Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AMERIGROUP IOWA'S PRIOR AUTHORIZATION AND APPEAL PROCESSES WERE EFFECTIVE, BUT IMPROVEMENTS CAN BE MADE

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

September 2023
A-07-22-07007

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

Office of Audit Services. OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. The audits examine the performance of HHS programs, funding recipients, and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations to reduce waste, abuse, and mismanagement.

Office of Evaluation and Inspections. OEI's national evaluations provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. To promote impact, OEI reports also provide practical recommendations for improving program operations.

Office of Investigations. OI's criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs and operations often lead to criminal convictions, administrative sanctions, and civil monetary penalties. OI's nationwide network of investigators collaborates with the Department of Justice and other Federal, State, and local law enforcement authorities. OI works with public health entities to minimize adverse patient impacts following enforcement operations. OI also provides security and protection for the Secretary and other senior HHS officials.

Office of Counsel to the Inspector General. OCIG provides legal advice to OIG on HHS programs and OIG's internal operations. The law office also imposes exclusions and civil monetary penalties, monitors Corporate Integrity Agreements, and represents HHS's interests in False Claims Act cases. In addition, OCIG publishes advisory opinions, compliance program guidance documents, fraud alerts, and other resources regarding compliance considerations, the anti-kickback statute, and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at https://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: September 2023
Report No. A-07-22-07007

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made

Why OIG Did This Audit

OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to people enrolled in Medicaid. The Senate Special Committee on Aging asked OIG to conduct a review of the Medicaid managed care organization (MCO) industry to determine whether MCOs are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight.

Our objective was to determine whether Amerigroup Iowa, Inc. (Amerigroup), complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, medical services that members had requested during 2018 and 2019.

How OIG Did This Audit

During 2018 and 2019, Amerigroup denied 12,910 of the 482,937 prior authorization requests it received. Our audit covered the 12,910 prior authorization denials, which included 2,572 denials that members or providers subsequently appealed. We selected and reviewed a judgmental sample of 50 prior authorization denials and 50 appeals of prior authorization denials to determine whether Amerigroup's processes complied with Federal and State requirements.

What OIG Found

Amerigroup complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, 80 of the 100 sampled prior authorization denials and appeals for medical services that members had requested during 2018 and 2019. However, it did not comply with Federal and State requirements when it denied the remaining 20 prior authorization requests and appeals that we sampled.

For 19 of the 20 sampled prior authorization denials and appeals that did not comply with Federal and State requirements, Amerigroup did not provide correct or any information to members regarding their State fair hearing rights. For the other 1 of the 20 sampled prior authorization denials and appeals that did not comply with requirements, Amerigroup was unable to locate or provide documentation to support a prior authorization denial.

Although Amerigroup denied only 3 percent of requested medical services during its prior authorization process, we noted that of the 2,572 prior authorization requests that Amerigroup denied in 2018 and 2019 and that were subsequently appealed, a total of 1,605 of those denials (62 percent) were overturned through Amerigroup's appeal process.

What OIG Recommends and Auditee Comments

We recommend that Amerigroup coordinate with Iowa to improve its prior authorization and appeal processes to ensure that members receive correct information regarding prior authorizations, the appeal process, and State fair hearing rights, procedures, and timeframes; and review and update its prior authorization process to improve communication with providers.

Amerigroup concurred with our recommendations and described actions that it had taken or planned to take. For our first recommendation, Amerigroup stated that it had implemented measures to provide correct information to members, and that it would add a dedicated workstream within its existing State contract amendment process. For our second recommendation, Amerigroup stated it offers an online portal to simplify information exchange and streamline the prior authorization and claims processes, as well as a program through which providers can allow Amerigroup direct access to their electronic medical record systems. Amerigroup also described steps it has taken to reduce the number of services that requires prior authorization.

The full report can be found at https://oig.hhs.gov/oas/reports/region7/72207007.asp.

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to people enrolled in Medicaid. Medicaid managed care organizations (MCOs) provide Medicaid enrollees with coverage for a variety of health care services through a network of contracted health care providers. Specifically, MCOs may cover medical (inpatient, outpatient, and laboratory), radiology, dental, and pharmacy services, which this report generally refers to as "medical services."

The Senate Special Committee on Aging asked OIG to conduct a review of the Medicaid MCO industry to determine whether these companies are meeting their obligations to serve children, older adults, and people with disabilities and their families. In addition, several articles have highlighted concerns related to the Medicaid managed care program and its oversight. Specifically, these articles identified concerns related to patient neglect because of MCO denials of requests for medically necessary services and lack of oversight by the Centers for Medicare & Medicaid Services (CMS).[1] This report is part of a series of OIG reports to examine Medicaid MCO denials.[2]

We selected Amerigroup Iowa, Inc. (Amerigroup), for this audit because it was the only MCO in continuous operation in Iowa during 2018 and 2019 (audit period).[3]

OBJECTIVE

Our objective was to determine whether Amerigroup complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, medical services that members had requested during 2018 and 2019.

---

[1] *Des Moines Register*, "Care Denied: How Iowa's Medicaid maze is trapping sick and elderly patients in endless appeals," Jan. 16, 2018; *Dallas Morning News*, "As patients suffer, companies rack up profits," Jun. 3, 2018; *Los Angeles Times*, "Coverage denied: Medicaid patients suffer as layers of private companies profit," Dec. 19, 2018; and the Pennsylvania Health Law Project, *Health Law News*, "Alert: Consumers Face Barriers Challenging Service Denials by Keystone First and AmeriHealth Caritas," Feb. 28, 2020.

[2] We have previously issued *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization* (A-03-20-00201), Dec. 20, 2022.

[3] The Iowa Medicaid program typically refers to its enrollees as "members." Therefore, beginning with our Objective just below, we will use "members" when focusing on Iowa's program and "enrollees" when speaking more generally about the Medicaid program.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

State Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid enrollees. States contract with MCOs to make services available to people enrolled in Medicaid. Under a risk-based managed care plan, State Medicaid agencies pay MCOs a capitation payment—a fixed amount per enrollee per month—for each enrollee. The State Medicaid agency makes the payment regardless of whether the enrollee receives services during the period covered by the payment.

