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NEWS RELEASE

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FOR RELEASE October 20, 2021

Auditor of State Rob Sand today released a report that shows the privatization of Medicaid in Iowa has resulted in a 500 to 890% increase in members being illegally denied services or care.

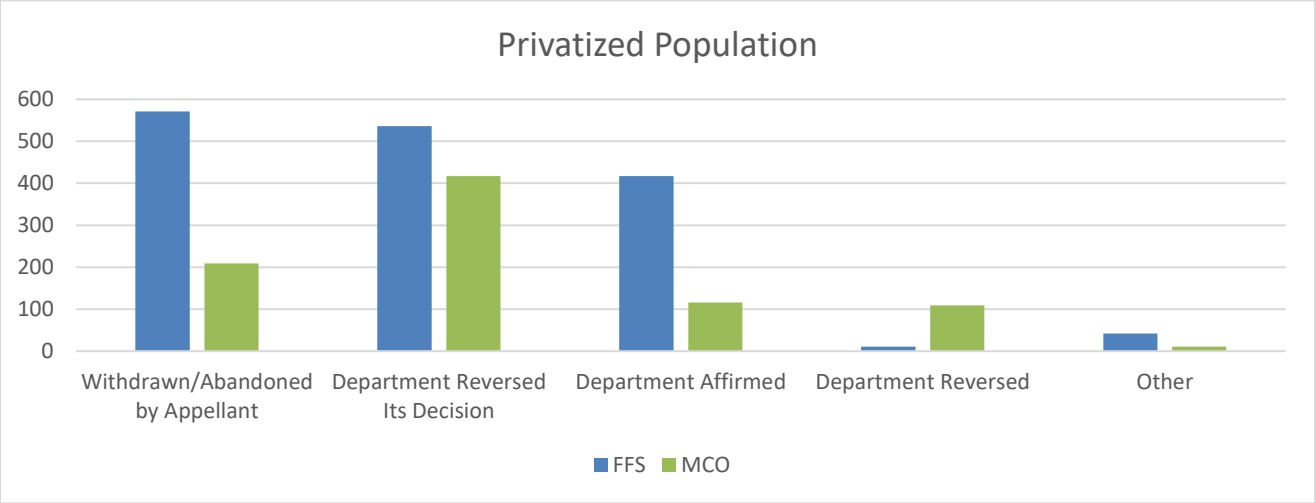
On April 1, 2016, Iowa transitioned Medicaid members from a fee-for-service system the Department of Human Services (DHS) administered to a managed care system called IA Health Link, which Managed Care Organizations (MCOs) administer in exchange for a fee. This is commonly referred to as "privatization."

Medicaid laws and rules set minimum standards for administering services to Medicaid members and ensuring appropriate resolution of disputes. Members can appeal a reduction and/or denial in service if they believe it was not appropriate, and an independent judge will rule in their case at a State Fair Hearing if the parties do not resolve it prior. Medicaid providers also have this process for payment disputes, but provider appeals are not a part of this review.

To determine whether Medicaid administration compliance had changed (and if so, how) under privatization, the results of State Fair Hearings ("appeals") were reviewed for a period of three years before privatization and three years after privatization.

A comparison of pre-privatization and post-privatization appeals shows the percentage of appeals where the judge agreed with the reduction and/or denial of services (ruling it legal and maintaining it) dropped by 72%, while the percentage of cases where the Court overturned a reduction and/or denial of services (ruling it illegal and re-instating the services) increased 890%. A Chi-square statistical test provides a less than 1% chance of seeing these change at random (p-value < 0.00001). If analysis from DHS's own review team is applied to this figure, it could be reduced to a 500% increase.

Appeal results within the privatized population changed as illustrated in the following chart:



The combination of the 72% decrease in affirmed appeals and 500-890% increase in reversed appeals for the period reviewed shows privatized Medicaid in Iowa is substantially less likely to follow the laws and regulations regarding providing care to members. The 45% overall drop in appeals cannot be said to be either positive or negative because the problem of denials being misclassified as grievances (which are not able to be appealed) is currently unmeasured, and MCO first-level reviews prior to hearings should logically reduce total appeals to judges regardless.

Sand also reported Amerigroup and Iowa Total Care (ITC) violated provisions of the contract established with DHS. Amerigroup failed to comply with one provision of the contract. ITC failed to comply with numerous provisions of the contract. For example, in multiple documented instances, MCO officials have claimed an inability to comply with the contract clause requiring Home and Community Based Services (HCBS) providers to continue providing services to a member until the member has been transitioned to a new HCBS provider. This has resulted in members going without services, such as bathing and wound care, thus violating the contract and state and federal law, while the MCO still receives payment for their care.

A copy of the report is available for review on the Auditor of State's web site at http://auditor.iowa.gov/reports/audit-reports/.

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REPORT ON A REVIEW OF MEDICAID MEMBER APPEALS AND MANAGED CARE ORGANIZATION CONTRACT COMPLIANCE

FOR THE PERIOD JULY 1, 2013 THROUGH AUGUST 31, 2019

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Auditor of State's Report

To the Governor, Members of the General Assembly,
the Director of the Department of Human Services
and the Director of the Iowa Medicaid Enterprise:

In conjunction with our audit of the financial statements of the State of Iowa and in accordance with Chapter 11 of the *Code of Iowa*, we reviewed Administrative Law Judge (ALJ) appeals pertaining to the Medicaid program administered by the Department of Human Services (DHS) under both the fee-for-service (FFS) method and managed care method carried out through contracts between DHS and Managed Care Organizations (MCOs). In addition, we compiled appeal outcomes as determined by ALJs in order to compare the decisions generated by the ALJs for appeals. The review covered the period July 1, 2013 through August 31, 2019. In conducting our review, we performed the following procedures:

(1) Obtained a population of appeals under subpoena related to Medicaid for the period July 1, 2013 through August 31, 2019 to determine if there were significant differences in the types or outcomes of appeals after a change to a risk-based managed care approach (MCO model) for the Medicaid program effective April 1, 2016.

(2) Created a searchable database and certain search criteria and parameters to perform analysis of over 31,000 appeal case file documents.

(3) Relied on search analysis results to determine appeal outcomes for a sample of cases, and verified the results to the actual appeal case files with 97% accuracy.

(4) Compared outcomes for the periods July 1, 2013 through June 30, 2016 and July 1, 2017 through August 31, 2019 to determine if there any key differences in appeal outcomes between the periods.

(5) Compared documents and information provided by Medicaid members who contacted our Office to information from MCOs and MCO contracts to determine compliance with contract requirements.

(6) Requested and received under subpoena supporting documents from the MCOs for selected provisions of the MCO contracts to assess compliance by the MCOs with the requirements under these provisions.

The procedures described above do not constitute an audit of financial statements conducted in accordance with U.S. generally accepted auditing standards. Had we performed additional procedures; other matters might have come to our attention which would have been reported to you.

We would like to acknowledge the assistance extended to us by officials and personnel of the Department of Human Services, the Department of Inspection and Appeals, and Dr. Brian Kaskie of the University of Iowa during the course of our review.

Rob Sand
Auditor of State

July 26, 2021

Executive Summary

Prior to 2016, authorized Medicaid providers billed and were paid by the Iowa Department of Human Services (DHS) for services to Medicaid members. In a process commonly referred to as "privatization," DHS transitioned most Iowa Medicaid members on April 1, 2016 from fee-for-service to a Medicaid managed care system called IA Health Link, which is managed by managed care organizations (MCOs). Medicaid laws and rules set minimum standards for administering services to Medicaid members and ensuring appropriate resolution of disputes.

To discover whether Medicaid administration compliance had changed (and if so, how) under privatization, we reviewed three components affecting the MCOs' administration of Medicaid member health services. These three components are: (1) State fair hearings and the Medicaid appeals process arising from DHS and/or MCO actions; (2) case studies of Medicaid members incurring negative conditions; and (3) testing of MCO compliance with selected provisions of their contracts with DHS.

The report on the review performed includes a detailed explanation of each finding; however, an overview of the findings is provided in this Executive Summary.

Changes in Appeals Outcomes after Privatization

DHS officials provided documents related to the full population of 5,074 non-eligibility appeals from Medicaid service reductions or denials for the period July 1, 2013 through August 31, 2019. The 5,074 appeal cases were analyzed and categorized. Observed totals of FFS and MCO appeal results from both before and after privatization were used to calculate the expected totals of appeal results from the population that underwent privatization. Those expected totals were then compared to actual totals after privatization.

The total number of appeals in the privatized population dropped by 45% after privatization. It was expected a decrease should have been seen in the number of appeals because of the grievance and first level review processes required by MCOs. Because of the issue of denials being misclassified as grievances (which are not appealable) and first level reviews is not measured, we are presently unable to determine whether the overall reduction in appeals is a good, bad, or a mixed outcome. However, looking at proportional outcome figures within the larger figures can provide a clearer picture. Seeing a denial affirmed is always a good result, because it means a legally correct decision was made. Unfortunately, denial affirmations dropped by 72%, statistically significant in its difference from the overall 45% reduction in appeals. Conversely, seeing a denial overturned is always a bad result, because it means a legally incorrect decision was made, which also negatively impacted the health care a member received. Unfortunately, denial overturnings increased by 890%, showing privatization has substantially increased the number of illegal denials of care in Iowa. The combination of these two measurements shows privatized Medicaid in Iowa for the period reviewed is less likely to treat members according to the law than the pre-privatization system.

Grievances and First Level Reviews

Our review identified numerous instances of issues that were appeals that should have been brought to an ALJ for review, but instead were misclassified as grievances and first level reviews. One member who experienced this repeatedly related to the care of his severely disabled daughter while under the care of United Healthcare Plan has seen an improvement now under the care of Amerigroup. The scale of this issue was not a subject of this engagement.

Medicaid Member Case Studies

Information regarding certain Medicaid members within the scope of MCO contract compliance is included in this report. The information for these members is summarized in the report as an example of noncompliance with various contract requirements, as a way to illustrate to the public what form these issues my take. Specifically, the examples illustrate Amerigroup did not comply

with its contract provisions regarding payment to an out-of-state provider claim for services. In addition, the report includes examples of members who did not receive consistent home health care after their providers provided notification of discontinuation of services, despite contract requirements with Iowa Total Care and Amerigroup which state, in art, "the transferring Participating Provider will continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider.

The information for the selected members also serve as an example of an instance of what should have been an appeal was misclassified as a grievance and first level reviews. While one of the members ultimately obtained resolution, it was only through repeated effort and going outside of the normal process for grievances and first level reviews.

MCO Contract Compliance

Amerigroup Iowa (Amerigroup) was one of the original MCOs contracted by DHS. Iowa Total Care (ITC) became a contractor effective July 1, 2019. The contracts between DHS and the MCOs contain many provisions such as the appeals system MCOs are required to maintain. In addition to our review of the appeals system, we selected certain contract provisions for review to determine the MCOs' compliance, including incurred but not yet paid data; Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services; medical loss ratios, annual reviews, and continuation of home and community-based services. The provisions we selected were the same for both MCOs and we received supporting documentation to assess compliance using information subpoenaed from Amerigroup and ITC. The results of our testing include both compliance and non-compliance.

