



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

January 1, 2026, to June 30, 2026



Executive Summary

Pursuant to 2018 Iowa Acts, SF 2418, the Iowa Department of Health and Human Services (HHS) conducts an analysis of Medicaid member State Fair Hearing (SFH) requests that have been withdrawn, dismissed, or overturned.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 SFH requests from **January 1, 2026**, to **June 30, 2026**.

In this report, HHS analyzed SFH requests that were withdrawn by a Medicaid member, dismissed by the MCO, or overturned by an Administrative Law Judge (ALJ). The MCOs serving Iowa Medicaid during the reporting period include Wellpoint Iowa, Inc. (WLP), Iowa Total Care (ITC) and Molina Healthcare (MOL).

The HHS [Iowa Medicaid Dashboard](#) contains MCO appeal and SFH request information. Timeframes and data may differ between this report and the dashboard due to data submission timeline 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 on the letter to initiate an appeal with the MCO, also referred to as a first level review.

The MCO initial appeal process includes an internal first level review between the member and the MCO. The MCO has 30 days to complete the first level review and report, in writing, their final decision to the member. If the member disagrees with the MCO's decision, the member can file a SFH with HHS through the SFH request process. A SFH request must be initiated within 120 days of the MCO's final decision. The SFH allows members to present their case to an ALJ for review. SFH's 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, **1,088** requests were submitted for SFH. HHS's Quality Improvement Organization (QIO) reviewed **119** SFH requests 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 consists of physicians, nurses, licensed social workers, and subject matter experts with experience in Medicaid services and support.

Of the number of SFH requests reviewed by the QIO, **29** favored the MCO, **42** were withdrawn, and **48** 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	42,028	2,241
ITC	221,683	15,403
MOL	196,920	8,978
WLP	242,226	19,974
Total	702,857	46,596

Key Findings

The HHS Dashboard was used in the collection claims and member counts for each plan. The Plans provided **15,217,897** unique, appealable services to their members. Out of those, members submitted **1,088** SFH requests, which is only **0.0071** percent of the total unique appealable services.

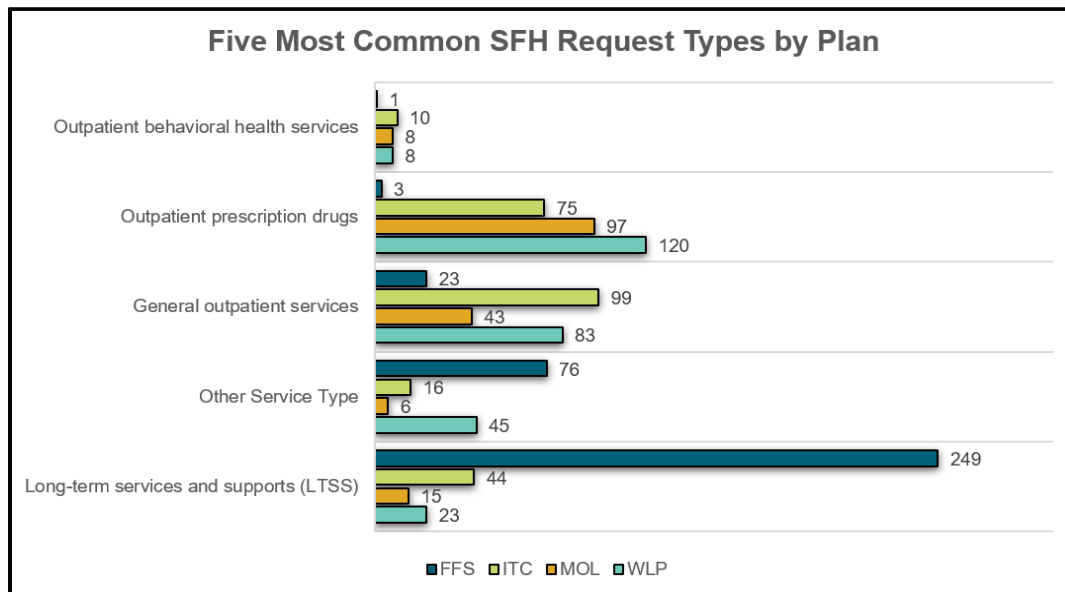
Table 2 depicts the number and percentage distribution of SFH requests completed, categorized by plan. Of the total requests filed, **33** percent involved FFS enrolled members, **24** percent involved ITC members, **16** percent involved MOL members, and **27** percent involved WLP members.