The contractual risk-based arrangements between State Medicaid agencies and MCOs shift financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO. If an MCO spends more on covered services than it receives in capitation payments, the MCO absorbs the loss; if it spends less, it keeps the gain. This financial risk gives MCOs a potential incentive to limit what they pay their network providers, either by improperly denying beneficiaries' access to covered services, by constraining their payments to providers, or both.

The State Medicaid agency is responsible for monitoring its Medicaid managed care program. The State Medicaid agency's monitoring system must address all aspects of the managed care program, including the performance of each MCO's administration and management, appeal and grievance systems, and claims management (42 CFR §§ 438.66(a) and (b)). Each contract between a State agency and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary (42 CFR § 438.210(a)(3)(ii)).

Iowa's Medicaid Managed Care Program

Iowa Medicaid Enterprise (State agency) is the division of the Iowa Department of Human Services that administers the Iowa Medicaid program. Effective April 1, 2016, the State agency transitioned most Medicaid members in Iowa to a managed care program called Iowa Health Link. This program has been and continues to be administered by several MCOs, which provide members with comprehensive health care services, including physical health, behavioral health, and long-term services and supports.

The State agency has the additional responsibility of overseeing the operations of the managed care program to ensure that it is effectively and efficiently administered throughout the State. Performance monitoring and data analysis are critical components in assessing how well the managed care plans are maintaining and improving the quality of care delivered to members.

To help facilitate the State agency's monitoring efforts, on a quarterly basis MCOs report their monthly totals of prior authorization requests to the State agency. These reports include information on the adjudication of these requests as well as the reasons that the MCO modified, approved, or denied requests. The State agency randomly selects and reviews some of these prior authorization requests to verify that the prior authorization process was timely with respect to the standards identified in agreements between the MCOs and the State agency.

Amerigroup Iowa, Inc.

Amerigroup, located in West Des Moines, Iowa, has been providing Medicaid coverage in Iowa since 2016 and continues to serve the State agency and Medicaid members as an MCO. During 2019, Amerigroup served more than 384,000 Medicaid members in Iowa and received approximately $2.4 billion in net premiums from the State agency to cover these services.

Amerigroup provides general direction and support for its network providers and assists its providers in delivering covered services such as behavioral health services, hospitalizations, and physical therapy.

Amerigroup's Prior Authorization Process

To be covered by Amerigroup's Medicaid MCO plan, health care services must be medically necessary as defined in Amerigroup's *Pre-Certification Policy Manual* and the Iowa Health Link contract between the State agency and Amerigroup. Amerigroup's Iowa Health Link *Provider Manual* includes a list of covered services that may require prior authorization. Amerigroup's online provider portal allows providers to access a full list of covered services, procedure codes, prior authorization rules, and a prior authorization lookup tool. Services requiring prior authorization must be approved by Amerigroup before the services are rendered.

Amerigroup's Medicaid managed care prior authorization process begins when a member's primary care physician (PCP) or other health care provider submits to Amerigroup a prior authorization request with supporting documentation.

Amerigroup's clinicians (who are licensed nurses or other licensed professionals) use medical guidelines approved by the State agency to review prior authorization requests. If the Amerigroup clinician determines that a request has insufficient clinical support, the reviewing clinician reaches out to the relevant provider via phone or fax and asks that the information be submitted within the timeframe specified by either the health plan or State-specific contractual requirements. If Amerigroup does not receive the required information within the specified

timeframe after the initial request, then Amerigroup's procedures permit the clinician to make one additional request to the provider for the information. If the provider does not furnish the required information within the specified timeframe, the Amerigroup clinician reviews the prior authorization request on the basis of only the medical information provided and either sends the request to a medical director to determine medical necessity or denies the request for lack of information. In general, Amerigroup issues a prior authorization decision within 14 days of the request for standard prior authorization requests, and within 72 hours of the request for expedited prior authorization requests.[4]

In cases when Amerigroup approves a prior authorization request, it notifies the member, provider, or both, either electronically or in writing. However, if the Amerigroup clinician does not approve the request, an Amerigroup medical director reviews it. If the medical director also denies the request, Amerigroup sends a notice of adverse decision to the member and the provider explaining the reason for the denial along with information explaining rights to appeal the decision. For this report, we refer to Amerigroup denials of prior authorization requests as "prior authorization denials."

In cases when members or providers disagree with Amerigroup's prior authorization denial, they may file an appeal with Amerigroup.

Amerigroup's Appeal Process

Under the provisions of Amerigroup's third contract amendment[5] with the Iowa Department of Human Services, effective July 1, 2017 (hereafter referred to as "third contract amendment"), members may appeal prior authorization denials to the Amerigroup appeals department (called the Quality Management Appeals Department) within 60 calendar days from the date of the notice of adverse decision. Providers or their authorized representatives may appeal prior authorization denials to the same Amerigroup department, but only with the member's consent. After receiving the appeal and sending a letter of acknowledgement, Amerigroup's appeals department reviews the appeal and determines whether: the associated medical records are complete, the member gave his or her consent (if applicable), and the appeal should be processed on a standard or expedited basis.

When the appeal is based (at least in part) on medical necessity, the appeals department sends the appeal and associated medical records to a physician reviewer and, when appropriate, a medical director, both of whom are Amerigroup associates but were not part of the initial determination and are not a subordinate of any person involved in the initial determination. The medical director then makes the final decision on the appeal. An appeal must be resolved and notice provided to the member as expeditiously as the member's condition requires and

[4] The material in this paragraph is summarized from Amerigroup's *Policies and Procedures for Pre-Certification of Requested Services*.

[5] This amendment is at Amerigroup Managed Care Contract, https://hhs.iowa.gov/Managed_Care_Plan_Contracts.

within State-established timeframes (also specified in the third contract amendment) generally not to exceed 30 calendar days from the receipt of a standard appeal request or 72 hours from the receipt of an expedited appeal request.[6]

If Amerigroup's appeals department overturns a prior authorization denial, it notifies the member and provider in writing that the denial has been overturned.

