How to Be Your Own Best Advocate:

Navigating Managed Care in Iowa

IOWA | Health and Human Services
Long-Term Care Ombudsman Program

Disability Rights Iowa
LEGAL PROTECTION AND ADVOCACY

IOWA DD Council
Preparation, Participation, Power

Introduction

On April 1, 2016, most Medicaid members in Iowa were enrolled in managed care and began receiving services from a managed care organization, also known as an MCO. Medicaid members can be their own best advocate, and that starts with knowing what managed care is and whether you receive coverage from an MCO. This guide can help you find information about your MCO, how your managed care works and your rights.

What is managed care?

A managed care organization (MCO) is a health insurance plan that helps organize and pay for your care. It works to make sure you have good care while keeping costs down. An MCO helps manage your overall health to keep you healthy or improve your health.

Am I in managed care?

While some Medicaid members continue to receive coverage through the Fee-for-Service (FFS) program, most Iowa Medicaid members are enrolled in Iowa Health Link, Iowa's Medicaid managed care program. To learn more, visit https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link. Iowa Health Link gives members health coverage through an MCO.

To find out if you are a managed care member, contact Iowa Medicaid Member Services at 1-800-338-8366.

Table of Contents

Words to Know

Key Word	Definition
Adverse Benefit Determination	A written notice to a member or provider to explain an action being taken.
Appeal	A request for a review of an adverse benefit determination. If you disagree with a decision made about your services, you or someone you trust can ask for a review of that decision and appeal it. You must file a request for an appeal within 60 calendar days from the date on the adverse benefit determination. A member may choose to appeal: ▸ Denial of/or limits on a service ▸ Reduction, suspension or termination of a service that had been authorized ▸ Denial in whole or in part of payment for a service ▸ Failure to provide services in a timely manner ▸ Failure of the MCO to act within required timeframes ▸ For a resident of a rural area with only one MCO, the denial of services outside the network ▸ The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities Members may file an appeal directly with the MCO. If you are not happy with the outcome of the appeal, you may file an appeal with the Iowa Department of Health and Human Services, or you may ask for a state fair hearing.
Case Management	Helps you manage your health care needs. Case managers help you get services.
Covered Services	Services your MCO provides to you under the Iowa Health Link program.
Emergency	Any condition that you believe endangers your life or would cause permanent disability if not treated immediately. If you have an emergency, you do not need to call your provider or your MCO. Go directly to the nearest hospital emergency room or call an ambulance. The following are examples of emergencies: ▸ A serious accident ▸ Stroke ▸ Severe shortness of breath ▸ Poisoning ▸ Severe bleeding ▸ Heart attack ▸ Severe burns

Words to Know

Key Word	Definition
Good Cause	Required for you to request to change your MCO (disenrollment) during your 12 months of closed enrollment. Some examples of good cause for disenrollment include: ▸ Your provider is not in the MCO's network ▸ You need related services to be performed at the same time. Not all related services are available within your MCO 's provider network. Your provider determined that receiving the services separately would subject you to unnecessary risk ▸ Lack of access to providers experienced with your health care needs ▸ Your provider has been terminated or no longer participates with your MCO ▸ Lack of access to services covered under the contract ▸ Poor quality of care given by your MCO ▸ The MCO plan does not cover the services you need due to moral or religious objections ▸ If you get long-term care or support services, you might have to switch where you live, work, or get care if your provider is no longer working with your MCO. This could cause a big change in your home or job
Grievance	A way to say you are unhappy with your MCO, about any matter other than a decision. You have the right to file a grievance with the MCO at any time. You, your representative, or provider who is acting on your behalf may file a grievance. If someone is acting on your behalf, they need written consent to do so. Examples include, but are not limited to: ▸ You are unhappy with the quality of your care ▸ The provider you want to see is not a provider with your MCO's network ▸ You are not able to receive culturally competent care ▸ You got a bill from a provider for a service that should be covered by your MCO ▸ Violation of rights and dignity ▸ Any other access to care issues
Health Insurance	Benefits that pay for or partially pay for medical services such as provider visits, hospital stays, and more.
Home and Community-Based Services (HCBS)	Provide supports to keep members in their homes and communities.
Home Health	Provides services in the home. These services include visits by nurses, home health aids and therapists.

