



Iowa Medicaid Review of State Fair Hearing (SFH) Appeals Biannual Legislative Report

July 1, 2025 to December 31, 2025

Executive Summary

Pursuant to 2018 Iowa Acts, SF 2418, the Iowa Department of Health and Human Services (HHS) conducts an analysis of Medicaid members State Fair Hearing (SFH) appeals that have been withdrawn, dismissed, or overturned. HHS develops plans as necessary to address any negative patterns or trends identified by the analysis. A report of the analysis and findings shall be submitted to the Governor and General Assembly on a biannual basis. This report provides an analysis of Medicaid Managed Care Organization (MCO) member appeals from **July 1, 2025**, to **December 31, 2025**.

In this report, HHS analyzed SFH appeals that were retracted prior to reaching a decision, resulted in an adverse decision for the member, or resulted in a favorable decision for the member. The MCOs serving Iowa Medicaid during the reporting period included Wellpoint Iowa, Inc. (WLP), Iowa Total Care (ITC) and Molina Healthcare (MOL).

The HHS Iowa Medicaid dashboard contains appeals reporting information publicly available on the [Iowa Medicaid Dashboard](#). The data displayed in the dashboard is driven by the required metrics from the Centers for Medicare and Medicaid Services (CMS). Timeframes and data may differ between this report and the dashboard due to data definition variances.

A Medicaid member or their representative(s) may initiate an appeal following a decision by the MCO to deny, reduce, or limit items or services. Following the adverse action by the MCO, the member receives a letter explaining the reason for the denial, reduction, or limitation of benefits. The member has 60 days from the date of the letter to initiate the appeal process, also referred to as a first level review.

The initial appeal process includes an internal first level review between the member and the MCO, during which members can appeal the adverse action. The MCO has 30 days to complete the first level review and report, in writing, the findings to the member. If the member disagrees with the MCO's decision, the member can file an appeal with HHS through the SFH appeals process within 120 days of the MCO's decision. The SFH allows members to present their case to an Administrative Law Judge (ALJ) for review. SFH appeals are legal proceedings like a non-jury trial in a court of law where an impartial ALJ presides over the hearing.

During the reporting period, **1,001** requests were submitted for SFH appeal review. HHS's Quality Improvement Organization (QIO) reviewed **152** SFH appeals to determine if the MCO's initial decision to deny, reduce, or limit the service request was consistent or inconsistent with Iowa Administrative Code (IAC) and state and federal criteria. The QIO clinical review team consisted of physicians, nurses, licensed social workers, and subject matter experts with experience in Medicaid services and supports.

Of the **152** of SFH Appeals reviewed by the QIO, **2** favored the MCO, **72** were withdrawn, and **78** favored the member.

Table 1 below outlines the membership of the three (3) MCOs along with Fee-for-Service (FFS) during this reporting period and the number of Long Term Services and Supports (LTSS) members. Member counts differ between plans, which in turn means some plans may have more requests than others.

While any member can appeal a decision by an Iowa Medicaid Plan to deny or limit items or services, LTSS members tend to receive more services through their person-centered service plan.

Table 1: Member Counts

Plan	Number of Members	Number of LTSS Members
FFS	42,826	6,370
ITC	219,713	48,019
MOL	192,483	22,591
WLP	242,122	61,703
Total	697,144	138,683

Key Findings

The HHS Dashboard was used in the collection of the claim and member counts for each plan. The Plans provided **7,139,938** unique, appealable services to members. Out of this, members submitted **1,001** SFH appeal requests, which is only **0.00014** percent of the total appealable services.

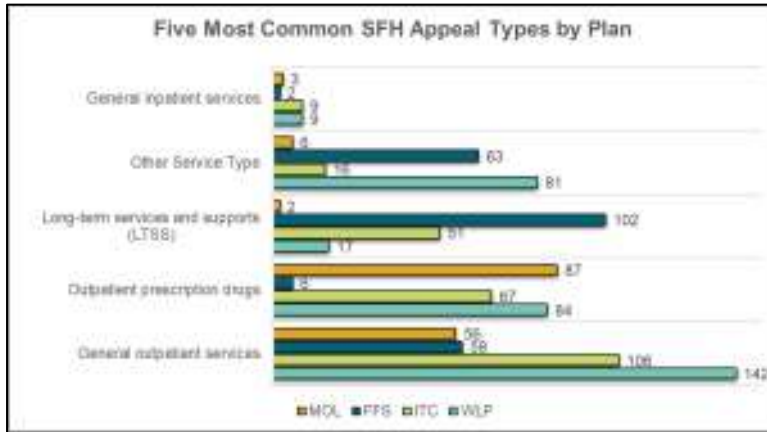
Table 2 depicts the number and percentage distribution of SFH appeal requests completed, categorized by plan. Of the total requests filed, **24** percent involved FFS enrolled members, **26** percent involved ITC members, **16** percent involved MOL members, and **34** percent involved WLP members.