If Amerigroup's appeals department determines to uphold a prior authorization denial, it notifies the member and provider in writing of this determination; this notification letter (appeal notice of decision) includes information on follow-on steps. For this report, we refer to Amerigroup appeals department decisions to uphold prior authorization denials as "appeal denials." After exhausting Amerigroup's appeal process, a member or provider may request a State fair hearing from the Iowa Department of Human Services's Appeals Section.

State Fair Hearing Process

When a member, managed care network provider, or authorized representative disagrees with an appeal denial rendered by Amerigroup, the member (or on behalf of the member if the member has given written consent, the provider or an authorized representative) may file a request for a State fair hearing. The case must first have been adjudicated through Amerigroup's appeal process, and as specified in the third contract amendment, the member, provider, or authorized representative must file the request for a State fair hearing within 120 calendar days from the date of the appeal notice of decision.

A member, provider, or authorized representative files a request for a State fair hearing with the Iowa Department of Human Services's Appeals Section. The Appeals Section obtains a copy of the appeal notice of decision from Amerigroup and reviews the request to ensure that it was filed in a timely manner and that (if applicable) the provider or representative obtained the member's consent. If all hearing requirements are met, the appeal file is forwarded to the Iowa Department of Inspection and Appeals for a State fair hearing to be scheduled.

During the State fair hearing, officials from the Department of Inspection and Appeals and the member, provider, or authorized representative give testimony and submit exhibits into evidence. An Administrative Law Judge conducts the hearing and issues a proposed decision. Parties to the State fair hearing have up to 10 days to submit an appeal to that proposed decision. After those submitted matters are received and considered, the Appeals Section, on behalf of the Administrative Law Judge, renders a Final Decision, which explains the rationale for the decision and outcome of the review process. If the Final Decision is to uphold the prior

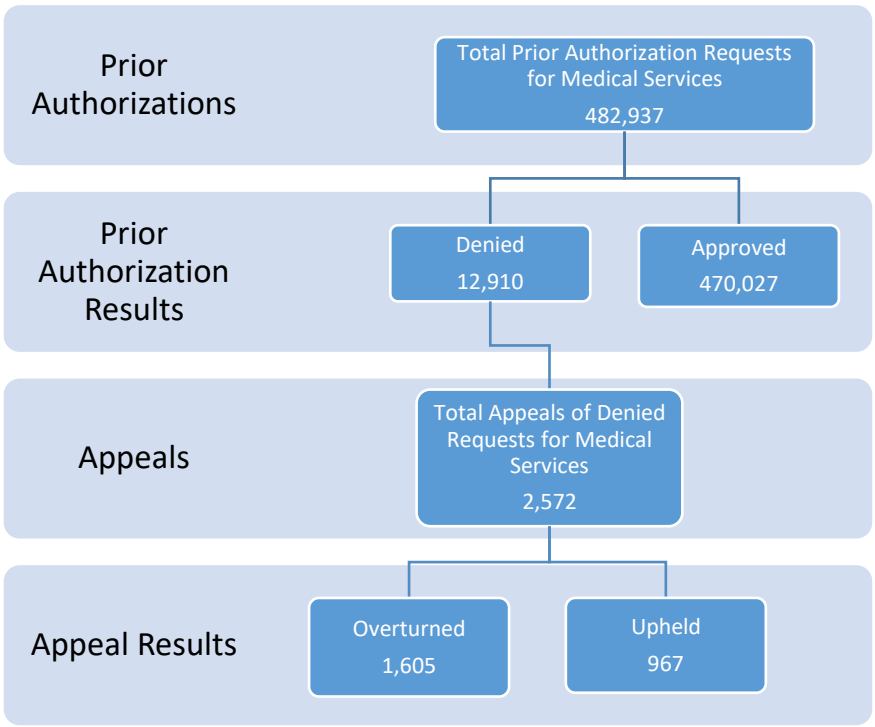
[6] As stated in Amerigroup's third contract amendment (effective July 1, 2017; footnote 5), "The Contractor may extend the timeframes . . . by up to 14 calendar days if— (1) the member requests the extension; or (2) The Contractor shows (to the satisfaction of the Agency, upon its request) that there is need for additional information and how the delay is in the member's interest" (Special Terms Appendix 1 – Scope of Work, section 8.15.4(c)). For this report, references to "Contractor" in State requirements and contractual language may be understood to be referring to Amerigroup.

authorization and appeal denials, the member may file a petition for redress in the member's County District Court.[7]

HOW WE CONDUCTED THIS AUDIT

During our audit period (January 1, 2018, through December 31, 2019), Amerigroup received a total of 482,937 prior authorization requests. Of these, Amerigroup approved 470,027 requests and denied 12,910 requests. Our audit covered the 12,910 prior authorization denials; this amount included 2,572 prior authorization requests that Amerigroup denied and that the members, providers, or authorized representatives subsequently appealed. Figure 1 depicts these data.

Figure 1: Amerigroup Prior Authorization and Appeal Results for 2018 and 2019



We selected and reviewed a judgmental sample of 100 prior authorization denials and appeals to determine whether Amerigroup's prior authorization and appeal processes complied with Federal and State requirements. Specifically, we selected for review 50 prior authorization denials (from the 12,910 total denials), as well as 50 appeals of prior authorization denials

[7] The material in this paragraph is summarized from the State of Iowa, Department of Health and Human Services, website. Available online at Appeal a HHS Decision | Iowa Department of Health and Human Services. Accessed on Jul. 6, 2023.

(from the 2,572 total). We reviewed all of these prior authorization denials and appeals to determine whether Amerigroup's processes complied with Federal and State requirements.[8]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology and Appendix B contains Federal and State requirements pertaining to prior authorizations for Medicaid managed care services.

FINDINGS

Amerigroup complied with Federal and State requirements when it denied, through its prior authorization and appeal processes, 80 of the 100 sampled prior authorization denials and appeals for medical services that members had requested during 2018 and 2019. However, it did not comply with Federal and State requirements when it denied the remaining 20 prior authorization requests and appeals that we sampled. We also determined that of the 2,572 prior authorization requests that Amerigroup denied in 2018 and 2019 and that were subsequently appealed, a total of 1,605 of those denials (62 percent) were overturned on appeal, as depicted in Figure 1.