Words to Know

Key Word	Definition
Hospital Inpatient Care	Also known as hospitalization, is hospital care that requires admission as an inpatient. This usually requires an overnight stay and can include serious illness, surgery or having a baby. It is important to know that sometimes you may be at the hospital overnight for what is called observation, and this is not inpatient care.
Hospital Outpatient Care	When you get hospital services without being admitted as an inpatient and may include: ▸ Emergency services ▸ Observation services (could stay the night but not be admitted) ▸ Outpatient surgery ▸ Lab tests ▸ X-rays
Level of Care	To receive long-term services and supports through your MCO, you need to meet a nursing facility, skilled nursing facility, hospital, or intermediate care facility for the intellectually disabled level of care. The level of care is determined by an assessment approved by the Iowa Department of Health and Human Services.
Long-Term Services and Supports (LTSS)	Help you maintain quality of life and independence. LTSS are provided in the home or in a facility, if needed.
Medically Necessary	Services or supplies needed for the treatment of a medical condition. They must meet the rules of good medical practice.
Network	Your MCO has a network of providers across Iowa who you may see for care. You don't need to call the MCO before seeing one of these providers. Before getting services from your providers, show them your MCO ID card to ensure they are in the MCO's network. There may be times you need to get services outside of your MCO's network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to you than if it was provided in-network.
Open Choice	Your 60-day annual timeframe where, after you have been with an MCO plan for 12 months, you may change your MCO for any reason, also known as "without good cause."
Person-Centered Service Plan (PCSP)	A written individual plan that reflects the services and supports that are important for you to meet your needs, goals and preferences as well as what is important to you regarding preferences for the delivery of such services and supports. Also referred to as a plan of care, care plan, or individual service plan (ISP).
Plan	Your MCO is your health plan, which pays for and coordinates your health care services.

Words to Know

Key Word	Definition
Prescription Drug	Your MCO provides payment for all or part of the cost of medications identified as covered on the Iowa Medicaid Preferred Drug List, for eligible members of Iowa Medicaid. This is known as prescription drug coverage.
Prior Authorization	Services or prescriptions that require approval from the MCO to be covered before you get the service or fill a prescription.
Provider	Means a physician, hospital, nursing home, pharmacy, lab, or any individual or group that provides a health care service. A provider may include your primary care provider (PCP), who is either a physician, a physician assistant or nurse practitioner, and is the main provider you will see for checkups, health concerns, health screenings, and specialist referrals.
Specialist	A health care professional who is highly trained to treat certain conditions.
State Fair Hearing	An appeal to the Iowa Department of Health and Human Services (HHS), as it is the agency that oversees the Medicaid program. In a state fair hearing, you make your case before an administrative law judge (ALJ).
Third-Party Liability	By law, Medicaid is generally the payer of last resort, meaning Medicaid only pays for items and services if there are no other payers that should be paying before Medicaid would pay.
Urgent Care	Is when you are not in a life-threatening or a permanent disability situation and have time to call your MCO or provider. If you have an urgent care situation, you should call your provider or MCO to get instructions. The following are some examples of urgent care: ▸ Fever ▸ Earaches ▸ Upper respiratory infection ▸ Stomach pain ▸ Sore throat ▸ Minor cuts and lacerations
Value-added services	Extra services provided to you at no cost by your MCO. Examples may include home delivered meals after you leave the hospital, bus passes or gas gift cards, and reward dollars for things like annual primary care provider (PCP) visits and flu vaccines.
Waiver of Administrative Rules	Also known as Exception to Policy (ETP), when you ask the Iowa Department of Health and Human Services (HHS) to waive a rule so you can get an item or service that Medicaid would not otherwise cover. A Waiver of Administrative Rules may be granted by HHS. You will get a written decision for all requests for Waiver of Administrative Rules.