Table 2: State Fair Hearings by Plan

Plan	Number of SFH Appeals	Percent of SFH Appeals
FFS	238	24%
ITC	264	26%
MOL	161	16%
WLP	338	34%
Total	1,001	100%

Graph 1 depicts the five (5) most common SFH appeal types broken out by plan. Note that General Outpatient Services are the most common type of SFH appeals received.

Graph 1: Five Most Common State Fair Hearing Appeal Types by Plan

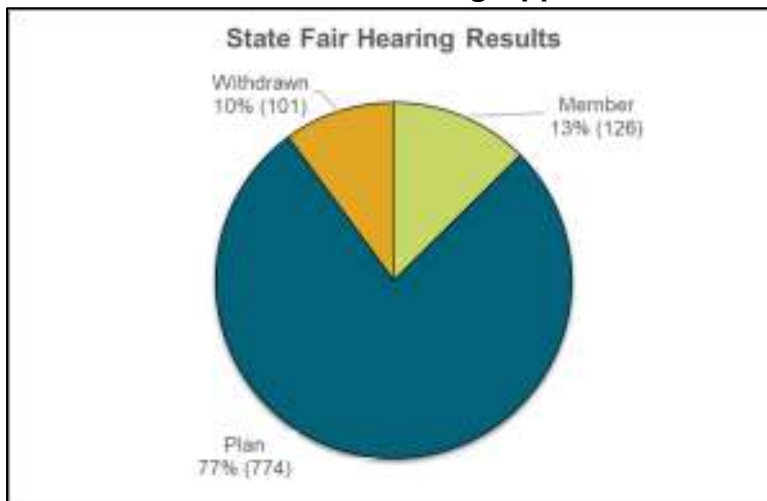


Requests during the reporting period were categorized by the type of action taken. These actions were:

- ▶ **Overtured:** Find in appellant's favor, initial plan decision overturned.
 - State Fair Hearings resulting in a favorable decision for the member
- ▶ **Upheld:** Initial plan decision is upheld.
 - State Fair Hearings resulting in an adverse decision for the member
- ▶ **Withdrawn:** Appeal retracted prior to reaching a decision.
 - State Fair Hearings retracted prior to reaching a decision

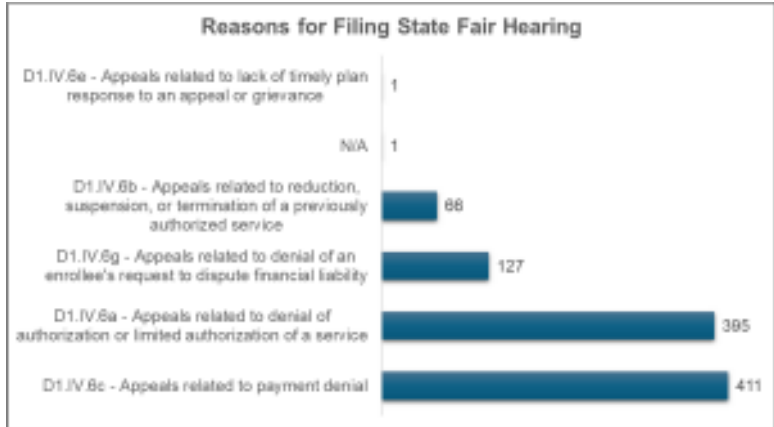
Graph 2 depicts whether the outcome of the SFH appeal favored the member, the plan, or if it was withdrawn prior to reaching a decision.

Graph 2: Breakdown of Total State Fair Hearing Appeal Decisions Results



Graph 3 shows the reasons a SFH was filed, broken out by CMS Managed Care Program Annual Report (MCPAR) filing reasons. The most common reason is related to payment denial.

Graph 3: Reason for Filing a State Fair Hearing



State Fair Hearing Appeals Withdrawn Prior to Reaching a Decision

SFH appeal requests are withdrawn solely at the member's discretion when they decide they no longer wish to proceed with the SFH appeal process.

Of the total SFH appeal requests received, members withdrew **101** appeals. Of the **101** requests withdrawn, **29** were FFS requests, **15** were ITC requests, **six** were MOL requests and **51** were for WLP. In total, only **ten** percent of the **1,001** requests were withdrawn.