For 19 of the 20 sampled prior authorization denials and appeals that did not comply with Federal and State requirements, Amerigroup did not provide correct or any information to members regarding their State fair hearing rights. Specifically, for 16 of these prior authorization denials and appeals, Amerigroup specified an incorrect timeframe for a member who had been denied medical services to file a request for a State fair hearing. In these cases, the notice of adverse decision or appeal notice of decision stated that a member who had been denied medical services had 90 days to file a request for a State fair hearing, when in fact the member had 120 days to file that request.[9] In addition, for 2 of these 19 prior authorization denials and appeals, the appeal notice of decision did not mention the member's right to request a State fair hearing. Also, for the remaining 1 of these 19 prior authorization denials and appeals, Amerigroup did not furnish the appeal notice of decision to the member who had appealed the prior authorization denial. If members do not receive accurate information about their right to request a State fair hearing, they may not fully understand the totality of the appeal process and their rights and options within that process.

[8] We did not review appeal denials that went through the State fair hearing process or the associated results.

[9] This 120-day timeframe is specified in Amerigroup's third contract amendment (effective July 1, 2017).

For the other 1 of the 20 sampled prior authorization denials and appeals that did not comply with Federal and State requirements, Amerigroup was unable to locate or provide documentation to support a prior authorization denial.

Finally, although Amerigroup denied only 3 percent of requested medical services during its prior authorization process, we noted that 62 percent of the requested medical services that Amerigroup denied—and for which members initiated an appeal process—were overturned through Amerigroup's appeal process. Even when denials are overturned on appeal, avoidable delays and extra steps that are integral to that process create administrative burdens for members, providers, or both, as well as delays in the provision of needed services to members. Moreover, the high percentage of prior authorization denials that were overturned on appeal suggests that Amerigroup can improve its prior authorization process, to include improved communications with providers, to reduce the number of instances in which denied medical services are subsequently overturned on appeal.

AMERIGROUP DID NOT ENSURE THAT ALL MEMBERS RECEIVED COMPLETE AND ACCURATE STATE FAIR HEARING INFORMATION

Federal and State Requirements

Federal regulations state that each Medicaid managed care contract must require the MCO to notify the requesting provider, and give the enrollee written notice, of any decision by the MCO either to deny a service authorization (i.e., prior authorization) request, or to authorize a service in an amount, duration, or scope that is less than requested (42 CFR § 438.210(c)). Federal regulations at 42 CFR § 438.404(b)(3) state that notices of adverse decision must explain the enrollee's right to request an appeal of the MCO's denial of services and must include information on exhausting the MCO's one level of appeal (described at 42 CFR § 438.402(b)) and the enrollee's right to request a State fair hearing (consistent with 42 CFR § 438.402(c)).

Federal regulations state that an appeal notice of decision for an appeal not resolved wholly in favor of the enrollee must include the enrollee's right to request a State fair hearing, and how to do so (42 CFR § 438.408(e)). Furthermore, Federal regulations state that an enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's appeal notice of decision (42 CFR § 438.408(f)(2)).[10]

This same 120-day timeframe is specified in the contract between Amerigroup and the State agency that was in effect during our audit period. Specifically, under the provisions of

[10] The Federal regulation in effect during our audit period stated that an enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's appeal notice of decision. This regulation was amended effective December 14, 2020 (after our audit period), to allow a 90-to-120-day timeframe to request a State fair hearing: "The enrollee must have no less than 90 calendar days and no more than 120 calendar days from the date of the MCO's . . . notice of resolution to request a State fair hearing" (85 Fed. Reg. 72754, 72842 (Nov. 13, 2020)).

Amerigroup's third contract amendment, effective July 1, 2017 (section 8.15.4), a member must request a State fair hearing no later than 120 calendar days from the date of the Contractor's appeal notice of decision.

Amerigroup Did Not Provide Correct or Any Information to Some Members Regarding Their State Fair Hearing Rights

For 19 of the 100 prior authorization denials and appeals that we sampled, Amerigroup did not provide correct or any information to members regarding their State fair hearing rights.

Specifically, for 16 of these 19 prior authorization denials and appeals, Amerigroup's notice of adverse decision, appeal notice of decision, or both specified an incorrect timeframe for a member who had been denied medical services to file a request for a State fair hearing. In these 16 cases, the notice of adverse decision or appeal notice of decision stated that a member who had been denied medical services had 90 days to file a request for a State fair hearing, when in fact the member had 120 days to file that request (footnote 9). Amerigroup's third contract amendment with the State agency, effective July 1, 2017 (before our audit period), changed the State fair hearing filing deadline from 90 days to 120 days. Amerigroup officials stated that it implemented the change in its Iowa Health Link *Member Handbook* in late 2017, but the revised notice of adverse decision that specified the 120-day filing deadline was not disseminated until late summer 2018, when it was approved by Amerigroup and the State agency.

For 2 of these 19 prior authorization denials and appeals, the appeal notice of decision did not mention the member's right to request a State fair hearing. For these two appeal notices of decision, Amerigroup mistakenly categorized the appeals as "provider appeals" (that is, appeals that providers file on their own behalf), which (according to Amerigroup) are therefore not entitled to a State fair hearing, and which do not require notice of State fair hearing rights. When we brought this issue to the attention of Amerigroup officials during our audit, they agreed that although Amerigroup's policy and regular practice were to notify members, in the appeal notices of decision, of the members' right to request a State fair hearing, Amerigroup inadvertently sent these notices with the incorrect information to the members.

For the remaining 1 of these 19 prior authorization denials and appeals, Amerigroup did not furnish the appeal notice of decision to the member who had appealed the prior authorization denial. When we inquired about this issue during our audit, Amerigroup officials stated that in this case, Amerigroup did not send an appeal notice of decision to the member because the appeal that the member filed was a duplicate of the appeal filed by the member's provider. These officials acknowledged that Amerigroup should have sent the appeal notice of decision to the member as well as the provider, despite the duplication.

Furnishing correct and timely information about the appeal and State fair hearing processes to members ensures that those processes are transparent to members. Without this information, members may not understand their rights and options within those processes. If—as in the

cases discussed just above—members do not receive accurate information about their right to request a State fair hearing, they may not fully understand the totality of the appeal process and their rights and options within that process.