Table 2: State Fair Hearing Requests by Plan

Plan	Number of SFH Requests	Percent of SFH Requests
FFS	369	33%
ITC	257	24%
MOL	171	16%
WLP	291	27%
Total	1,088	100%

Graph 1 depicts the five (5) most common SFH request types broken out by plan. Note LTSS is consistently the most common type of SFH requests received.

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

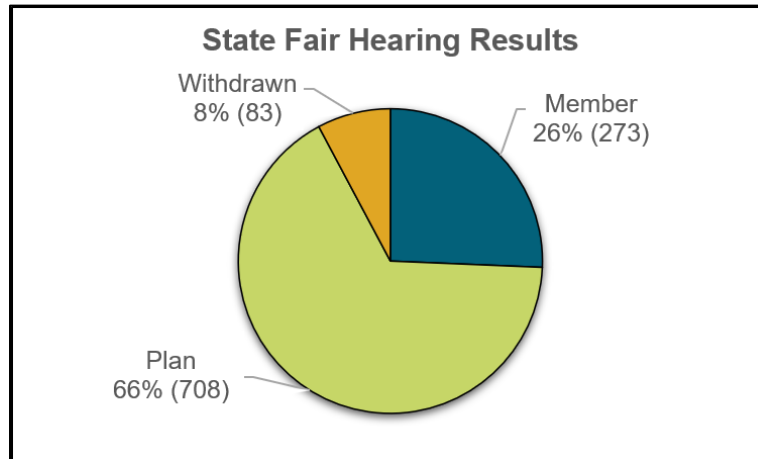


Requests during the reporting period were categorized by the type of action taken.

- ▶ **Overtured:** Find in appellant's favor, initial MCO decision reversed.
 - State Fair Hearings resulting in a favorable decision for the Member
- ▶ **Upheld:** Initial MCO decision is upheld.
 - State Fair Hearings resulting in an adverse decision for the Member
- ▶ **Withdrawn:** Request retracted by member or representative prior to a decision is reached.

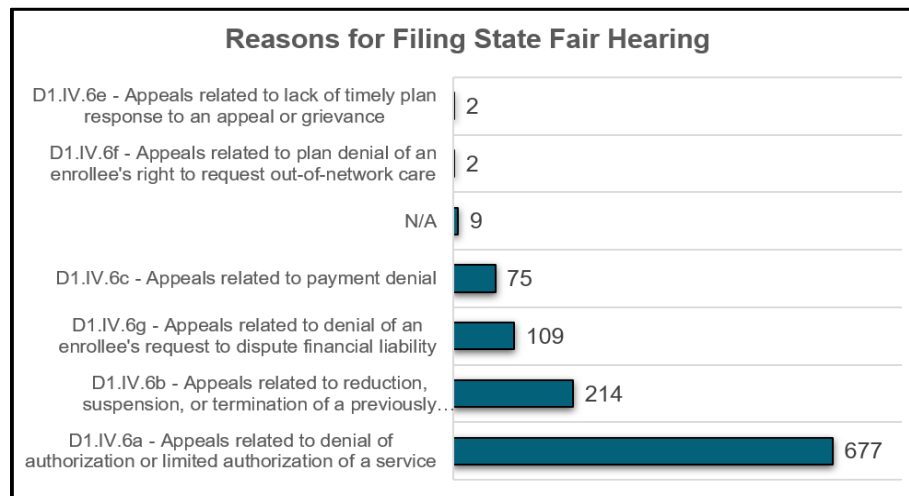
Graph 2 depicts whether the outcome of the SFH request favored the member, the plan, or if it was withdrawn prior to reaching a decision.

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



Graph 3 shows the reasons an SFH request was filed, broken out by CMS Managed Care Program Annual Report (MCPAR) filing reasons. The most common reason for this reporting period is related to the denial of authorization or limited authorization of a service. Last reporting period was 395, now it is 677.