Introduction

Medicaid Background

Title XIX of the Social Security Act is the legal basis for Medicaid. Medicaid is a state administered program which provides medical assistance to financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women who meet certain eligibility criteria. As part of the Social Security Act, each state establishes its own guidelines regarding eligibility and services.

At the federal level, the program is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services. In order to participate in Medicaid, the state legislature must appropriate funds and designate a state agency to administer the program.

The Medicaid program in Iowa is managed by the Iowa Department of Human Services (DHS). Medicaid pays for health care services for individuals with limited income and resources who meet Medicaid eligibility requirements. Section 249A.3 of the *Code of Iowa* states mandatory medical assistance shall be provided to individuals residing in the State of Iowa who meet eligibility requirements. Medicaid is funded by both the state and federal government and costs are shared.

Prior to 2016, providers who want to serve Medicaid eligible individuals applied to DHS through Medicaid's provider enrollment process. Providers who were determined to be licensed and in good standing were allowed to become an authorized Medicaid provider. After providing services to Medicaid members, authorized providers billed DHS for the services and were paid on a fee-for-service basis.

DHS released a Request for Proposal (RFP) for Medicaid Modernization (managed care) on February 16, 2015. The RFP requested bids from potential vendors as the State converted to a privately managed care approach (MCO model) for Iowa's Medicaid program. On August 17, 2015, DHS issued a notice of intent to award contracts to four Managed Care Organizations (MCOs) to administer the program. Specifically, the notice of intent identified the Amerigroup Iowa, AmeriHealth Caritas Iowa, United Healthcare Plan of the River Valley, and WellCare of Iowa. On December 18, 2015, the selection of WellCare of Iowa was terminated.

DHS intended to make the switch to managed care on January 1, 2016; however, CMS determined additional time was needed to make the transition. Based on available documentation, CMS indicated the state failed to meet certain implementation goals, such as MCO provider networks were not fully developed and lacked key providers. As a result, DHS transitioned most Iowa Medicaid members from a fee-for service to a Medicaid managed care system called IA Health Link on April 1, 2016.

AmeriHealth Caritas Iowa exited the managed care program in November 2017 which left two MCOs providing services. United Healthcare Plan of River Valley exited the managed care program in June 2019; however, DHS established a contract with the MCO Iowa Total Care – Centene which was effective July 1, 2019. As a result, services have been provided by two MCOs since November 2017.

As previously stated, prior to implementation of managed care, Medicaid services were primarily paid using a fee-for-service method. Under the fee-for-service method, health care providers were paid for each allowable covered service provided to a Medicaid beneficiary. Payments were made by DHS, Iowa Medicaid Enterprise (IME) after receipt of a claim from a provider. Under managed care, IME pays a monthly capitation payment to the MCO for each member enrolled in the plan. The MCO then pays providers for the allowable services provided to Medicaid beneficiaries. A capitation payment, similar to an insurance premium, is the payment made each month by the State to the MCO on behalf of each beneficiary enrolled in the plan, based on the actuarially determined capitation rate for the provision of services under the State plan.

Each MCO is licensed as a Health Maintenance Organization (HMO) through the State of Iowa and is required to comply with all rules applicable to HMOs. Under the MCO structure, DHS still retains control over eligibility determinations, sets policy, and determines level of care (LOC) for each individual deemed eligible under Medicaid. In addition, DHS still enrolls Medicaid providers; however, the providers must also enroll with the MCOs.

Eligibility determination is done by staff in the Department of Human Services local offices, by the Centralized Facility Eligibility Unit or, for certain groups, by staff of the Social Security Administration or by qualified providers. The Department has local offices throughout Iowa. Income maintenance workers are responsible for maintaining the Medicaid eligibility records for all members. Each member's eligibility information is entered into a centralized automated system.

To be eligible for Medicaid an individual must:

- Live in Iowa.
- Be a U.S. citizen or an alien who is in this country legally.
- Provide a Social Security number or proof that they have applied for one.
- Provide other information (such as financial and size of family).

Eligibility for Medicaid is based primarily on an individual's financial situation. The federal government requires states to provide coverage for:

- A child under the age of 21.
- A parent living with a child under the age of 18.
- A woman who is pregnant.
- A person who is elderly (age 65 or older).
- A person who is disabled according to Social Security standards.
- A woman in need of treatment for breast or cervical cancer.
- In addition, others may qualify:
    - Adults aged 19 to 64 with income up to and including 133% of the Federal Poverty Level.
    - If the individual's income is too high for Medicaid but their medical costs are so high that it uses up most of their income, they may qualify for some payment help through the Medically Needy plan.
    - If the individual's income is low and they have a hard time paying Medicare premiums, Medicaid may be able to help pay the premiums.
    - If individuals are between the ages of 12 to 54, Iowa's family planning program may be able to help with the cost of family planning related services.
    - Individuals 65 or older, blind, or disabled and have a special financial need not met by Social Security, may be eligible for an additional benefit through State Supplementary Assistance.

Medicaid Appeals Process

Federal regulations governing State medical assistance (Medicaid) programs are contained in Title 42 of the Code of Federal Regulations (CFR). As part of its administration of the Medicaid program, each State Agency is required to submit a comprehensive State Plan to CMS describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX, Title 42 CFR, and other applicable official issuances of CMS. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation in the State's Medicaid program.

In accordance with federal regulations, State Plans are required to provide Medicaid members with due process by providing for the opportunity for a fair hearing to any person whose claim for medical assistance is denied or not acted upon promptly, or who has incurred an action taken against them to suspend, terminate, or reduce Medicaid eligibility, or services provided under Medicaid. A State Agency must grant an opportunity for a hearing to any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, or issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness.

Because MCOs contract with DHS to provide Medicaid services, Title 42 CFR, Section 438.402 provides general requirements for the appeals systems that must be maintained by MCOs. Under federal regulations, MCOs must have at least one level of appeal for enrollees. At the MCO appeal level, if an MCO upholds its adverse benefit determination, the enrollee may request a fair hearing at the State level to appeal this MCO action.

As previously stated, DHS transitioned most Iowa Medicaid members from fee-for service to the managed care system on April 1, 2016. Currently, DHS has contracts with two MCOs serving these members under the managed care system: Amerigroup Iowa and Iowa Total Care. Contracts with these MCOs include provisions describing the appeal systems in place at the MCOs as required under federal regulations.

In Iowa, DHS has established an Appeals Section within the department to facilitate the adjudication of appeals filed by Medicaid members and to ensure persons affected by DHS decisions have access to due process of law. Any Medicaid member may file an appeal with the DHS Appeals Section which can be made in person, by telephone, or in writing. For MCO actions, a network provider or authorized representative may also file an appeal on behalf of a member if the member gives express written consent.

After an appeal is filed with DHS, the Appeals Section reviews each appeal to determine if a state fair hearing can be granted. Per DHS, each appeal must meet the following criteria:

- The Department has taken an action that can be appealed.
- The Department has issued a written notice about the negative action.
- The appeal was filed timely. Medicaid appeals must be filed within 90 days of written notice.
- For MCO appeals, the Appeals Section will also confirm that:
    - The first level review process through the managed care organization has been exhausted, and
    - The member has provided written authorization for the provider or representative to file an appeal on their behalf, if applicable.

If a member is eligible for a fair hearing, the Appeals Section will send the appeal file to the Department of Inspections and Appeals (DIA), Administrative Hearings Division where a hearing is scheduled. If the member is not eligible for a hearing, the Appeals Section will send a letter to the member explaining why the appeal was denied.

Department of Inspections and Appeals (DIA)

DIA is a multifaceted regulatory agency charged with protecting the health, safety, and well-being of Iowans. DIA is responsible for inspecting and licensing or certifying health care providers and suppliers, restaurants and grocery stores, social and charitable gambling operations, and hotels and motels. In addition, DIA staff investigate alleged fraud in Iowa's public assistance programs and conduct contested case hearings to settle disputes between Iowans and various State and local government agencies. Such case hearings and disputes include state fair hearings for Medicaid member appeals.

The Administrative Hearings Division is the office within DIA that handles the contested case hearings and other administrative proceedings for nearly all State agencies and some local government agencies. The division is authorized by the legislature in Iowa Code 10A.801, and is governed by the Iowa Administrative Procedures Act, Iowa Code chapter 17A, the division's administrative rules, and the relevant statutes and rules of the agency for which the division is conducting a particular contested case proceeding.

Administrative Law Judges (ALJs) within the Administrative Hearings Division have the responsibility to preside over telephone or in-person hearings, rule on motions or objections, decide cases fairly and impartially, and write proposed agency decisions. The majority of the division's cases are conducted for DHS and the Iowa Department of Transportation.

After an ALJ has made a decision on a member's appeal, a "Proposed Decision" is issued. This Proposed Decision explains the issue of the appeal, provides a brief summary of the testimony given during the hearing, and states the ALJ's decision. Either the member or DHS can request a review of a Proposed Decision if one of the parties to the appeal disagrees with the decision by the ALJ. This request for review of the Proposed Decision must be filed with the DHS Appeals Section within 10 calendar days of the date of the Proposed Decision.

Once a decision has been reached on the review request, or if no request for review is filed, a Final Decision will be made and an explanation of the outcome of the review process will be provided. If a member disagrees with the Final Decision, the member may file a petition in District Court in the county where the member resides. This petition must be filed within 30 days of the date of the Final Decision.

Outside of appeals and the appeals process, there are other objection mechanisms that rest entirely within an MCO's discretion and does not reach an independent body for resolution. These are called grievances and first level reviews. The contracts define an "Appeal' as "a member's request for review of an action" and a grievance as "a written or verbal expression of dissatisfaction about any matter other than an action." An "action" is defined as the denial or limited authorization of a requested service; reduction, suspension or termination of a previously authorized service; denial of payment for a service; or failure to provide services in a timely manner. Our review raised concerns that issues that should be treated as appeals are regularly, if not systematically, misclassified as grievances or first level reviews. This means that the member never reaches an independent judge that can review the issue and determine the legal and appropriate resolution. Because appeals have to do with the provision of and payment for medical services, a resolution that restores cut services or requires payment has a negative financial impact on the MCO. When misclassified as a grievance, the cutting of services or refusal of payment for services cannot be reviewed and reversed. As a result, misclassifying appeals as grievances and first level reviews has a positive financial impact for the MCO. Because our review did not set out to measure the scale of this misclassification difference, we cannot currently quantify that impact.

Objectives, Scope, and Methodology

Objectives

Our review included three related components impacting the administration of Medicaid member health services by the MCOs. These three components are: (1) State fair hearings and the Medicaid appeals process arising from DHS and/or MCO actions; (2) Case studies of Medicaid members incurring negative conditions; and (3) testing of MCO compliance with selected provisions of their contracts with DHS.

Our review was conducted to:

- Determine how state fair hearing appeal outcomes under the MCO model for Medicaid compare to the appeal outcomes experienced under the fee-for-service (FFS) model.
- Provide examples of conditions experienced by Medicaid members in conjunction with the MCO contract environment when provisions of the contract are not followed, as a way to illustrate the impact and functioning of the state fair hearing process.
- Assess how MCOs have performed in meeting selected contract provisions.