AMERIGROUP WAS NOT ABLE TO LOCATE OR PROVIDE DOCUMENTATION

State Requirements

The Iowa Health Link Contract between Amerigroup and the State agency in effect for our audit period requires Amerigroup to assure that its records and those of participating providers document all medical services that members receive. "The Contractor's providers shall maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment" (Special Terms Appendix 1 – Scope of Work, section 6.1.9). Additionally, this contract includes language related to prior authorization denials, which states that for all prior authorization denials, "the Contractor shall maintain a record of the following information, at a minimum . . . (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational [*sic*] supporting the denial (i.e. insufficient documentation)" (Special Terms Appendix 1 – Scope of Work, section 11.2.6.2).

Amerigroup Was Unable To Locate or Provide Documentation for One Sampled Prior Authorization Denial

For 1 of the 100 prior authorization denials and appeals that we sampled, Amerigroup officials stated that they were unable to locate or provide documentation to support a prior authorization denial. Without being able to review the supporting documentation we requested, we could not verify whether the sampled prior authorization denial complied with Federal or State requirements. Moreover, in the absence of any supporting information, we could not determine the impact that this denial had or may have had on the member. We did not identify this as a systemic issue; therefore, we are not making a recommendation.

AMERIGROUP'S HIGH RATE OF PRIOR AUTHORIZATION DENIALS THAT WERE OVERTURNED ON APPEAL SUGGESTS THAT IMPROVEMENTS CAN BE MADE TO ITS PRIOR AUTHORIZATION PROCESS

Federal and State Requirements

Federal regulations direct that MCOs and other contractors not structure compensation to individuals or entities that conduct utilization management (UM) activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member (42 CFR § 438.210(e)).

The Iowa Health Link contract between Amerigroup and the State agency in effect for our audit period states (third contract amendment, Special Terms Appendix 1 – Scope of Work, section 11.2.1(e)), states:

> The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for prior authorization decisions. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. Consultation with the requesting provider shall be ensured when appropriate.

The Iowa Health Link contract between Amerigroup and the State agency in effect for our audit period (third contract amendment, Special Terms Appendix 1 – Scope of Work, section 11.2.5.1), cites to 42 CFR § 438.210 "and related rules and regulation which include, but are not limited to, provisions regarding decisions, notices, medical contraindications, and the failure of a Contractor to act timely upon a [prior authorization] request." This provision of the contract also states:

> The Contractor shall have in place mechanisms to ensure that all prior authorization requests are processed within the appropriate timeframes . . . for: (i) completing initial requests for prior authorization of services; (ii) completing initial determinations of medical necessity and psychosocial necessity; (iii) completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity and psychosocial necessity, in accordance with law; (iv) notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity and psychosocial necessity; and (v) notifying providers and members of the Contractor's decision on appeals and expedited appeals of prior authorization requests and determinations of medical necessity and psychosocial necessity.

Amerigroup's Appeals Department Overturned 62 Percent of Prior Authorization Denials That Members or Providers Appealed During Our Audit Period

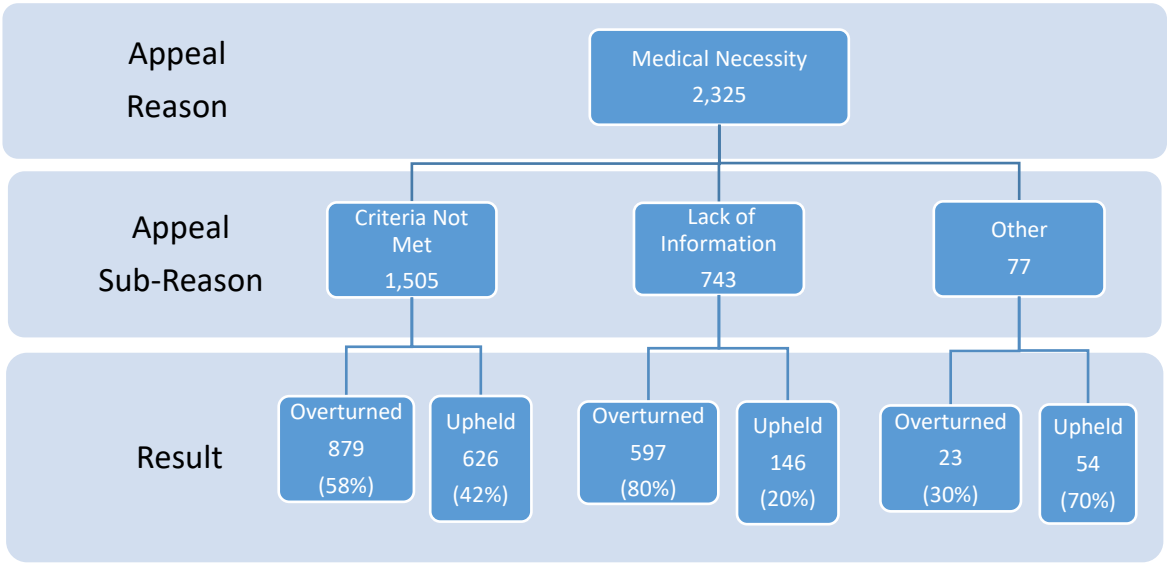
Of the 482,937 medical services for which members requested prior authorizations during our audit period, Amerigroup denied only 12,910 services (3 percent) during its prior authorization process. However, of the 12,910 prior authorization denials, members filed a total of 2,572 appeals during our audit period, and of these, 1,605 prior authorization denials (62 percent) were overturned or partially overturned through Amerigroup's appeal process.