Graph 3: Reason for Filing a State Fair Hearing

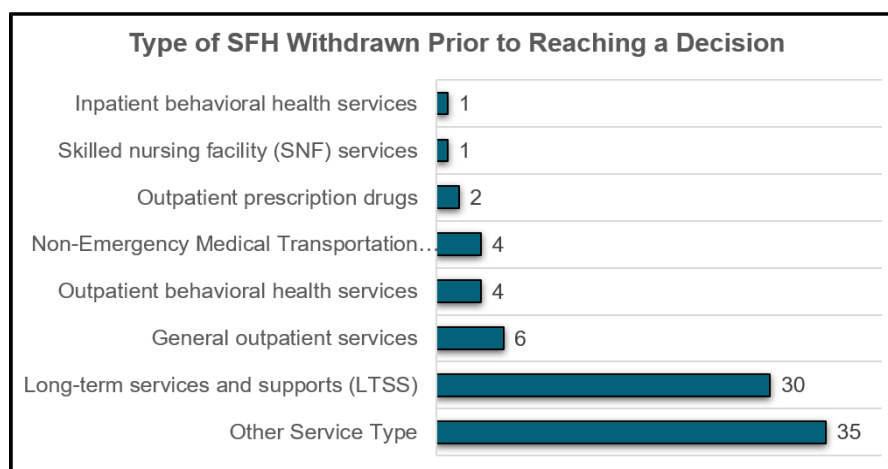


State Fair Hearing Requests Withdrawn Prior to Reaching a Decision

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

Of the total SFH requests received, members withdrew **83** requests. Of the **83** requests withdrawn, **49** were FFS requests, **10** were ITC requests, **8** were MOL requests and **16** were for WLP. In total, only **8** percent of the **1,088** requests were withdrawn.

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



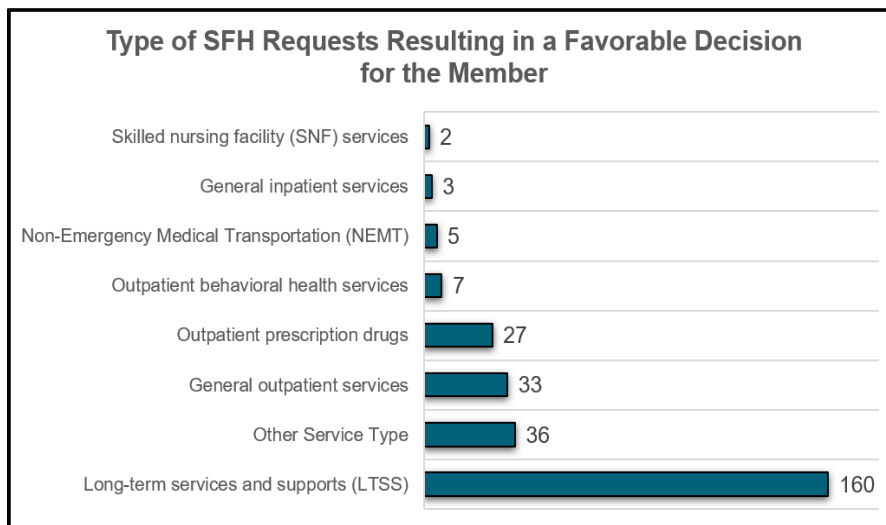
State Fair Hearing Requests Resulting in a Favorable Decision for the Member

A SFH request 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 Administrative Law Judge (ALJ). This can be done before, during, or after the hearing.

Of the **273** favorable SFH decisions received, **60** percent were FFS, **16** percent were ITC, **8** percent were MOL, and **16** percent were WLP.

Further breakdown indicates the percentage of favorable requests compared to the total number filed. FFS shows **15** percent, ITC had **4** percent MOL had **2** percent WLP was also **4** percent. In total, **25** percent of the **1,088** requests were favorable for the member.