Graph 4: Type of State Fair Hearing Appeals Withdrawn Prior to Reaching a Decision by Plan



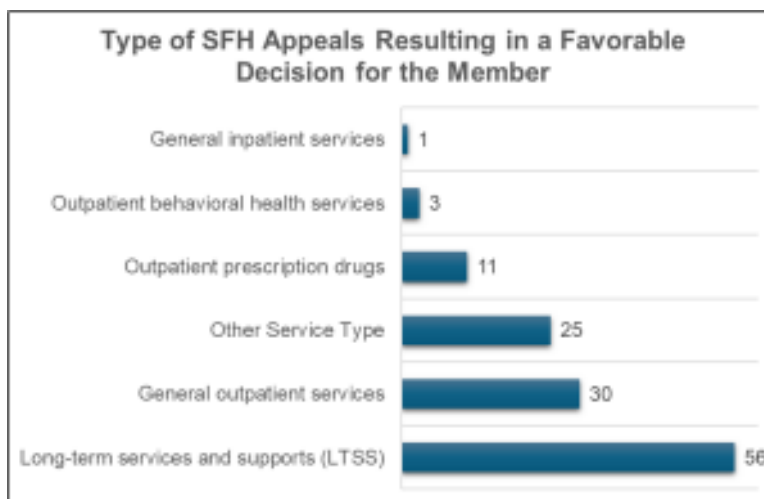
State Fair Hearing Appeals Resulting in a Favorable Decision for the Member

A SFH appeal is determined to be favorable for the member when the Plan reverses their original decision to deny, reduce, or limit a service, or as ruled by the ALJ. This can be done before, during, or after the hearing.

Of the **126** favorable SFH decisions received, **35** percent were FFS, **25** percent were ITC, **nearly 6** percent were MOL, and **35** percent were WLP.

Further breakdown indicates the percentage of favorable requests compared to the total number filed. FFS shows **4.4** percent, ITC had **3.1** percent, MOL had **0.7** percent and WLP was also **4.4** percent. In total, nearly **13** percent of the **1,001** requests were favorable for the member.

Graph 5: State Fair Hearing Appeal Types Resulting in a Favorable Decision for the Member

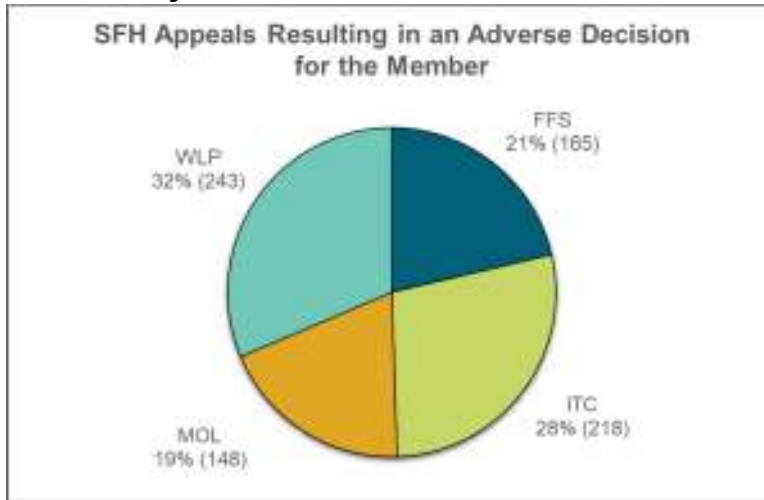


State Fair Hearing Appeals Resulting in an Adverse Decision for the Member

A SFH appeal is determined to be an adverse decision for the member when the ALJ upholds the Plans original decision to deny, reduce, or limit a service.

Graph 6 shows of the **774** SFH appeals resulting in an adverse decision for the member, **WLP** had the highest number at **32** percent.

Graph 6: Breakdown of State Fair Hearing Appeals Resulting in an Adverse Decision for the Member by Plan



Graph 7: State Fair Hearing Appeal Types Resulting in an Adverse Decision for the Member



Clinical Review

The clinical review team reviewed each overturned, upheld and withdrawn SFH appeal to determine whether the MCO’s original decision to deny, reduce, or limit services was based off state and federal criteria as well as IAC. *FFS was not included in this review.*

Graph 8 shows whether the original denial was consistent, inconsistent, or if there was not enough information to complete an objective review. The findings indicate of the **152** reviewed, **18** percent of the time, the MCOs were consistent with state and federal criteria; **26** percent of the time, the MCOs were inconsistent with state and federal criteria; and **56** percent of the time, there was not enough information to perform an objective review.