Of these 2,572 appeals of prior authorization denials that members filed during our audit period, Amerigroup cited "Medical Necessity" as the reason for denial in 2,325 (90 percent) of those cases; of these 2,325 denials, 1,499 (64 percent) were overturned or partially overturned on appeal. Almost all (2,248 or 97 percent) of the denials that cited "Medical Necessity"

specifically pointed to one of two sub-reasons: "Criteria not met" and "Lack of information." Figure 2 depicts the 2,248 prior authorization requests that were denied on the basis of "Medical Necessity" and breaks out, by sub-reason, the numbers and percentages of these prior authorization denials that Amerigroup's appeals department overturned on appeal.[11]

An MCO may overturn its initial prior authorization denial upon appeal for several reasons. In some cases, the MCO may determine that its original decision was incorrect, and therefore overturn the denial. In other cases, the MCO may determine that it made the correct initial denial decision based on the information available at the time, but find that the provider or enrollee added new information in an appeal that demonstrates that the denial should be overturned. Although overturned denials do not necessarily mean that the MCO inappropriately denied the initial request, each overturned denial represents a case in which enrollees or providers had to file an appeal to receive services or payment that are covered by Medicaid.

Figure 2: Prior Authorization Denials Based on "Medical Necessity," Reasons for Denials, and Results of Appeals



As an example of a prior authorization denial that Amerigroup's appeals department overturned on appeal, a member was diagnosed with nasal septum deviation, maxillary chronic sinusitis, and nasal obstruction noted at approximately 90 percent. On January 3, 2019, the member's PCP requested prior authorization for surgery for the member's deviated nasal septum. On January 12, 2019, Amerigroup denied this request based on lack of information. The provider filed an appeal request on February 19, 2019, which included a letter explaining

[11] Figure 2 depicts a total of 2,325 prior authorization denials that were subsequently appealed. For the 77 denials that we have consolidated in the "Other" block, the "Medical Necessity" sub-reasons included "Experimental/Investigational," "Length of Stay," "Level of Care" and "Null."

the members' physical abnormalities. Amerigroup's appeals department overturned the prior authorization denial on March 6, 2019. Amerigroup thus overturned its prior authorization denial 62 days after the date that the member's PCP had requested the surgery and 53 days after Amerigroup had issued its notice of adverse decision denying that request.

As another example, a PCP requested prior authorization for an insulin pump on May 14, 2019, for a member who had been diagnosed with type 1 diabetes. On May 21, 2019, Amerigroup denied this request based on lack of information. The PCP filed an appeal request on July 17, 2019, which included the member's blood glucose logs for that month. Amerigroup's appeals department overturned the prior authorization denial on July 30, 2019. Amerigroup thus overturned its prior authorization denial 77 days after the date that the member's PCP had requested the insulin pump and 70 days after Amerigroup had issued its notice of adverse decision denying that request.

Amerigroup officials told us during our audit that Amerigroup had denied these prior authorization requests because its clinical nurse, medical director, or both had been unable to determine the medical necessity of the requested services because of a lack of information. Amerigroup could have prevented the members from sustaining delays in services by requesting additional supporting documentation or by engaging in consultation with the requesting provider, when appropriate, before it denied the prior authorization requests for service.

Although Amerigroup denied only 3 percent of requested medical services during its prior authorization process, we noted that 62 percent of the requested medical services that Amerigroup denied—and for which members initiated an appeal—were overturned through Amerigroup's appeal process. Even when denials are overturned on appeal, avoidable delays and extra steps that are integral to that process create administrative burdens for members, providers, or both, as well as delays in the provision of needed services to members. Moreover, the high percentage of prior authorization denials that were overturned on appeal suggests that Amerigroup can improve its prior authorization process, to include improved communications with providers, to reduce the number of instances in which denied medical services are subsequently overturned on appeal. For instance, in the examples cited above, the opportunity existed for Amerigroup to request additional supporting documentation from the PCPs before denying the prior authorization requests—rather than denying those requests and subsequently obtaining the additional documentation when and if the members or providers initiated an appeal.

RECOMMENDATIONS

We recommend that Amerigroup Iowa, Inc., coordinate with the State agency to:

- improve its prior authorization and appeal processes to ensure that members receive correct information regarding prior authorizations, the appeal process, and State fair hearing rights, procedures, and timeframes; and

- review and update its prior authorization process to improve communication with providers and thereby avoid or minimize delays that prevent members from receiving needed medical services.

AUDITEE COMMENTS

In written comments on our draft report, Amerigroup concurred with our recommendations and described actions that it had taken or planned to take to address them. Amerigroup said that it had "already implemented several measures since the audit period to address the areas of improvement" that we had identified. For our first recommendation, Amerigroup stated that it had revised its adverse notice of decision letters in late 2018 to update the State fair hearing timeframe from 90 days to 120 days. Amerigroup also said that it would add a dedicated workstream within its existing State contract amendment process, "specifically focused on improving the timeliness of updates to any relevant member communications that are impacted by contract changes." Furthermore, Amerigroup described updates that it had made to its internal distribution and tracking system for new requirements.

For our second recommendation, Amerigroup stated that it had made "significant investments in tools to make it easier for providers to share information during the initial prior authorization request process." Specifically, Amerigroup said that it offers an online portal "to simplify information exchange and streamline the prior authorization and claims processes. Providers can securely upload [member] medical records, submit requests, and check the status of claims in a centralized location." In addition, Amerigroup stated that it offers an electronic medical record (EMR) access program in Iowa, "through which providers can allow Amerigroup direct access to their EMR systems. This allows Amerigroup to evaluate the relevant clinical records, without requiring any work on the part of the provider." Amerigroup added that it is working to educate and onboard providers to this program. Moreover, Amerigroup said that it had worked with the State agency to review, annually, every service that requires prior authorization "to determine whether or not to remove that service from prior authorization criteria. The goal of this process is to have fewer denied [prior authorization] requests."

Amerigroup's comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During our audit period (January 1, 2018, through December 31, 2019), Amerigroup received a total of 482,937 prior authorization requests. Of these, Amerigroup approved 470,027 requests and denied 12,910 requests. Our audit covered the 12,910 prior authorization denials; this amount included 2,572 prior authorization requests that Amerigroup denied and that the members, providers, or authorized representatives subsequently appealed. See Figure 1 earlier in this report.

We selected and reviewed a judgmental sample of 100 prior authorization denials and appeals to determine whether Amerigroup's prior authorization and appeal processes complied with Federal and State requirements. Specifically, we selected for review 50 prior authorization denials (from the 12,910 total denials), as well as 50 appeals of prior authorization denials (from the 2,572 total). We reviewed all of these 100 prior authorization denials and appeals to determine whether Amerigroup's processes complied with Federal and State requirements (footnote 8).