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

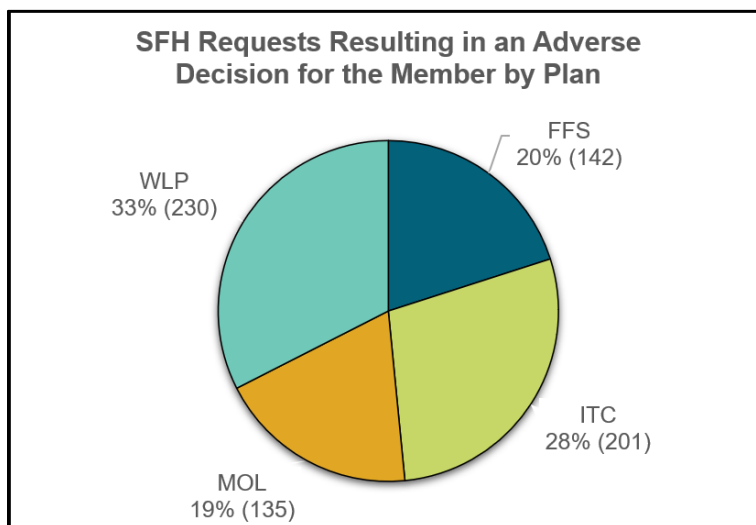


State Fair Hearing Requests Resulting in an Adverse Decision for the Member

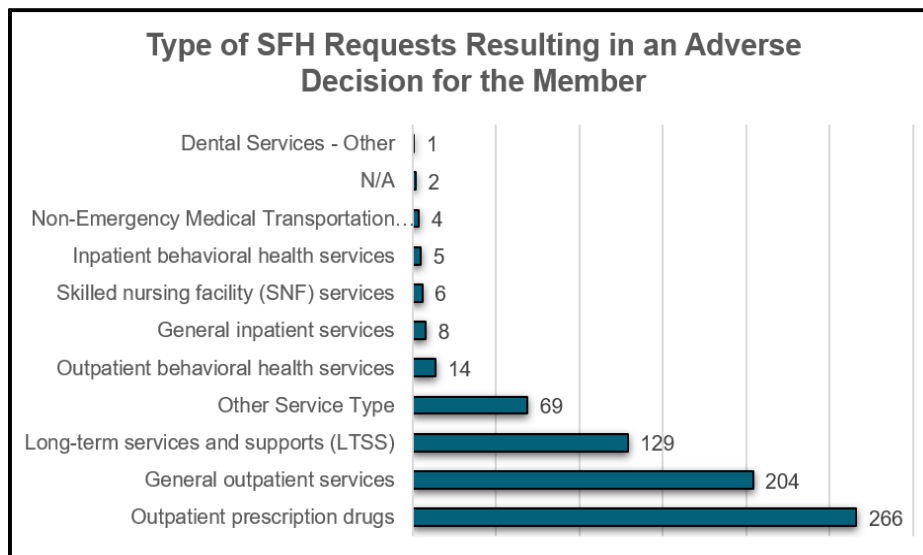
A SFH request is determined to be an adverse decision for the Member when the ALJ upholds the Plan's original decision to deny, reduce, or limit a service.

Graph 6 shows the **708** SFH requests resulting in an adverse decision for the Member. Percentages appear to be consistent with prior report submission.

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



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

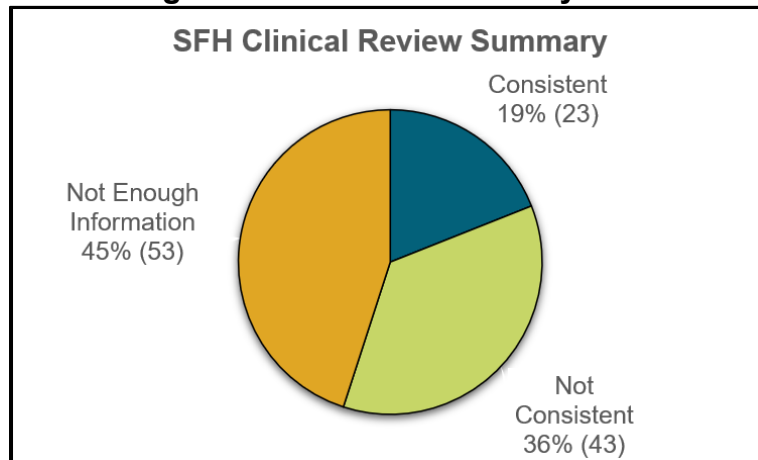


Clinical Review

The clinical review team reviewed each overturned, upheld and withdrawn SFH request 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 SFH requests were not included in this review.*

Graph 8 shows the breakdown, by MCO, whether the original denial was consistent with state and federal criteria, inconsistent with state and federal criteria, or whether there was insufficient information to complete an objective review. The findings indicate of the **119** SFH requests reviewed, **19** percent of the time, the MCOs were consistent; **36** percent of the time, the MCOs were inconsistent; and **45** percent of the time, there was not enough information for an objective review.

