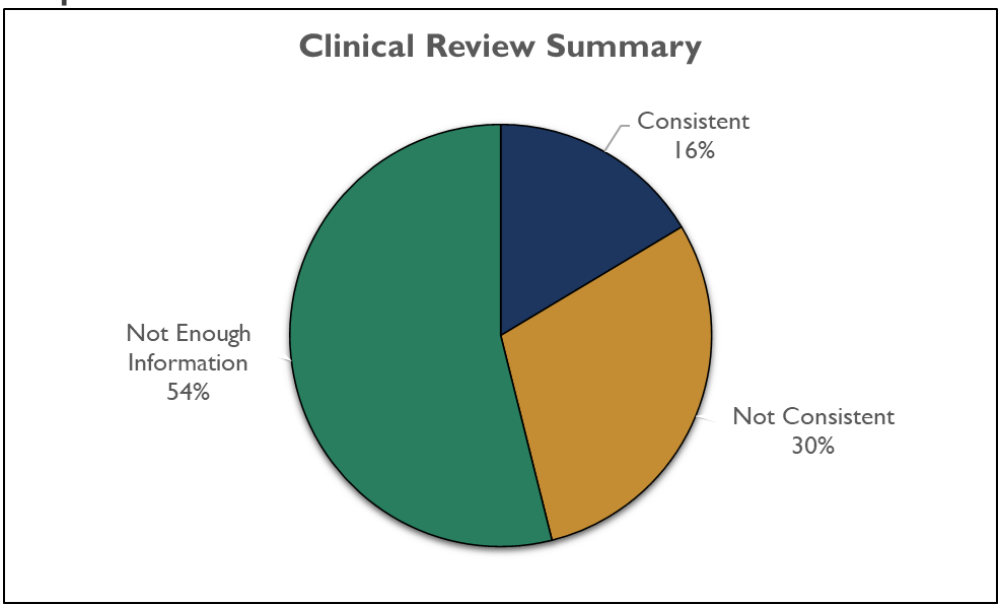
Table 7 and Graph 13 show the breakdown, by MCO, whether the original denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate that of the 128 reviewed, 16 percent of the time, the MCOs were consistent with state and federal criteria; 30 percent of the time, the MCOs were inconsistent with state and federal criteria; and 54 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	9%	27	21%	20	16%	58
ITC	10	8%	10	8%	49	38%	69
MHC	0	0%	1	1%	0	0%	1
Total	21	16%	38	30%	69	54%	128

Percentages are calculated using the total appeals reviewed (128: 61 Withdrawn, 44 Dismissed, 23 Overturned)

Graph 13



Clinical review outcome

PROGRESS REPORT

Listed below is an update on the improvement opportunities identified in the previous report (January 1, 2023 to June 30, 2023 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 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 continues to meet monthly and includes subject matter experts from the MCOs and Iowa Medicaid, including the QIO unit.

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 continues to review monthly appeals reports and has presented the findings to the MCOs.
- A tracking tool is used to monitor trends and perform analysis.

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 continues to monitor the first level appeal process trends for each 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. 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.
- 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 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 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 continues to be a focus as it was identified as an outlier for both dismissed and overturned appeals.
- Year over year comparison and trends of appeals data will be included in the next biannual report.

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
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
MHC	Molina Healthcare
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 of the requested item or service is found to be incorrect
SFH	State Fair Hearing heard before an ALJ
Withdrawn	The member or representative decided they no longer wished to pursue the appeal process prior to or at the appeal hearing