We reviewed the design, implementation, and operating effectiveness of Amerigroup's internal controls related to our objective. We obtained an understanding of the laws, regulations, and contractual requirements that were relevant to Amerigroup and to the State agency's monitoring process to ensure that Amerigroup complied with requirements for requested medical services that required a prior authorization. We reviewed Amerigroup's 2018 and 2019 reviews of the UM activities that it used to determine whether Amerigroup complied with recognized standards set forth by the National Committee for Quality Assurance and Federal and State regulations.

We conducted our audit work from December 2020 to July 2023.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal regulations and the Iowa Health Link Contract between the State agency and Amerigroup (to include the third contract amendment) that was in effect for our audit period;

- interviewed State agency officials to gain an understanding of the State agency's monitoring of Amerigroup's prior authorization denial process;

- obtained and reviewed Amerigroup's policies, procedures, and program requirements regarding its approval and denial processes for medical service requests that require a prior authorization;

- interviewed Amerigroup staff to understand Amerigroup's policies and procedures for processing medical service requests that require a prior authorization and Amerigroup's processes and monitoring activities;

- selected and reviewed a judgmental sample of 100 prior authorization denials and appeals, which consisted of 50 prior authorization denials (from the 12,910 total denials) and 50 appeals of prior authorization denials (from the 2,572 total), to determine whether those denials complied with Federal and State requirements;

- obtained and reviewed documentation related to the sampled prior authorization denials and appeals;

- reviewed notices of adverse decision and appeal notices of decision, as applicable, for the prior authorization denials and appeals that we sampled, to determine whether they were sent to the members and providers within the required timeframes and that they included the correct content and details;

- reviewed Amerigroup's Iowa Health Link *Provider Manual* and *Member Handbook* to determine whether the sampled denials were for a covered service;

- reviewed the administrative process that Amerigroup used to determine whether the services requested in the sample were medically necessary, including the prior authorization requests submitted by treating physicians and other supporting documentation for those services that were denied and subsequently appealed; and

- discussed the results of our audit with Amerigroup and State agency officials on April 21, 2023.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Federal regulations (42 CFR § 438.210(c)) state:

> Each contract [between a State and an MCO] must provide for the MCO . . . to notify the requesting provider, and give the enrollee written notice of any decision by the MCO . . . to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs . . . the enrollee's notice must meet the requirements of § 438.404.

Federal regulations (42 CFR § 438.402(c)(1)) state:

> i. An enrollee may file a grievance and request an appeal with the MCO. . . . An enrollee may request a State fair hearing after receiving notice under § 438.408 that the adverse benefit determination is upheld. . . .
>
> ii. If State law permits and with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in § 438.420(b)(5).

Federal regulations (42 CFR § 438.404(b)) state that a notice of adverse decision must explain the following:

> (1) The adverse benefit determination the MCO . . . has made or intends to make.
>
> (2) The reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
>
> (3) The enrollee's right to request an appeal of the MCO's . . . adverse benefit determination, including information on exhausting the MCO's . . . one level of appeal described at § 438.402(b) and the right to request a State fair hearing consistent with § 438.402(c). . . .

(4) The procedures for exercising the rights specified in this paragraph (b).

(5) The circumstances under which an appeal process can be expedited and how to request it.

(6) The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

Federal regulations state that an appeal notice of decision must include: "(1) The results of the resolution process and the date it was completed. (2) For appeals not resolved wholly in favor of the enrollees—(i) The right to request a State fair hearing, and how to do so" (42 CFR § 438.408(e)).

Federal regulations state that the requirements for a State fair hearing include: "(1) *Availability*. An enrollee may request a State fair hearing only after receiving notice that the MCO . . . is upholding the adverse benefit determination. . . . (2) *State fair hearing*. The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's . . . notice of resolution" (42 CFR § 438.408(f)).

Federal regulations state that for processing requests for initial and continuing authorization of services, each contract must require that the MCO "[c]onsult with the requesting provider for medical services when appropriate" (42 CFR § 438.210(b)(2)(ii)).

Federal regulations state that for processing requests for initial and continuing authorization of services, each contract must require "[t]hat any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs" (42 CFR § 438.210(b)(3)).

STATE REQUIREMENTS

State regulations (Iowa Administrative Code 441—7.6(17A), "Informing Persons of their Rights," states (section 7.6(1)): "*Written and oral notification*. The department [i.e., the Department of Human Services] shall advise each applicant and [member] of the right to appeal any adverse decision affecting the person's status."

The Iowa Health Link contract (MED-16-018) between Amerigroup and the State agency, in effect for our audit period, includes the following provisions in its "Special Terms Appendix 1—Scope of Work" (section 6.1.9, "Medical Records"):

> In any Work Plan required by Section 2.13, the Contractor shall develop and implement policies, procedures and contractual requirements for participating

> provider medical records content and documentation in compliance with the provisions of Iowa Admin. Code 411 Chapter 79.3. After [State] Agency approval, the Contractor shall communicate those policies and procedures to network providers. The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with law and consistent with utilization control requirements in 42 C.F.R. Part 456. The Contractor's providers shall maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records shall be legible, signed, dated and maintained as required by law.

The provisions that follow are all drawn from the third contract amendment:

"For all denials of prior authorization requests, the Contractor shall maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of caller or submitter, (ii) date and time of call or submission, (iii) clinical synopsis inclusive of timeframe of illness or condition, diagnosis and treatment plan; and (iv) clinical guidelines or other rational [*sic*] supporting the denial (i.e. insufficient documentation)" (Scope of Work, section 11.2.6.2, "PA [Prior Authorization] Denials").

"The Contractor shall maintain records that fully disclose the extent of services provided to individuals under the Contract for the period of ten (10) years, or the duration of contested case proceedings, whichever is longer" (Scope of Work, section 2.4.2, "Medical Records"). (See also footnote 6.)

"The member must request a State fair hearing no later than 120 calendar days from the date of the Contractor's notice of resolution" (Scope of Work, section 8.15.4(f)(2), "State fair hearing").