Scope and Methodology

To conduct our review of State fair hearing appeal outcomes, we:

- Requested all state fair hearing appeal case files from DHS for the period July 1, 2013 through August 31, 2019.
- Uploaded the appeal case documents into searchable databases for two different time periods: one covering the period before and one covering after the Medicaid model changed on April 1, 2016.
- Applied analytical procedures to the searchable databases and determined appeal outcomes for the period of July 1, 2013 through June 30, 2016, and the period of July 1, 2016 through August 31, 2019. For example, although the MCOs initiated operation on April 1, 2016, we did not expect any of the appeals filed from April 1, 2016 through June 30, 2016 to be a result of a decision made by an MCO.
- Compared appeal outcomes for the two different time periods and analyzed any changes occurring from the fee-for-service model period to the MCO model time period.
- Consulted with Dr. Brian Kaskie, Associate Professor in the Health Management and Policy Department of the University of Iowa, regarding the analysis performed.

To conduct our review of Medicaid member case studies, we:

- Reviewed documents and records maintained by the MCOs for selected members to determine compliance with contract provisions.
- Reviewed information and documents from members who requested our review of their individual situations and circumstances while interacting with the MCOs in conjunction with administration of health care needs of the member.

To conduct our review of MCO contract compliance, we:

- Selected MCO contract clauses to determine MCO compliance with requirements under these provisions.
- Received information from the MCOs relevant to the selected contract clauses and assessed MCO compliance with the contract provisions based on analysis of the information provided by the MCOs.

Detailed summaries of all three of the above components is provided in the summary sections *State Fair Hearing Appeal Outcomes, Medicaid Member Case Study, and MCO Contract Compliance* below.

State Fair Hearing Appeal Outcomes

Searchable Database for Appeal Case Files

As previously stated, we requested all state fair hearing appeal case files from DHS for the period July 1, 2013 through August 31, 2019. Because of the high volume of information provided by DHS in response to our request, we uploaded the electronic appeal case file documents into a searchable database to perform analysis and determine the outcomes for the appeals. Each of the appeal case files and the documents contained within were identified by a DHS assigned case number. Contents of the case files varied from one appeal to the next and depended on the activity that occurred during the appeal process. For example, an appeal that was filed and scheduled for hearing with DIA, but later withdrawn by the member may have only one document, such as a withdrawal order, in the case file. Conversely, an appeal that was presented at a hearing before an ALJ may contain numerous documents in the case file to document the hearing activities and outcome.

As previously stated, two different time periods covering the period before and after the Medicaid model changed for most members from fee-for-service to the MCOs were reviewed and analyzed. After loading the case file documentation into the searchable database for each time period reviewed, we calculated the total number of documents and appeal case files that were provided by DHS in **Table 1**. As the **Table** illustrates, there were 31,288 total documents contained within 19,149 appeal case files.

Table 1

	Number of	
Period	**Appeals**	**Documents in Appeal Case Files**
07/01/13 - 06/30/16	10,959	18,120
07/01/16 - 08/31/19	8,190	13,168
Totals	19,149	31,288

Of the 19,149 appeals provided by DHS, 14,075 were a dispute regarding eligibility. Even though DHS established contracts with MCOs to provide services to Medicaid eligible individuals effective April 1, 2016, DHS retained the responsibility to determine an individual's eligibility for Medicaid services. Because MCOs did not determine eligibility, we separated the 14,075 appeals related to eligibility from the 5,074 appeals that were not related to eligibility using information provided by DHS. The eligibility appeals were segregated from the other appeals prior to performing our analysis of the appeal outcomes for both the "before" and "after" periods. However, for all appeals we performed analysis of the appeals' 31,288 total documents using the following process:

1. Determined available identifiable information in the document electronic filename. The filename for each document indicated the type and nature of the document. For example, a Proposed Decision that was issued by an ALJ contained "Proposed Decision" in the electronic filename and, thus, this description indicated the type and nature of the document.
2. Used the search function within a searchable database. Searches for key words or phrases allowed the database to compile all documents containing those words or phrases efficiently and without manual review of each document. For example, the word and phrase "department" and "is affirmed" was used as search parameters in order to efficiently and quickly identify and list all documents in the database that contained these terms. We applied over 30 different search parameters to the 31,288 documents in the database.

Because of this high volume of documentation, we relied on the database search function to identify the documents meeting each search parameter. The results of these searches were then used, along with the type and nature of each document determined from the electronic filenames, to determine the outcome of each appeal.

Because we relied on searchable database results to efficiently calculate appeal outcomes, we performed testing measures to ensure the appeal outcomes we determined through analysis were consistent with the actual outcomes in the appeal case file. The testing measures we performed were as follows:

- During our analysis of the results from the database searches, we judgmentally selected our determined outcomes and manually verified them to the appeal case file.
- On some occasions, our analysis of database searches did not identify an appeal outcome. In these instances, we determined the outcomes from manual review of the appeal case files.
- After we completed our analysis using the searchable database to determine appeal outcomes, we selected a sample of these outcomes and compared them to the appeal case file. We performed this operation separately for the period prior to and after July 1, 2016 and found our determination of appeal outcomes matched the appeal case file 96% and 98.7% of the time each time period.

Appeal Outcomes

Based on our analysis of the appeal documents, and the results of the database searches, our review identified the appeal outcomes listed in **Table 2** for the 5,074 appeal cases provided by DHS which were not related to eligibility.

Table 2

Appeal Outcome Category	Pre-Privatization	Post-Privatization	Total
Withdrawn by Appellant	650	475	1,125
Abandoned by Appellant	556	394	950
Subtotal	1,206	869	2,075
Department Reversed Its Decision	794	695	1,489
Department Affirmed	663	390	1,053
Department Reversed	139	231	370
Department Affirmed and Reversed	28	2	30
Department in Default	16	9	25
Dismissed Appeal	10	14	24
Remanded Appeal	-	7	7
Unable to Determine	-	1	1
Totals	2,856	2,218	5,074

As illustrated, we identified 10 categories of outcomes for the appeals based on our analysis of appeal documents. Descriptions of each outcome and how we categorized the appeals are summarized in the paragraphs below.

Withdrawn by Appellant – These appeals were withdrawn by the appellant before reaching a state fair hearing and categorized during our review as withdrawn by appellant. Appeal files that did not contain a reason for the withdrawal were included in this category. For some withdrawals, language was included with the appeal file stating the reason for the withdrawal was the department reversed its decision and the appellant wished to withdraw the appeal. In these instances, we classified the appeal outcome with the appeals categorized as department reversed its decision.

Abandoned by Appellant – These appeals were determined by the ALJ to be abandoned due to the appellant's failure to appear for the hearing. Our review found appeals that were abandoned by the appellant were typically dismissed by the ALJ or ruled as the department (DHS) was affirmed.

Although ruled as department was affirmed, we categorized such appeals as abandoned by the appellant in our review. According to language in ALJ decisions, an appeal that is determined by an ALJ to be abandoned by the appellant may be reopened if the appellant can demonstrate good cause for missing the hearing.

Department Reversed Its Decision – Our review found DHS would reverse its decision regarding an adverse decision under appeal and grant the relief, or benefit, requested by the appellant. Oftentimes DHS would request a dismissal of an appeal due to this change by the department. In these instances, we categorized the appeal outcome as department reversed its decision. Our review also found there were appeals where an appellant would request a withdrawal of an appeal due to the department reversing its decision. We categorized these such appellant initiated withdrawals with department reversed its decision outcomes as well.

Department Affirmed – Hearings where DHS was determined to be correct in its action under appeal by the appellant were found by ALJs to be affirmed and categorized as department affirmed during our review. As stated earlier, DHS was affirmed in some ALJ rulings when the appellant abandoned the hearing. However, we did not categorize those appellant abandonments as department affirmed.

Department Reversed – ALJs reversed department adverse actions taken against appellants when information at the hearings convinced the ALJs that DHS was incorrect. As such we categorized these appeals as department reversed during our review. As stated earlier, there were appeals where DHS failed to appear for hearings and ALJs found DHS to be in default due to abandonment. While ALJs often determined DHS was reversed in these instances, we did not categorize such rulings with department reversed.

Department Affirmed and Reversed - In these decisions, an ALJ ruled the department is both affirmed and reversed. Our review found such appeals usually involved more than one issue or adverse action under review with the ALJ ruling both in favor and against DHS.

Department in Default – There were ALJ decisions where default decisions were entered as a result of the DHS failing to appear for the hearing. Some of these were also considered to be abandoned appeals. When these type of appeal outcomes occurred, default decisions led the ALJs to reverse the adverse action of the department towards the appellant. While the adverse action was reversed, we categorized these abandonments, or failure to appear, events by DHS as the department in default.

Dismissed Appeal - During our review we determined there were appeals that were dismissed by an ALJ with no specific reason or decision in favor or either party. For these appeals, we categorized the outcome as a dismissed appeal.

Remanded Appeal - Our review of appeal case files revealed instances where the matter was remanded to a lower body for review and final outcome. We categorized such appeals as remanded appeals.

Unable to Determine – Appeal case files that did not contain enough information to determine an appeal outcome were categorized as unable to determine during our review.

Non-Eligibility Appeals

As illustrated by **Table 2**, DHS provided us 2,218 appeal cases from the post-privatization period which were not related to eligibility. To eliminate some of the "cross-over" effect of moving from the FFS model to the privatized model, such as FFS appeals that were unresolved at the time of the transition and appeals which occurred during the initial weeks of the conversion, we eliminated from our analysis all post-privatization appeals with decision dates from July 1, 2016 through December 31, 2016. Allowing for this temporal window provides a more reasonable basis for comparison of the number of appeals between the pre- and post-privatization periods. Once the

appeals with decision dates during this temporal window were eliminated from our analysis population, we were left with 1,904 non-eligibility appeals for the post-privatization period.

For the 1,904 non-eligibility appeal case files, DHS was able to identify the Medicaid payer type involved in each appeal. In this regard, we were able to determine whether the payer involved with each appeal was under FFS or an MCO. As previously stated, while most Medicaid members transitioned to the MCOs on April 1, 2016, some remained under FFS in terms of payer type for member benefits. The payer type information was available for appeals that occurred prior to and after July 1, 2016. The pre-privatization time period is 36 months and the post-privatization time period is 32 months. To account for the difference in time measured, we applied a differential of 36/32 = 1.125 to the post-privatization figures and rounded to the nearest whole number. **Table 3** summarizes the outcomes of the appeals for pre-privatization and post-privatization periods. In addition, **Table 3** summarizes the appeal outcome increases and/or decreases in FFS and MCO from the pre-privatization and post-privatization periods. This calculation assumes that the number of appeals would stay reasonably constant through both time periods, thus attributing any changes to privatization itself.