Graph 8: State Fair Hearing Clinical Review Summary



Ineligible for State Fair Hearing

A State Fair Hearing request is deemed ineligible for the State Fair Hearing process if:

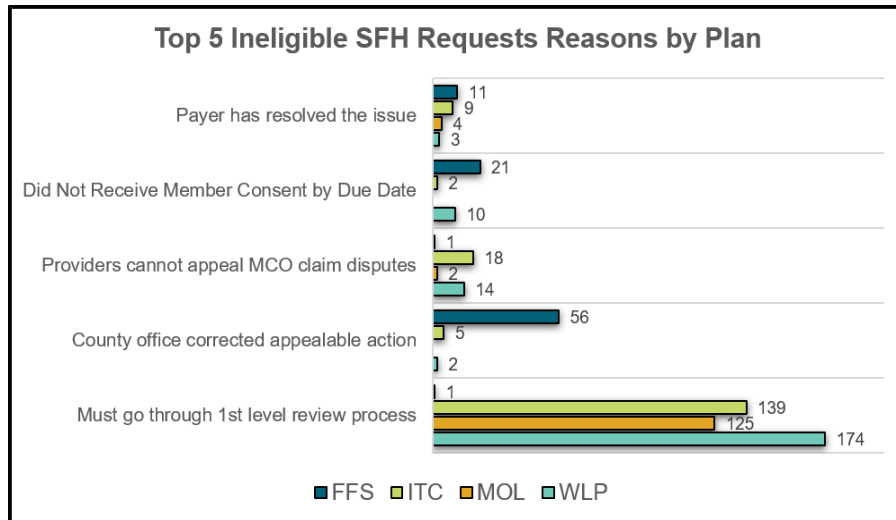
- ▶ The internal MCO first level review process has not been completed, OR
- ▶ The appeal is not filed within the required time frame, OR
- ▶ There is an absence of a Notice of Decision (NOD) or Adverse Benefit Determination (ABD) to the member or legal representative(s), OR
- ▶ A provider is attempting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

There were **680** SFH requests filed during the reporting period that were determined to be ineligible. While the clinical review team did not review these requests, data points were captured.

Table 3: Ineligible State Fair Hearing Requests by Plan

Plan	Number of Ineligible Requests	Percent of Ineligible Requests	Percent of Total Requests
FFS	132	19%	12%
ITC	191	28%	18%
MOL	138	20%	13%
WLP	219	32%	20%
Total	680	100%	63%

Graph 9: Top Five Ineligible State Fair Hearing Request Reasons by Plan



Progress Report

Listed below is an update on the improvement opportunities identified in the prior report, **July 1, 2025, to December 31, 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 prior to submission of a SFH request.

Progress Updates:

- ▶ HHS initiated a workgroup with the MCOs with the goal of working in collaboration to understand processes and expectations for first level reviews and SFHs.
 - This workgroup continues to meet on a bimonthly basis, or as needed.
- ▶ Based on feedback from the MCOs HHS has made edits to the SFH Request Form.
 - New request form was sent to MCOs for immediate use.
 - HHS shared updated form during the monthly MCO Operations Meeting
 - In future state, HHS will have new appeals website, which will house an electronic SFH Request Form.
- ▶ Work will continue between HHS and MCOs to update other forms
 - Member Handbooks, Authorized Representatives Forms, Etc.
- ▶ HHS will continue to monitor the first level review and SFH request 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 reports this action item is now MET.

Analysis

This analysis identified the following opportunities for improvement:

- ▶ The MCOs could collaborate with their providers to establish clearer, more specific payable coding for services.
 - MCOs and providers could schedule periodic review meetings to ensure coding guidance remains current
 - MCOs could provide newsletters to MCOs with updates
- ▶ More member specific attention should be given by the MCOs to those experiencing extenuating circumstances, especially when service units are substantially reduced, as this may place their ongoing progress and goals at risk.
- ▶ Iowa Medicaid and the MCOs may work in collaboration with one another to conduct a root-cause analysis of overturned decisions.
 - Review historical SFH requests and ALJ decisions to identify patterns and recurring reasons for overturned decisions.
- ▶ Iowa Medicaid could complete an evaluation to determine the effectiveness of the revised SFH request form in reducing the overall volume of appeal submissions.
- ▶ Iowa Medicaid may conduct an analysis to determine whether the recent modification to the LTSS assessment and level-of-care (LOC) process is correlated with the observed increase in LTSS Services SFH requests.

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

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 Medicare 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
IAC	Iowa Administrative Code
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
Overturned	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