"Contractor shall notify the requesting provider, and give the member written notice of any decision by Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The member's notice must meet the requirements of 42 C.F.R. § 438.404" (Scope of Work, section 11.2.1(c), "Notice of adverse benefit determination").

> Consistent with 42 C.F.R. § 438.3(i), and 42 C.F.R. § 422.208, Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. Contractor and subcontractor written policies and procedures for processing requests for initial and continuing authorizations of services are subject to [State] Agency review and approval. The Contractor shall have in effect

mechanisms to ensure consistent application of review criteria for prior authorization decisions. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the UM criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. Consultation with the requesting provider shall be ensured when appropriate (Scope of Work, section 11.2.1(e), "Compensation for utilization management activities").

Prior authorization requests shall be processed in accordance with 42 C.F.R. § 438.210 and related rules and regulations which include, but are not limited to, provisions regarding decisions, notices, medical contraindications, and the failure of a Contractor to act timely upon a request. The Contractor shall have in place mechanisms to ensure that all prior authorization requests are processed within appropriate timeframes (as set forth in Section 11.2.1) for: (i) completing initial requests for prior authorization of services; (ii) completing initial determinations of medical necessity and psychosocial necessity; (iii) completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity and psychosocial necessity, in accordance with law; (iv) notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity and psychosocial necessity; and (v) notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity and psychosocial necessity. Instances in which a member's health condition shall be deemed to require an expedited authorization decision by the Contractor shall include requests for home health services for members being discharged from a hospital or other impatient setting when such home health services are needed to begin upon discharge (Scope of Work, section 11.2.5.1, "Processing").

Troutman Pepper Hamilton Sanders LLP
3000 Two Logan Square, 18th and Arch Streets
Philadelphia, PA 19103-2799

troutman.com

Barbara T. Sicalides
D 215.981.4783
barbara.sicalides@troutman.com

August 18, 2023

VIA EMAIL

James Korn
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

Re: Response to Report Number: A-07-22-07007

Dear James:

I write on behalf of Wellpoint Iowa Inc. (f/k/a Amerigroup Iowa, Inc.) ("Amerigroup") to provide a response to report #A-07-22-07007 titled *Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, But Improvements Can Be Made*, prepared by the U.S. Department of Health And Human Services' Office of Inspector General ("HHS-OIG"). Amerigroup welcomes this opportunity to respond.

Amerigroup began administering Medicaid managed care benefits to Iowa's most vulnerable population at the inception of the state sponsored Medicaid managed care program in 2016. Since that time, Amerigroup has worked to improve the lives of its members and to build healthier communities across the state, creating a local presence that members recognize, trust, and rely on. Amerigroup is the only managed care organization to serve Iowa's Medicaid members for the entirety of the managed care program and remains dedicated to serving these members.

Amerigroup appreciates and concurs with HHS-OIG's conclusion that its prior authorization and appeal processes during the 2018 – 2019 audit period were effective and that its prior authorization denial rate was only 3% during that timeframe. Amerigroup's low denial rate is reflective of the care that Amerigroup takes in fully assessing prior authorization requests before making a denial decision. However, Amerigroup acknowledges that improvements can be, and have been, made. Amerigroup agrees with both recommendations and has already implemented several measures since the audit period to address the areas of improvement identified by HHS-OIG.

1. Coordinate with the State agency to improve its prior authorization and appeal processes to ensure that members receive correct information regarding prior authorizations, the appeal process, and State fair hearing rights, procedures and timeframes.

Amerigroup concurs with this recommendation and has already made improvements to its processes to ensure that members receive correct information regarding prior authorizations, appeals process, and state fair hearing rights. Amerigroup maintains a publicly available Member Handbook, which provides accurate and up-to-date information regarding Amerigroup's processes and member rights including prior authorization and appeal procedures as well as state fair hearing rights. Additionally, Amerigroup sends letters to members regarding adverse decisions that detail members' rights and Amerigroup's processes. Consistent with this recommendation, Amerigroup revised its 'adverse notice of decision' letters in late 2018 to update the state fair hearing timeframe from 90 days to 120 days, and currently provides members with correct information.

Amerigroup will also continue to improve its processes by adding a dedicated workstream within its existing state contract amendment process specifically focused on improving the timeliness of updates to any relevant member communications that are impacted by contract changes. Further, the existing internal distribution and tracking system for new requirements has been updated to require the submission of evidence by business owners and requiring two levels of compliance review before closing an item identified for implementation within the tracking system.

2. Coordinate with the State agency to review and update its prior authorization process to improve communication with providers and thereby avoid or minimize delays that prevent members from receiving needed medical services.

Amerigroup concurs with this recommendation and has already made improvements to its prior authorization processes, significantly reducing the percentage of prior authorization denials overturned on appeal. The majority of overturned denials during the 2018-2019 audit period were overturned because additional information was provided during the appeal process. Amerigroup relies on healthcare providers to provide accurate and complete medical record information so that Amerigroup can properly evaluate requests for prior authorization. Good communication is essential to that process. Therefore, Amerigroup has made significant investments in tools to make it easier for providers to share information during the initial prior authorization request process. For example, Amerigroup offers an online portal, Availity, to simplify information exchange and streamline the prior authorization and claims processes. Providers can securely upload patient medical records, submit requests, and check the status of claims in a centralized location. This eliminates the need for paper records and increases the speed and accuracy of prior authorization decisions.

Additionally, Amerigroup offers an Electronic Medical Record ("EMR") access program in Iowa, through which providers can allow Amerigroup direct access to their EMR systems. This allows Amerigroup to evaluate the relevant clinical records, without requiring any work on the part of

the provider. Amerigroup continues to work to educate and onboard providers to this program, where feasible.

Finally, in addition to streamlining the information exchange process, Amerigroup has worked with the State to reduce the number of services that require preauthorization by reviewing every service that requires prior authorization annually to determine whether or not to remove that service from prior authorization criteria. The goal of this process is to have fewer denied preauthorization requests.

***

Amerigroup appreciates the work of HHS-OIG in conducting this audit and is discussing this report and its recommendations with the State. Amerigroup deeply values and strives for transparency and accountability to the State, as well as to its members, providers, and stakeholders.

Sincerely,

/s/ Barbara Sicalides
Barbara T. Sicalides