Table 3

	FFS			MCO			Change from Pre- to Post-Privatization	
Appeal Outcome	**Pre-P^**	**Post-P ^ (1.125)**	**Privatized Pop**	**Pre-P**	**Post-P ^ (1.125)**	**Privatized Pop**	**Raw Increase/ (Decrease)**	**Percentage Increase/ (Decrease)**
Appeal Withdrawn	590	259	**331**	60	204	**144**	(187)	(56.50%)
Appeal. Abandoned	549	309	**240**	7	72	**65**	(175)	(72.92%)
Subtotal	1,139	568	**571**	67	276	**209**	(362)	(63.40%)
Dept Reversed Itself	777	241	**536**	17	434	**417**	(119)	(22.20%)
ALJ Affirmed Dept	631	214	**417**	32	148	**116**	(301)	(72.18%)
ALJ Reversed Dept	**125**	**114**	**11**	**14**	**123**	**109**	**98**	**890.91%**
ALJ Mixed Result	24	-	24	4	2	**(2)**	(26)	(108.33%)
Dept Defaults	15	2	**13**	1	2	**1**	(12)	(92.13)
Dismissed Appeal	10	3	**7**	-	6	6	(1)	(14.29)
Remanded Appeal	-	1	(1)	-	6	6	7	(700.00%)
Unable to Determine	-	1	(1)	-	-	0	1	(100.00%)
Total Appeals by type and period	2,721	1,144	**1,577**	135	997	**862**	-715	-45.34%

^ - Payer type identified by DHS.

Pre-P = Pre-privatization

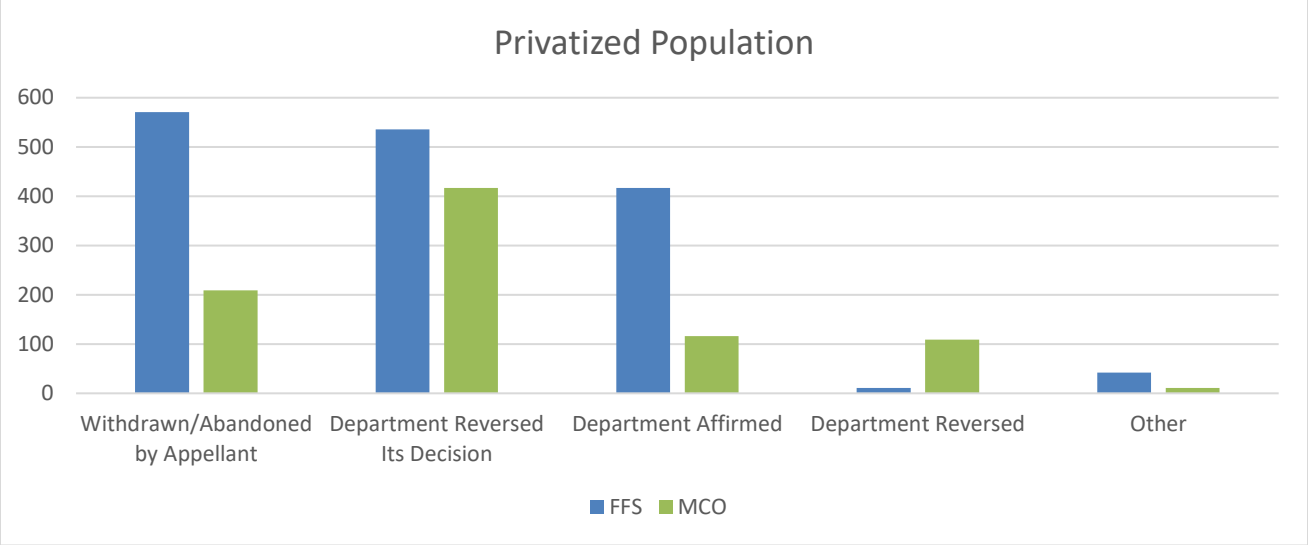
Post-P = Post-privatization

Privatized Pop = Population that was privatized as a result of the transitioning Medicaid member from fee-for-service to a Medicaid managed care system.

Using **Table 3**, we identified the population of Medicaid members who transitioned from FFS to MCO coverage from the pre-privatization and post-privatization periods. We identified the population who received services through an MCO during the pre-privatization period will continue receive services in that manner and the remaining individuals who received services through the MCO model during the post-privatization period.

In addition, using **Table 3**, we identified which appeal outcomes had significant changes due to privatization. **Chart 1** compares the approximate appeal outcomes for the Medicaid members who were transitioned from the FFS to MCO model to the approximate appeal outcomes for the privatized Medicaid members during the post-privatization period summarized in **Table 3**, if all other factors remained unchanged.

Chart 1



Grievances and First Level Reviews

Our review identified numerous instances of issues that were appeals that should have been brought to an ALJ for review, but instead were misclassified as grievances or first level reviews. One member who experienced this repeatedly related to the care of his severely disabled daughter while under the care of United Healthcare Plan has seen an improvement now under the care of Amerigroup. The scale of this issue was not a subject of this engagement.

Conclusions

The total number of appeals in the privatized population dropped by 45% after privatization. It was expected a decrease should have been seen in the number of appeals because of the grievance and first level review processes required by MCOs. Because of the issue of denials being misclassified as grievances (which are not appealable) and first level reviews is not measured, we are presently unable to determine whether the overall reduction in appeals is a good, bad, or a mixed outcome. However, looking at proportional outcome figures within the larger figures can provide a clearer picture. Seeing a denial affirmed is always a good result, because it means a legally correct decision was made. Unfortunately, denial affirmations dropped by 72%, statistically significant in its difference from the overall 45% reduction in appeals. Conversely, seeing a denial overturned is always a bad result, because it means a legally incorrect decision was made, which also negatively impacted the health care a member received. Unfortunately, denial overturnings increased by 890%, showing privatization has substantially increased the number of illegal denials of care in Iowa. The combination of these two measurements shows privatized Medicaid in Iowa for the period reviewed is less likely to treat members according to the law than the pre-privatization system.

A chi-square test of independence was performed to examine the relationship between privatization and the number of affirmed appeals compared to the total number of appeals. The relation between the variables was significant ($p < 0.00001$). A second chi-square test of independence was performed to examine the relationship between privatization and the quantity of appeal outcomes by category. The relation between the variables was significant, ($p < 0.00001$). In addition, we shared our analyses with University of Iowa Professor of Public Health Policy, Brian Kaskie who affirmed our approach in identifying these differences provided a valid indication that observed

differences in appeals before and then after the implementation of the Iowa Medicaid program were not driven by chance. In plain English, the differences in appeal outcomes after privatization compared to before privatization cannot be explained by randomness or chance. We suspect the differences may be related, in some part, to how Medicaid contractors internally manage the appeals process. However, at this time, we lack information needed to reach any more definitive conclusions.

Medicaid Member Case Studies

As previously stated, our objectives included a review of information, services, and Medicaid policies regarding medical care received by certain Medicaid members. The information regarding certain Medicaid members was within the scope of MCO contract compliance. The information for these members is summarized in the following paragraphs as an example of noncompliance and as an example of an instance of what should have been an appeal was misclassified as a grievance. While one of the members ultimately obtained resolution, it was only through repeated effort and going outside of the normal grievance process. These are not the only cases we learned of that dealt with these types of issues. To protect the individuals' privacy, we refer to them as "Members 1 through 4."

Member 1 - Member 1 received an emergency surgical procedure while in another state. The out of state surgeon performing the procedure submitted a paper claim to Amerigroup in the amount of $4,340.00 but received notification in a letter dated two and a half months later that the claim could not be processed because Amerigroup no longer accepted paper claims in this market. In a letter dated one month after that, the surgeon advised Member 1 he does not utilize electronic billing because it is too expensive. According to the surgeon's office, they contacted Amerigroup to attempt to resolve the outstanding claim but were not offered a solution by Amerigroup. The surgeon informed Member 1 the claim would be his responsibility if Amerigroup failed to pay the claim and recommended he attempt to contact with Amerigroup to resolve the claim.

Member 1's parent handled the matters pertaining to resolving the unpaid claim for the out-of-state surgeon. According to his parent, the following occurred on Member 1's behalf regarding attempts to get Amerigroup to pay the provider for the emergency surgical procedure:

- Member 1 filed a grievance with Amerigroup regarding the non-payment of the claim and received correspondence from Amerigroup stating the grievance was received three and a half months after the surgery and was being investigated by Amerigroup's claims support team.
- Member 1 corresponded with the surgeon regarding the status of the claim as follows:
    - Member 1 informed the surgeon of the filing of the grievance with Amerigroup the same day it was filed.
    - One month after filing the grievance, Member 1 informed the surgeon he was originally told by Amerigroup the grievance would take 7 to 10 days for a response. When Member 1 contacted Amerigroup after this 7 to 10-day period, he was informed by Amerigroup a response would actually take 30 days. Member 1 advised the surgeon in this letter that Amerigroup was contacted for a status update three days prior, only to be told the claim was still being investigated and no timeframe for a decision could be provided by Amerigroup.
    - Nearly six months after the surgery, Member 1 provided a status update to the surgeon stating he had contacted Amerigroup a number of times and still had no decision on the claim. Member 1 contacted DHS in attempt to receive assistance since 30 days for a decision had lapsed, but was referred back to Amerigroup.
    - Nearly seven months after the surgery, Member 1 provided another status update to the surgeon stating Amerigroup had contacted him and advised "out-of-state emergency claims" in general have been problematic and that Amerigroup is looking to fix the situation. Member 1 understood Amerigroup would contact the surgeon to resolve the outstanding claim.

- Just shy of a full year after the surgery, the surgeon advised Member 1 because it had been almost a year since the emergency procedure had been performed and with no receipt of payment from Amerigroup towards the $4,340.00 claim, the account was to become self-pay. The surgeon also informed Member 1 the account was subject to 1.5% monthly interest penalties and that some payment amount must be submitted by Member 1.
- Thirteen months after the surgery, Member 1 advised the surgeon he had contacted DHS to inform them Amerigroup is out of compliance with its contract with DHS for not paying out-of-state paper claims. Member 1 also submitted $100 to the surgeon due to the non-payment of the claim and in response to the surgeon's most recent letter.

In a letter over thirteen months after surgery, Amerigroup acknowledged a second grievance request by Member 1 a few weeks earlier and advised him the provider solutions department had been in contact with the out-of-state surgeon to set-up a mechanism to get the outstanding claim submitted to Amerigroup electronically. Amerigroup advised the claim would be paid within 30 days of the claim entering Amerigroup's billing system.

Amerigroup paid the claim to the out-of-state surgeon over fourteen months after surgery. According to Member 1's parent, Amerigroup did not reimburse Member 1 for the $100 payment towards the past due account balance. Documentation available for our review indicates the provider did not charge interest to the outstanding account.

We initially contacted Amerigroup about this issue on August 21, 2020, stating "please provide me with your initial rationales for refusing to make this payment, your decision to require the provider to submit their claim electronically, and an update as to whether or not the payment has been made and whether it included the amounts of interest."

According to Amerigroup officials, the paper claim was not the reason for the payment delay. Rather, payment was delayed on this claim because the out-of-state provider was not enrolled with the Iowa Medicaid program and Amerigroup's system is automatically set-up to reject claims from providers who are not enrolled. Consequently, the rejected claim was not subject to review by Amerigroup. However, we observed a rejected claim report dated September 9, 2019 sent by Amerigroup to the provider which states the claim was not paid due to "Reason 481 – Paper claims no longer accepted in this market."