Graph 8: State Fair Hearing Clinical Review Summary



Ineligible for State Fair Hearing Appeals

An appeal is deemed ineligible for the State Fair Hearing Appeal process if:

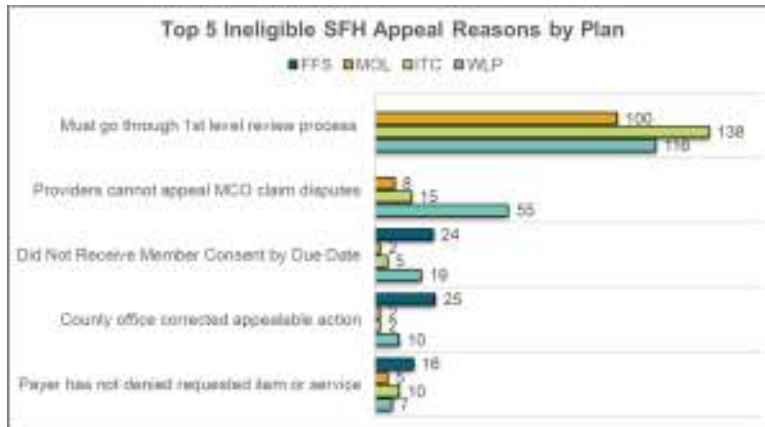
- ▶ The internal MCO first-level review process has not been completed, OR
- ▶ If the appeal is not filed within the expected time frame, OR
- ▶ There is an absence of an adverse Notice of Decision to the member or legal representative(s), OR
- ▶ A provider is attempting to appeal a claim dispute

There were **671** SFHs filed during the reporting period that were determined to be ineligible. While the clinical review team did not review these appeals, data points have been captured.

Table 3: Ineligible State Fair Hearing Appeals by Plan

Plan	Number of Ineligible Appeals	Percent of Ineligible Appeals	Percent of Total Appeals
FFS	112	17%	11%
ITC	201	30%	20%
MOL	137	20%	14%
WLP	221	33%	22%
Total	671	100%	67%

Graph 11: Top Five Ineligible State Fair Hearing Appeal Reasons



Progress Report

Listed below is an update on the improvement opportunities identified in the previous report (**January 1, 2025 to June 30, 2025**):

Action Item: HHS will collaborate with the MCOs to identify ways to support members and providers in their understanding of the steps in the appeals process and how to access a first-level review and SFH’s.

Progress Updates:

- ▶ HHS initiated a workgroup with MCO’s with the goal to work in collaboration to understand processes and expectations for first-level reviews and SFH’s.
- ▶ MCO’s discussed barriers from members and providers with current state.
 - Process and Forms
- ▶ Based on feedback HHS made edits to the Appeal Form.
- ▶ Work will continue with HHS and MCO’s to update other forms
 - Member Handbooks, Authorized Representatives Forms, Etc.
- ▶ HHS and MCO’s have plans to provide education to the public through member and provider townhalls once processes and forms are updated.
- ▶ HHS will continue to monitor the first-level review and SFH process trends for each MCO.

Action Item: HHS will work on alignment between the Biannual Legislative Report and the Iowa Medicaid Dashboard.

Progress Updates:

- ▶ HHS worked to align required metrics between CMS and Iowa Medicaid.
- ▶ Biannual Legislative Report now reflects aligned data from required CMS reporting fields, which are reflected on the Iowa Medicaid Dashboard.
- ▶ HHS will continue to monitor alignment.

Analysis

This analysis identified the following opportunities for improvement:

- ▶ The MCOs should seek additional information from members and providers, when necessary, prior to deciding on a member's request. This information may provide additional insight into the reasons for a member's request for services that allow for a more informed, defensible decision.
 - In nearly two (2) percent of the clinical reviews, additional information would have been helpful in making the determination.
- ▶ More consideration by the MCOs should be given to members with extenuating circumstances, including a significant decrease in units of service, as this could put the members' continued progress and goals in jeopardy.

The benefit of actively addressing these opportunities will create a timelier response to members' needs and ultimately a reduction for decisions resulting in the need for a SFH.

Glossary of Terms

Term	Definition
Adverse Decision	A decision that results in a denial, reduction or limitation of services
ALJ	Administrative Law Judge
CMS	Centers for Medicaid and Medicaid Services
Favorable Decision	A decision that results in the services being requested by the member or member's representative
FFS	Fee-for-Service
First Level Review	The first step in the member appeal process. The member appeals to their MCO directly
IAC	Iowa Administrative Code
LTSS	Long Term Services and Supports
MCO	Managed Care Organization
Overtured	The appeal was heard by an ALJ and the original decision to deny was reversed
SFH	State Fair Hearing heard before an ALJ
Upheld	The initial MCO decision to deny or reduce services was correct
Withdrawn	The member or representative decided they no longer wished to pursue the appeal process prior to the appeal hearing