Amerigroup Non-compliance with MCO Contract for Member 1 – Section 3.2.5 of DHS' contract with Amerigroup requires provision of emergency services without the need for prior authorization and specifies Amerigroup may not limit reimbursement to in-network providers. In addition, Amendment 9 to the contract, signed on July 3, 2019, requires Amerigroup to maintain a claims processing system for both in and out-of-network providers capable of processing all types of claims, including paper claims. Out-of-network provider is defined as any provider that is not directly or indirectly employed by or does not have a provider agreement with the MCO or any of its subcontractors pursuant to the contract between DHS and the MCO. The Amerigroup contract with DHS further states Amerigroup shall not require out-of-network providers to establish an Amerigroup-specific provider number in order to receive payment for claims submitted.

Based on our review of the documents and correspondence for Member 1, including correspondence from the out-of-state provider, Amerigroup did not comply with its contract provisions regarding payment to the out-of-state provider claim for services provided to Member 1. While Amerigroup eventually paid the out-of-state surgeon's claim, payment for the claim occurred almost one year after originally denied by Amerigroup. Furthermore, payment of the claim occurred after Member 1 filed 2 separate grievances and paid $100 towards the outstanding balance in an effort to avoid past due account charges. These circumstances and the unreasonable amount of time to pay this claim for Member 1 illustrates Amerigroup did not maintain a claims processing system for out-of-network providers capable of processing paper claims as required under its MCO contract.

As previously stated, Amerigroup required the provider to submit the claim paperless even though the provider previously submitted the claim via paper. Because Amerigroup made it harder for the provider to seek payment, the Member incurred additional cost.

Members 2 and 3 – On May 24, 2021, Member 2 received a 30-day notification from his HCBS provider notifying him they would no longer provide him with home health services, including skilled nursing and home health aid visits. Around June 1, 2021, Member 2's parent, who is a primary contact for communication purposes, had a discussion with Member 2's long term care coordinator. Member 2's parent reported during that discussion the coordinator suggested Member 2 might have to be placed in a nursing home because of the services he needed and the lack of providers available to assist with his needs. Member 2's parent told the long term care coordinator "a nursing home is not an appropriate placement" for her son. As of October 13, 2021, Member 2's long term care coordinator has been working to find a HCBS provider from which services can be obtained for Member 2's care. However, Member 2 remained without consistent, long term home health care in the interim.

Member 3 is a quadriplegic who has received ongoing services through Medicaid's Home and Community Based Services (HCBS) program while living alone at home. HCBS services are those that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for individuals with intellectual disabilities, or to delay or prevent placement in a nursing facility.

Services provided to Member 3 under HCBS included skilled nurse and aide care on a daily basis by a home health provider. Beginning in July 2019, Amerigroup became Member 3's MCO and according to Member 3, the covered skilled nursing care was reduced from 4 to 3 days per weeks thereafter by Amerigroup. In addition, Member 3 advised there were multiple occasions when scheduled services were not performed due to the home health agency's lack of staff.

In November 2020, Member 3's home health provider sent a notice of discharge to Member 3 and advised the provider would discontinue the skilled nurse and aide services on December 31, 2020. According to the home health agency, this discharge was due to an inability to continue to provide skilled nursing service at the requested frequency due to decreased staff. This action by the home health agency caused Member 3 to have to conduct a search for skilled caregivers in order to meet Member 3's healthcare needs.

Non-compliance with MCO Contract for Members 2 and 3 – Section 5.14.2 of DHS' contract with Iowa Total Care and Amerigroup states:

> "Regarding 6.1.2.2.2 State contract provision requirement, please note inclusion of this provision in section 24.2 of provider agreement – excerpt below: 24. HCBS Providers. If Participating Provider is a Home and Community-Based Services ("HCBS") provider, this Section applies. 24.2 Continuation of Services. In the event that a HCBS provider change is initiated for a Covered Person, regardless of any other provision in the Agreement, the transferring Participating Provider **will continue to provide** [emphasis added] services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by the Health Plan, or as otherwise directed by the Health Plan, which may exceed thirty (30) days from the date of notice to the Health Plan."

Based on correspondence and our review of documents regarding Members 2 and 3, Iowa Total Care and Amerigroup did not comply with its contract provisions regarding continuation of services until the members transitioned to new providers. Iowa Total Care and Amerigroup are obligated by their contracts to continue to provide care and have the ability to require members' HCBS providers continue to provide services until equivalent services are obtained from another provider.

Member 4 – We also identified a separate instance where a Member was denied a service because Amerigroup did not assist its Member with a procedural step for appealing denials. A Member must

appeal any decision regarding Medicaid within 90 days after notification of the action at issue. A member may verbally appeal a decision made by an MCO but is required to follow up with a written request. This information was included in the proposed decision provided to the Member who was denied service.

The proposed decision also stated Amerigroup received the written appeal within 90 days, accepted the appeal, and stated it would render a decision on the merits within 45 days. However, Amerigroup gave no indication that it was missing a document required from the Member and/or their provider to proceed until it dismissed the Member's appeal 5 days before the deadline. By the time the Member submitted the written requested information, it was deemed untimely by Amerigroup.

However, Amerigroup is legally required to provide its members reasonable assistance in taking the requisite procedural steps related to their appeal. Therefore, Amerigroup was obligated to clearly explain the documents it required of the Member and their provider to proceed and the timeframe in which they had to submit them.

As documented in the proposed decision, the Judge stated Amerigroup failed to notify the Member and provider that it was missing a written consent necessary to move forward with the appeal. Instead, Amerigroup waited until the appeal deadline was nearly closed before it informed them the appeal was dismissed for failure to comply with this procedural requirement. The Judge found Amerigroup's action particularly egregious because it had previously issued a letter to the Member and provider indicating the appeal had been accepted and would be considered. The Judge wrote that this was "a sort of 'gotcha' tactic employed by Amerigroup to avoid determining the underlying dispute on the merits, and [it] runs afoul of basic due process requirements."

MCO Contract Compliance

As previously stated, DHS currently has contracts with two MCOs serving Medicaid members under the managed care system that was initiated in Iowa beginning April 1, 2016. The contractor Amerigroup Iowa (Amerigroup) was one of the original MCOs contracted by DHS and the other MCO, Iowa Total Care (ITC), became a contractor effective July 1, 2019.

The contracts between DHS and the MCOs contain many provisions such as the previously discussed appeals system MCOs are required to maintain. In addition to our review of the appeals system, we selected certain contract provisions for review to determine the MCOs' compliance. The provisions we selected were the same for both MCOs and we received supporting documentation to assess compliance using information subpoenaed from Amerigroup and ITC.

On December 16, 2019, we issued subpoenas requesting supporting documentation for selected contract provisions. In a letter dated January 8, 2020, Amerigroup acknowledge the subpoena and advised it would respond with assembled documents. In addition, after reviewing information provided, clarification for certain provisions of the subpoena was requested by ITC on January 9, 2020 and provided by our office on January 15, 2020.

After we received the information under subpoena from each MCO, we assessed the documents provided to determine if clarification of the documents was needed or if more information was necessary from the MCOs to fulfill the subpoena response. We requested and received further information from Amerigroup after their initial records production and were advised by Amerigroup in a letter dated September 3, 2020 that all information in response to the subpoena had been produced completely and comprehensively as of that date. Because we requested selected contract provisions documentation directly from the MCOs to determine the MCOs compliance with contract provisions, we have not requested any supporting documentation from DHS.

The following summarizes the contract provisions we selected to review along with our assessment of the MCOs' compliance based on the information they provided to our office.

Incurred But Not Yet Paid Data – The MCO contracts require the contractors to have an information system with an ability to maintain data on incurred, but not yet reimbursed/paid claims. According to the MCO contracts, this category of claims is described as having been received by contractor, but not yet paid to the provider. Specifically, the contract clause 13.1.1.18 states,

> "Maintain data on incurred but not yet reimbursement claims."

Our subpoena requested the MCOs provide quarterly data regarding incurred but not yet paid claims. Specifically, our subpoena requested,

> "Incurred but Not Paid" (IBNP) claims, on a quarterly basis from when Amerigroup/ITC started in Iowa to the present (reference contract clause 13.1.1.8)

After review of information from each MCO, we determined both Amerigroup and ITC provided information in response to the subpoenas which included total quarterly amounts for incurred but not yet paid claims. Detailed supporting claims data was not provided. However, based on the information was provided, both MCOs appear to meet the requirements of this contract provision requiring an information system be in place with the ability to maintain data for incurred but not yet paid claims.

EPSDT Services – The MCO contracts require the contractors to ensure Early, Periodic Screening, Diagnosis and Treatment (EPSDT) services are provided and that outreach, monitoring, and evaluation strategies are implemented for EPSDT services. EPSDT services are benefits required under federal regulations for Medicaid members under the age of 21 years that expands coverage for children and adolescents beyond adult limits to ensure availability of (1) screening and diagnostic services to determine physical and mental deficiencies and (2) healthcare, treatment, and other measures to address any deficiencies or chronic conditions discovered. Specifically, the contract clause 3.2.7.2 states,

> "The Agency has the obligation of assuring the Federal government that EPSDT services are being provided as required. The Contractor shall ensure that all requested records, including medical and peer review records, shall be available for inspection by State or Federal personnel or their representatives. The Contractor shall record health screenings and examination related activities and shall report those findings in an Agency approved format at the Agency established frequency."

Our subpoena requested the MCOs' materials related to outreach, monitoring, and evaluation strategies for EPSDT. Specifically, our subpoena requested,

> "All materials related to outreach, monitoring, and evaluation strategies for EPSDT, as obligated under contract clause 3.2.7.2."

After review of information from each MCO, we determined the following:

- Amerigroup provided detailed information including policies and procedures for EPSDT services, outreach and guidance for providers, summary data demonstrating contact with members, and detailed member outreach mailings for EPSDT services. Based on review of the information provided, it appears Amerigroup is compliant with this provision of the contract.
- ITC provided outreach materials related to EPSDT services. However, no information regarding monitoring or evaluation was provided. From a complete review, it appears ITC has made no monitoring efforts, which is a violation of the contract at 3.2.7.2. In addition, it appears the State has never set required reporting deadlines, and ITC has never reported, which is also a violation of the contract.

Medical Loss Ratios – The MCO contracts require contractors to report certain information to DHS, including calculation methodologies regarding the contractor's Medical Loss Ratios (MLR). The MLR

is defined as the percentage of the DHS capitation payments to the MCO that is used to pay medical expenses of members. Specifically, the contract clause 2.7 states,

> "The Contractor shall maintain, at minimum, an annual Medical Loss Ratio (MLR) as set forth in Attachment 2.7 – Medical Loss Ratio. In the event the MLR falls below the established target, the Agency shall recoup excess capitation paid to the Contractor."

Our subpoena requested all MCO correspondence or communication with DHS regarding the MLR and its calculation. Specifically, our subpoena requested,

> "Any correspondence or communication with representatives of the State of Iowa regarding Medical Loss Ratio and its calculation."

After review of the information from each MCO, we determined the following:

- Amerigroup provided correspondence and communication documents, and additional information demonstrating how the MLR was calculated. Based on review of the information provided, it appears Amerigroup is compliant with this provision of the contract.
- ITC advised it had no records of correspondence or communication with DHS regarding the MLR. As a result, it appears ITC is not compliant with the contract provision.

Encounter Claim Reporting Requirements – The MCO contracts require DHS monitor encounter claims accuracy as well as MCO submission of encounter claims reports to DHS. Corrective action plans and non-compliance remedies are required when the MCO fails to comply with reporting requirements. An encounter claim is a record of medically-related services rendered by a provider to member on a specified date of service. Specifically, the contract clause 13.5.3.1 states,

> "The Contractor shall implement policies and procedures to ensure that encounter claims submissions are accurate. The Agency reserves the right to monitor encounter claims for accuracy against Contractor internal criteria as well as State and Federal requirements. The Agency will regularly monitor the Contractor's accuracy by reviewing the Contractor's compliance with its internal policies and procedures for accurate encounter claims submissions and by random sample audits of claims. The Agency will implement a quarterly Encounter Utilization Monitoring report and review process to be implemented in the first quarter following the contract effective date. The Contractor shall submit timely and accurate reports in the format and timeframe designated by the Agency. The Contractor shall investigate root cause of report inaccuracies and submit a revised report in the timeframe designated by the Agency. The Contractor shall fully comply with requirements of these audits and provide all requested Documentation, including, but not limited to, applicable medical records and prior authorizations. The Agency will require the Contractor to submit a corrective action plan and will require non-compliance remedies for Contractor failure to comply with accuracy of these reporting requirements."

Our subpoena requested any reports or audits regarding the MCOs' encounter data submission system whether or not provided to representatives of DHS. The subpoena also requested a record of whether or not each report or audit was provided to DHS representatives. Specifically, our subpoena requested,

> "Any reports or audits on MCO's Encounter Data submission system under contract clause 13.5.3.1, whether or not provided to representatives of the State of Iowa, but also including record of whether or not each report or audit was provided to representatives of the State of Iowa."

After review of the information from each MCO, we determined both Amerigroup and ITC provided information in response to the subpoena which included encounter data submission reports generated by the MCOs to ensure accuracy in encounter information. However, ITC specifically stated the reporting information was for internal purposes. They did not provide reports that were submitted to DHS for monitoring, as specified by the subpoena. As a result, we can conclude based on the information provided by ITC the MCO and DHS are not complying with the encounter data monitoring obligations.

Oversight Provision – The MCO contracts require ongoing monitoring of the MCOs by DHS to ensure proper oversight of MCO activities and measurement of MCO performance. The method and frequency of monitoring is at the discretion of DHS and may include, but not be limited to, both scheduled and unannounced onsite visits, review of policies and procedures, and performance reporting. Specifically, the contract clause 2.18 states,

> "The Agency will conduct ongoing monitoring of the Contractor, in accordance with 42 C.F.R. § 438.66, to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of the Agency and may include, but is not limited to, both scheduled and unannounced onsite visits, review of policies and procedures and performance reporting."

Our subpoena requested all MCO correspondence with DHS concerning ongoing monitoring activities of the MCOs. Specifically, our subpoena requested,

> "All correspondence with representatives of the State of Iowa referencing contract clause 2.18 from 2016 to present."

After review of the information from each MCO, we determined the following:

- Amerigroup provided documents and correspondence regarding DHS oversight including notification letters of noncompliance with measured standards, as well as corrective action plans. In some instances, liquidated damages were assessed for noncompliance. Based on information provided, DHS has engaged in ongoing monitoring of Amerigroup activities as required under the MCO contract.
- ITC provided information stating onsite visits and oversight meetings by DHS occurred, but no reports or monitoring information was provided. Based on this limited information provided, it appears ITC is not compliant with the contract provision requiring DHS ongoing monitoring.

Annual Reviews – The MCO contracts contain a provision stating DHS will use the results of its monitoring activities and other relevant data to assess the MCO's overall performance and compliance with the contract and will, at a minimum, conduct an annual review of this standard. Specifically, the contract clause 1.3.2.2 states,

> "The Contract Manager or designee will use the results of monitoring activities and other relevant data to assess the Contractor's overall performance and compliance with the Contract. At a minimum, the Agency will conduct a review annually; however, reviews may occur more frequently at the Agency's discretion. As part of the review(s), the Agency may require the Contractor to provide additional data, may perform on-site reviews, and may consider information from other sources. The Agency may require one or more meetings to discuss the outcome of a review. Meetings may be held in person. During the review meetings, the parties will discuss the deliverables that have been provided or are in process under this Contract, achievement of the performance measures, and any concerns identified through the Agency's contract monitoring activities."

Our subpoena requested the MCOs provide all written reports from DHS concerning annual reviews of overall contract performance and compliance. Specifically, our subpoena requested,

> "All written reports from representatives of the State of Iowa of annual reviews under contract clause 1.3.2.2."

After review of the subpoenaed information from each MCO, we determined both Amerigroup and ITC provided DHS contractor Health Services Advisory Group (HSAG) annual reports in which HSAG assessed such areas as quality and timeliness of, and access to, care and services provided by Amerigroup and ITC. Based on review of these documents, it appears Amerigroup and ITC have maintained the information necessary for DHS to perform the required annual reviews.

However, according to the HSAG Operational Readiness Review Summary report, HSAG identified 9 out of 174 elements, or 5%, were both incomplete and critical during their review of ITC's operational readiness. According to the HSAG report, elements identified as "incomplete – critical" indicated noncompliance and required ITC to correct the deficiency prior to commencing services. Despite the "incomplete – critical" elements identified, according to the HSAG report, DHS accepted ITC's remediation plan and DHS subsequently enrolled ITC as a MCO provider anyway.

Continuation of HCBS – The MCO contracts with DHS require that the MCO contracts with providers require that, in the event an HCBS (Home and Community-Base Services) provider change is initiated for a member, the transferring HCBS provider continues to provide services to the member in accordance with the member's plan of care until the member has been transitioned to a new provider, which may exceed 30 days from the date of notice to the contractor. As previously stated, HCBS services are those that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for individuals with intellectual disabilities, or to delay or prevent placement in a nursing facility. Specifically, the contract clause 5.14.2 states,

> "Regarding 6.1.2.2.2 State contract provision requirement, please note inclusion of this provision in section 24.2 of provider agreement – excerpt below: 24. HCBS Providers. If Participating Provider is a Home and Community-Based Services ("HCBS") provider, this Section applies. 24.2 Continuation of Services. In the event that a HCBS provider change is initiated for a Covered Person, regardless of any other provision in the Agreement, the transferring Participating Provider will continue to provide services to the Covered Person in accordance with the Covered Person's plan of care until the Covered Person has been transitioned to a new provider, as determined by the Health Plan, or as otherwise directed by the Health Plan, which may exceed thirty (30) days from the date of notice to the Health Plan."

Our subpoena requested the MCOs provide all external or internal memos, policies, practices, discussions, or other documentation regarding HCBS members transferring from one provider to another. Specifically, our subpoena requested,

> "All external or internal memos, policies, practices, discussions, or other documentation regarding contract clause 5.14.2 in the MCO's provider contracts, including discussions of circumstances to which 5.14.2 may or may not apply."

After review of the information from each MCO, we determined both Amerigroup and ITC provided language from provider and/or policies and procedures manuals stating its compliance with this contract provision. However, MCO officials have also expressed their inability to require HCBS providers to continue providing services to a member until the member has been transitioned to a new provider.

Since Medicaid encompasses different programs with different requirements such as individual's needs, we are unable to provide a specific recommendation that would apply to every member regarding the best way to ensure that services are continued to be provided without interruption. However, because the contract requires HCBS providers to continue providing services to a member until the member has been transitioned to a new provider, MCO's must ensure they identify ways to maintain required services for members. A simple suggestion is to increase pay for service

providers to ensure the work and in some cases the travel is sufficiently rewarded. Contract compliance—in this case, providing the required service to Medicaid members—is mandatory, and must legally be prioritized over financial costs for the MCOs.

Case Managers – The MCO contracts outline requirements for case managers and the work they perform for the MCOs in providing services to members who require case managers as part of their health care needs. According to §4.3 of the contract, requirements include general provisions for instructing and guiding case managers on their work and the obligations of the MCO in providing case management services.

Our subpoena requested the MCOs provide all training and instructional materials, including brochures, handbooks, policies, and any other record of document intended to instruct case managers on their work, as well as the MCOs' obligations regarding case management services. Specifically, our subpoena requested,

> All training and instructional materials, including brochures, handbooks, policies, and any other record or documentation intended to instruct case managers on (1) their work and (2) MCO's obligations, whether contractual or legal, as well as updates and/or amendments of the aforementioned.

After review of the information from each MCO, we determined both Amerigroup and ITC provided policies and procedures, training manuals, guidance, and other documents relative to instructing case managers on their work, as well as the MCOs' obligations to provide services to members requiring case management services. Based on the information provided, it appears Amerigroup and ITC are compliant with the contract provision.

Appeals Procedure – The MCO contracts require the contractors to maintain an internal appeals procedure for members in accordance with law. Specifically, §8.15 of the contract addresses grievance appeals and State Fair hearings. Applicable law includes federal regulations under the Code of Federal Regulations, as well as Iowa law under Chapter 17A. Chapter 17A is intended to provide a minimum procedural code for operation of all state agencies, including DHS, when they take action affecting the rights and duties of the public.

Our subpoena requested the MCOs provide documentation relating to administrative appeals pursuant to Iowa Code Chapter 17A from denials of care including, but not limited to, policies, procedures, internal memos, and any other record or document. Specifically, our subpoena requested,

> "Documentation relating to administrative appeals pursuant to Iowa Code Chapter 17A from denials of care, including but not limited to policies, procedures, internal memos, and any other record or documentation."

After review of the information from each MCO, we determined the following:

- Amerigroup provided policies and procedures relating to member appeals and listings of grievances, appeals, expedited appeals, and top reasons for appeals. Based on the information provided, it appears Amerigroup is compliant with the contract provision requiring an appeals system for members.
- ITC provided no documents, but ITC stated its MCO contract does not discuss Chapter 17A and that ITC has not had any administrative/benefit appeals at the time of production under the subpoena. While the contract with ITC does require procedures regarding internal appeals, we concur the contract does not specify Chapter 17A. In addition, ITC's contract with DHS became effective July 1, 2019 and ITC responded to the subpoena shortly after December 31, 2019. We are unable to verify ITC's response that they did not have any administrative/benefit at the time of production under the subpoena.

Emergency Room Services – According to §3.2.5 of the contract, the MCO contracts require emergency room services to be covered using a prudent layperson standard. In this regard, the MCOs are required to cover such services when the presenting symptoms at the time of visit are of a severity to constitute an emergency by a prudent layperson.

Our subpoena requested,

> "Any internal memos, policies, practices, discussions, or other documentation related to any reclassifications or other methods of changing to non-emergent services claims submitted by providers for emergent services."

After review of the information from each MCO, we determined the following:

- Amerigroup provided policies and procedures and DHS guidance regarding coverage for emergent and non-emergent care. Based on this information, it appears Amerigroup is compliant with this contract provision.
- ITC provided no documents but stated in response to the subpoena it pays all emergency service claims without changing them to non-emergent claims. Based on this information provided, we cannot determine whether ITC is compliant with this contract provision.

Timely Payment of Claims – The MCO contracts establish requirements for the timely payment of "clean claims" submitted by healthcare providers. A clean claim is defined as a claim in which all information required for processing is present on the claim, or request, for payment. Specifically, the contract clause 13.4.6 states,

> "The Contractor shall pay providers for covered medically necessary services rendered to the Contractor's members in accordance with Law. The Contractor shall pay or deny ninety percent (90%) of all clean claims with thirty (30) calendar days of receipt, ninety-five percent (95%) of all clen claims within forty-five (45) calendar days of receipt and ninety-nine percent (99%) of all claims within ninety (90) calendar days of receipt. A "clean claim" is one in which all information required for processing is present."

Our subpoena requested the MCOs provide any internal memos, policies, practices, discussions, or other documentation related to the definition of a clean claim, as well as all materials showing payment date monitoring by the MCOs. Specifically, our subpoena requested,

> "Any internal memos, policies, practices, discussions or other documentation related to the definition of a "clean claim" under contract clause 13.4.6, as well as all materials showing payment date monitoring, as measured by the difference between the date stamp on a claim and the date of payment, as well as all materials discussing any differences between the date on a check and the date it is sent to its payee."

After review of the information from each MCO, we determined the following:

- Amerigroup provided policies and procedures concerning processing of clean claims, as well as correspondence and relevant provider manual sections used to inform providers of claims processing requirements. Amerigroup also provided information supporting monitoring activities of Amerigroup with its contracted timely payment parameters for clean claims. Based on this information, it appears Amerigroup is compliant with this contract provision.
- ITC provided policies and procedures and email discussions concerning processing of clean claims. ITC included information demonstrating its monitoring of clean claims payment parameter requirements under its contract. Based on this information, it appears ITC is compliant with this contract provision.

Neither Amerigroup nor ITC provided information regarding payment date monitoring. However, such information is not required under the MCO contracts. As previously stated, a clean claim is defined as a claim in which all information required for processing is present on the claim, or request, for payment. Based on testing in previous engagements, claims are submitted in batches and during review of those batches, if a problem is identified with one claim, the whole batch is sent back for corrections and reprocessed. This is inefficient for medical providers and creates additional costs.

Quality and Performance Standards – The MCO contracts contain contract compliance provisions as a means to ensure the MCOs deliver quality healthcare to members. To assess the MCOs, DHS monitors certain quality and performance standards and holds the MCOs accountable for being in compliance with the contract. In the event the MCOs fail to meet performance requirements or standards in the contract, DHS provides written notice of non-compliance to the MCOs and may require corrective actions or remedies such as liquidated damages.

Liquidated damages are assessed by DHS when the MCOs fail to meet specified performance or reporting requirements that are subject to liquidated damages. One such performance standard is timely claims processing which impacts payments to providers. Because it is impractical and difficult to ascertain actual damages for failure to meet such performance standards, payment of damages is based on pre-determined assessments for failure to meet performance standards. In support of the MCO contract provisions assessing damages for failure to pay claims in a timely manner, Iowa Administrative Code regulations also provided for interest to be paid by insurers, such as MCOs, who fail to pay clean claims within 30 days of receipt by the insurer. Specifically, Exhibit E of the contract states, in part,

> "In the event that the Contractor fails to meet performance requirements or reporting standards set forth in the Contract, or other standards set forth by the Agency, it is agreed that damages shall be sustained by the Agency, and the Contractor shall pay to the Agency its actual or liquidated damages."

Our subpoena requested the MCOs provide quarterly totals of any interest, penalties, or other payments required or made due to any delay in paying provider claims. Specifically, our subpoena requested,

> "Quarterly totals of any interest, penalties or other payments required or made due to any delay in paying provider claims."

After review of the information from each MCO, we determined the following:

- Amerigroup provided a listing of eight providers to which Amerigroup made payments due to its failure to pay claims in a timely manner. Based on the information provided, it appears Amerigroup is compliant with this contract provision and has remitted payments to a low number of providers when payments were not timely.
- ITC provided a statement that ITC has not paid any interest, penalties, or other payments due to delay in paying providers.

Value-Based Purchasing – According to §6.1.2 of the MCO contracts, Amerigroup and ITC are required to have 40% of their member populations in a value-based purchasing (VBP) arrangement with the healthcare delivery system by a pre-assigned date. For Amerigroup, this date was calendar year 2018 and for ITC, this date was the end of state fiscal year 2020 (June 30, 2020). In a value-based purchasing arrangement, improved provider performance is linked to provider payment. This form of payment holds healthcare providers accountable for both the cost and quality of care they provide. A value-based model also attempts to reduce inappropriate care and identify and reward the best performing providers.

Our subpoena requested the MCOs provide quarterly records showing the percentage of their total assigned population that is in a VBP arrangement with a healthcare delivery system. Specifically, our subpoena requested,

> "Records showing percentage of MCO's total assigned population that is in a value-based purchasing (VBP) arrangement with the healthcare delivery system, by quarter since 2016."

After review of the information from each MCO, we determined the following:

- Amerigroup provided quarterly provider incentive information to show the percentage of its members in a VBP agreement. According to the information provided by Amerigroup, it met the 40% requirement during the first quarter of 2019, or after the calendar year 2018 requirement in its MCO contract. Based on the information provided, Amerigroup appeared to meet the 40% requirement throughout 2019 and, as a result, it appears Amerigroup was compliant with this provision of the MCO contract.
- ITC provided information stating ITC did not currently have a VBP arrangement and, therefore, no documents were provided. This is a violation of the contract.

Utilization Management – The MCO contracts contain provisions addressing utilization management at both Amerigroup and ITC. Utilization management is defined as the process of managing costs and use of services through effective planning and decision-making to assure that services provided are appropriate and cost effective and is comprised of the following elements: 1) deciding who will be served; 2) assessing service needs and identifying desired outcomes; 3) deciding what services to provide; 4) selecting service providers and determining costs; and 5) implementing, monitoring, changing, and terminating services. As part of their utilization management programs in the MCO contracts, the MCOs are required to have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the member's diagnosis, type of illness or condition. Specifically, the contract clause 11.1 states,

> "The Contractor shall have mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness or condition."

Our subpoena requested the MCOs provide descriptions of the mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition, as well as data and records demonstrating that such mechanisms are utilized and effective. Specifically, our subpoena requested,

> "Descriptions of "mechanisms in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition" as contemplated under contract clause 11.1, as well as data and records demonstrating that such mechanisms are utilized and effective."

After review of the information from each MCO, we determined the following:

- Amerigroup provided policies and procedures prohibiting denial of services based solely on diagnosis, type of illness, or condition. Amerigroup also provided policy describing requirements for appropriate medical directors or practitioners to review claims where medical determinations are necessary. Based on the overall information provided, it appears Amerigroup is compliant with this contract provision. However, no data or records demonstrating utilization or effectiveness were provided; as a result, Amerigroup has not complied with that portion of the contract.
- ITC provided assessment instruments for providers to use in managing members, as well as support for ITC's internal utilization management database. However, ITC did not provide any record of agency approvals or data and records showing their system is "utilized and effective." As a result, ITC is in violation of this contract provision.

Program Integrity – The MCO contracts require the MCOs to develop and implement a plan which is designed to detect fraud and abuse in the Medicaid program. As part of this implementation, the MCOs are required to provide monthly program integrity activity reports outlining the contractor's program integrity related activities for the previous calendar month. Included in the monthly reports are such items as the identification of progress in meeting program integrity goals and objectives, identification of the recoupment totals for the reporting period, state fiscal year-to-date summary information, and detailed information for providers under review by the MCO. Specifically, the contract clause 12.3.1 states,

> "In addition to any reporting required by the federal regulations, including 42 C.F.R §438.608(d)(3), the Contractor shall provide the Agency with a monthly Program Integrity Activity Report outlining the Contractor's program integrity activities for the previous calendar month."

Our subpoena requested the MCOs provide all monthly program integrity report as required under the contracts. Specifically, our subpoena requested,

> "All monthly Program Integrity Activity Reports under contract clause 12.3.1."

After review of the information from each MCO, we determined both Amerigroup and ITC provided monthly case tracking database information to include fraud, waste, and abuse activities for the period. Audit recovery, cost avoidance, and savings measures were also included in the reports. Based on the information provided, it appears Amerigroup and ITC are compliant with this contract provision.

Financial Records – The MCO contracts contain general service clauses pertaining to financial records to be maintained by the MCOs. According to the contracts, the MCOs shall maintain accurate, current, and complete records of financial activity which sufficiently and properly document and calculate all charges billed to DHS. Furthermore, the contracts require the MCO to permit the Auditor of State access to examine and audit MCO information relating to documentation or materials pertaining to the contract. Specifically, the contract clause 2.13.25.1 states,

> "The Contractor shall maintain accurate, current, and complete records of the financial activity of this Contract which sufficiently and properly document and calculate all charges billed to the Agency during the entire term of this Contract, which includes any extensions or renewals thereof, and for a period of at least ten (10) years following the date of final payment or completion of any required audit (whichever is later)."

Under the financial access to records requirement of the MCO contracts, our subpoena requested the MCOs provide totals, on a quarterly basis, of any interest, return on investment, or other growth of funds received from the State of Iowa, as well as the length of time in between receipt of the principal and receipt or crediting of any growth therefrom. Specifically, our subpoena requested,

> "Totals on a quarterly basis of any interest, return on investment, or other growth of funds received from the State of Iowa, as well as the length of time in between receipt of the principal and receipt or crediting of any growth therefrom."

After review of the information from each MCO, we determined both Amerigroup and ITC provided quarterly returns on investment related to the funds received from DHS under the MCO contracts. Neither MCO provided information concerning the length of time in between receipt of the principal and receipt or crediting of any growth from the funds received from DHS. ITC provided a statement that it invests all DHS funds immediately and, therefore, receipt or crediting of any growth therefrom is nil since all receipts are invested immediately and earnings credited daily or immediately upon maturity. Based on the information provided, it appears Amerigroup and ITC are compliant with this contract provision.

Other Item of Concern

Low Wages for Providers Potentially Increases Other Costs

Services provided to Medicaid members who receive long-term care under the HCBS program in order to remain living in their own home or community need varying levels of services which range from those provided by skilled nursing personnel to services provided by individuals with no healthcare experience. Providers of HCBS services range from those employed by home health agencies to individuals hired directly by Medicaid members using budgeted funds supplied under certain HCBS provisions. Such HCBS services include the Consumer Choices Option (CCO) and Consumer Directed Attendant Care (CDAC) programs where members have more control over how to choose their services and have help in their own homes.

During our review, we identified a concern regarding the funds available to members to pay providers under the HCBS program. As an example, we identified multiple quadriplegic members residing in their own homes and receiving a monthly budget under the CCO program to pay for assistance with activities of daily living in order to remain living at home. According to information we obtained, because of limitations in funding under Iowa Administrative Code 441-78, these members' monthly budget only allows the member to pay for individual assistance with activities of daily living at a rate that is less than $10 per hour after deductions. This wage does not compete with other employers in the area where the member resides and undermines the member's ability to hire and retain qualified caregivers on a long-term basis. This situation for this member existed as recently as January 2020.

In an Executive Order (EO) dated July 4, 2005, Governor Tom Vilsack addressed the provision of services under the HCBS program. In this EO, Governor Vilsack identified the rates of pay for caregivers providing care under HCBS are inadequate to attract and maintain quality staff and that the State intends to remedy this deficiency.

Based on our review of information from Medicaid members and the identified weakness with funding HCBS services as early as 2005 by Governor Vilsack, funds provided to some members to use as budgeted amounts to pay for individualized care continues to be inadequate which leads to difficulties obtaining appropriate services for some members. In addition, resolving this issue can reduce Medicaid costs in the long term. According to the MCO contracts with DHS, HCBS services are considered alternatives to long-term care institutional services in a nursing facility or an Intermediate Care Facility for individuals with intellectual disabilities, or to delay or prevent placement in a nursing facility. In addition to providing a home and community interaction for members and meeting the members' legal rights under the Americans with Disabilities Act (ADA) as laid out in the *Olmstead* decision, the cost to the Medicaid program to provide HCBS services to members in their own home is less than what Medicaid would spend for members residing in an institutionalized or nursing facility setting.

During our review, we identified an item of concern which supports the need for MCO contractors in Iowa to ensure members under HCBS services continue to receive such services and avoid institutional or nursing facilities that are at a greater cost to the Medicaid program. As an example, we identified a Medicaid member who is a quadriplegic receiving services under HCBS to include skilled nurse and aide care on a daily basis by a home health provider. This member resides at home and is employed full time.

In May 2019, the member was discharged by the home health agency that was providing the member's daily skilled and aide care. The discharging agency made this decision as it was unable to staff the ordered skilled and aide visits that were necessary for the member's needs. The MCO did not use its contractual obligation to require the continuation of services, and did not offer increased payments. As a result, in order to continue to reside at home and report to their place of employment, the member had to travel to a local hospital to receive the required daily care that used to be performed by the discharging home health agency staff. The member drove to the local

hospital on a daily basis for much of June 2019 until he found a new home health agency to provide the daily skilled and aide care in his home.

According to information obtained during our review, this member in our example received the necessary daily care at home under the HCBS program at a cost to the Medicaid program of $54.86 per day. When discharged by the home health agency in May 2019, the cost for this member to receive the same services at the local hospital he traveled to cost an average of $948.14 per day during from June 17, 2019 through July 5, 2019. The member received services at the hospital for nonconsecutive fourteen days at a total cost of $13,274.00. As he is a public employee, his employer's insurance paid $5,996.69 in additional costs. Had he no additional insurance beyond Medicaid, the MCO would have covered the cost. As illustrated in this example, the interruption in the HCBS services resulted in significant cost increases.

During our review of the circumstances with this Medicaid member's discharge, as well as the circumstances with other members facing similar discharges from home health providers, we reviewed applicable provisions of the MCO contracts with DHS. According to the MCO contract, in the event a change in provider occurs with a member receiving HCBS services, the MCO can require an existing healthcare provider to continue to provide services to a member during a transition phase to a new provider, which may exceed 30 days from the date of notice, until the member has been transitioned to the new provider. We contacted Amerigroup regarding its ability as an MCO to require that a discharging provider continue with services until a new provider is found for an HCBS member. Amerigroup acknowledged the ability to require specific performance by a provider to perform services, but Amerigroup stated it was "dealing with the art of the possible" and would not seek such a remedy with a provider when, (1) such performance is impossible because of provider capacity as that would only reduce the quality of care provided, or (2) where doing so would put a provider in an unsafe situation or a hostile working environment.

But they also do not consider as "possible" something that could fix both of those as well as additional issues that cause noncompliance: additional renumeration that results in legally required care levels being easier to provide while remaining less expensive than institutionalization. The current attitude towards these issues is that breaking the law is necessary. That is not acceptable. The current mixture of issues results in a reduction of services to HCBS recipients that is illegal and harmful to them and to taxpayers. It is likely best solved through an increase in pay to CDAC and CCO providers that makes their pay competitive yet still cheaper than institutionalization, combined with enforcement of the law and contract provisions that services be maintained.

DHS Response

On August 26, 2021, the DHS Medicaid Director, Elizabeth Matney, provided a written response which is included as **Appendix 1**. As illustrated by the **Appendix**, she responded to each of the topics discussed in previous sections of this report. Specifically, she expressed concerns regarding comparable groups for pre-privatization compared to post privatization and the number of reversed appeals. In addition, she identified reports DHS had prepared, called Review of State Fair Hearing Appeals (reports), which reviewed withdrawn, dismissed, or overturned appeals by the MCOs or ALJs.

We reviewed the reports, covering January 1, 2017 through June 30, 2020. The reports compared the number of appeals for overturned, withdrawn, and dismissed to the total number of appeals. The reports identified several opportunities for improvement which include collaborating with the MCOs to develop clear and consistent information to providers, collaborating with MCOs to engage in targeted outreach to providers, and collaborating with the MCOs on any trends identified. While the DHS reports reviewed certain aspects of appeals for the post-privatization period, our review compared appeals from the pre-privatization to the post-privatization period. As a result these reports are not duplicative nor contradictory of this report.

As illustrated by the **Appendix**, the response states, in part, "In short, we believe that much more information would be needed to substantiate that a higher number of 'reversed' administrative law

judge state fair hearing dispositions was caused by managed care." The suggestion that the fact that reversed appeals have increased 891% may not be *caused* by privatization neglects an important point: an 891% increase is too large to suggest the switch to privatization is merely a coincidence. The contention that "more complicated" cases does not make sense either, as the people who were Medicaid members before privatization, by and large, are the same that are Medicaid members after. The administrative process changed, not the people.

DHS also pointed out their team said in 67% of cases, there was not enough information in the file to determine if the denial was "inconsistent with state or federal criteria." But this misses the larger point: whatever the reason for a care denial, if it is overturned that means a member was denied care that they should have received. When measuring the quality of and access to care, that is what matters. Whether a member's care was denied due to a reduction in care that was actually care within state or federal criteria, or instead an MCO's procedural error, for example, is merely a detail.

It also misses that the very same report (Review of State Fair Hearing Appeals, issued in November 2019[1]) says that, in cases *with* enough information to make a determination, their QIO Team was more than twice as likely to disagree with the MCO's denial (22%) as they were to agree with it (10%). In other words, roughly two-thirds of determined cases were illegal denials. If we apply that sample to our increased in denials shown in our report, then privatization has caused an (891*66%) = 588% increase in illegal denials of care.

DHS' written responses also expressed willingness to review case information for specific members identified in our report. In addition, DHS stated they will review our conclusions regarding contract compliance and compare to their notices of noncompliance. This Office will continue to work on these issues with DHS.

[1] https://www.legis.iowa.gov/docs/publications/DF/1132395.pdf

Report on a Review of
Medicaid Member Appeals and Managed Care Organization
Contract Compliance

Staff

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Report on a Review of
Medicaid Member Appeals and
Managed Care Organization Contract Compliance

Department of Human Services' Response

Kim Reynolds, Governor Adam Gregg, Lt. Governor Kelly Garcia, Director

August 26, 2021

Dear Auditor Sand,

We are appreciative of the opportunity to review the findings of your team's report on the disposition of administrative law judge state fair hearings pre- and post- implementation of the IA Health Link program. The Department welcomes all eyes on the program and any opportunity for improvement.

Ensuring that Medicaid members receive accurate and timely determinations for services is a critical priority for our program and team members. That is why the Department tracks service denials, first level appeals, and administrative law judge determinations as closely as we track utilization. While we have not found systemic or intentional errors through this internal review, we certainly find opportunities for improvement on an individual basis and work diligently with the managed care organizations to follow up with additional trainings and remediation.

The Legislature has had a similar interest in receiving information on appeals which is why the Department submits bi-annual reports outlining the findings of reviews on all administrative law judge state fair hearings that are withdrawn, dismissed, or reversed. In this review process, we leverage the state's Quality Improvement Organization's seasoned clinical staff who are experienced with Medicaid programs and services to review the managed care organizations initial decision to deny and whether it was consistent or inconsistent with state and federal criteria. The Quality Improvement Organizations team consists of physicians, nurses, licensed social workers and other subject matter experts that can appropriately conduct the review. These reports can be found at the Reports Required to be Filed with General Assembly page of the Iowa Legislature website.

Regarding the draft report that your team shared, we have outlined comments below grouped consistent with the focus areas of the report. If you would like to have a follow up conversation related to these comments, this would be a welcome dialogue.

State Fair Hearing Appeal Outcomes

1. We are unclear on the exact methodology used to establish comparable groups and what appears to be a causal, rather than a correlational, conclusion.
    a. Because managed care organizations do have first level reviews, we would anticipate that this inherently creates skewed results in the pre- versus post- IA Health Link administrative law judge state fair hearing comparison groups.
    b. In short, we believe that much more information would be needed to substantiate that a higher number of "reversed" administrative law judge state fair hearing dispositions was caused by managed care. Rather, it could be indicative of a more complicated set of cases moving to administrative law judge for review, information being presented at the time of hearing that was not available during the managed care review and first level appeal, or any other number of circumstances.

1305 E. Walnut Street, Des Moines, IA 50319-0114

Report on a Review of
Medicaid Member Appeals and
Managed Care Organization Contract Compliance

Department of Human Services' Response

   c. While we do find in our own Review of State Fair Hearing Appeals, for a similar time period, that there are cases where we did not agree with the initial decisions of the managed care organizations, the team found that in sixty-seven percent (67%) of the reversals they could not find sufficient information to determine that the initial managed care decision was inconsistent with state or federal criteria.
2. Regarding the claim that there are a high number of instances where state fair hearings should have been allowed but, were instead, misclassified as grievances or first level appeals, we are requesting that information be shared with the Department so that we can look into it further and determine the merits of this statement such that appropriate action can be taken.

Member Case Studies

1. We would be happy to follow up in any review of case information where you have found that a managed care program was operating in a manner that is not compliant with the contract.
2. Regarding Member 2 and Member 3, we acknowledge that it is unacceptable when a provider discharges without notice or does not show up for scheduled services.
   a. The Department requires the managed care organizations to include involuntary discharge language in their provider contracts to avoid such circumstances.
   b. Managed care organizations are not a regulatory body but can terminate their contract with a provider that violates this provision.
   c. This, unfortunately, has occurred prior to the IA Health Link program regardless of language in provider contracts or agreements. Follow up is required with the regulatory entity that has oversight of that particular provider.

MCO Contract Compliance

1. The Department acknowledges that contract compliance is something that requires diligent oversight. We are reviewing all of the conclusions in your report to compare with notices of noncompliance and remedies issued for similar timeframes.
2. If your team would like to have a more in depth conversation about your findings related to contract compliance, please let me know and I would be happy to arrange.

If you would like to have further discussions regarding the focus area of your report and the Department's feedback, please let me know.

Sincerely,

Elizabeth Matney
Medicaid Director