MCO Enrollment

How do I get started with my MCO?

When you become eligible for Medicaid, you are most likely assigned to a managed care organization (MCO). If you decide this is not the best MCO for you, you might be able to change to another MCO. This section explains when and how you can change your MCO. All MCOs must give the same basic Medicaid services to their members, but each one has its own way of providing care and extra value-added services that can be different.

Each MCO has contracts with providers that deliver health and long-term services and supports. The word "provider" means a physician, hospital, nursing home, pharmacy, lab, or any individual or group that provides a health care service. These contracted providers are considered the MCO's "network" of providers. You must seek care from providers within the MCO's network.

When choosing your MCO, consider the following:

- Is my provider in the MCO network?
- Is my pharmacy in the MCO network?
- Does the MCO have specialists close to my community?
- Does the plan have value-added services that would help me? https://hhs.iowa.gov/media/12769/download?inline
- Does the MCO have call centers or helplines available beyond regular business hours?

There are many resources available to help you identify which MCO you should choose:

Iowa Medicaid Member Services: You can utilize resources on HHS's website, such as Iowa Health Link Member Resources to view the MCO Plan Summary or the Provider Search Portal to assist in choosing an MCO.

Member Services also offers MCO Choice Counseling to members in person or by phone at 1-800-338-8366.

Providers: Ask your providers which MCO(s) they have agreed to work with.

MCOs: Contact the MCOs to ask questions and learn about their provider networks and other services they provide that might benefit you.

Your MCO's member handbook will help you understand the rules and services available to you. It also provides you with important contact information and a place to keep a record of your providers. To get a printed copy of your member handbook or a version in another language or format like Braille, large print, or audio, contact your MCO's member services.

It is important to keep your member handbook in an easy-to-find location. If you have a question about your MCO or would like information about a service, your member handbook is a great place to start.

As an MCO member you will have two (2) ID cards:

1. **Medical Assistance Eligibility Card**
2. **Mangaed Care Organization (MCO) Card**

It is important to keep both cards. Your MCO card will state your MCO, your MCO ID number, your Medicaid ID, and important phone numbers. It is important to note that your Medicaid number and your MCO ID number may not be the same. Be sure to have both cards with you and ready to present when you go to your provider.

If you didn't receive your member handbook or MCO ID card, contact Iowa Medicaid Member Services at 1-800-338-8366.

How can I change my managed care organization (MCO)?

You can change your MCO throughout your managed care experience. You can change your MCO for the following reasons:

1. Within 90 days of the date your managed care coverage begins. You have 90 days from your initial enrollment to an MCO to change your MCO for any reason. For example, if your MCO coverage starts on February 1, you can change your MCO for any reason until May 2.
2. During the annual Open Choice period. After you have been with an MCO plan for 12 months, you may change your MCO for any reason, also known as "without good cause," during your 60-day annual Open Choice period. You will receive a letter from Iowa Medicaid to let you know when you are in your annual Open Choice period. If you wish to keep your current MCO, you do not need to take any action.
3. For "Good Cause" reasons. If you are past the first 90 days and are not in your annual Open Choice period, you must have "Good Cause" to change your MCO. Examples of good cause include:
   - Your provider or dentist is not in your MCO or dental carrier's network
   - You need different but related services to be performed at the same time and not all related services are available within your current MCO or dental carrier's network. Your provider or dentist determined that receiving the services separately would subject you to unnecessary risk

- Lack of providers in your area experienced with your health care and dental needs
- Your provider or dentist has been terminated from or no longer participates with your MCO or dental carrier
- The lack of services in your area is covered by your MCO
- Poor quality of care from your MCO or dental carrier plan
- The MCO or dental carrier plan does not cover the services you need due to moral or religious objections

To change your MCO within 90 days of the date your managed care coverage begins or during your annual Open Choice period, you may:

- Call Iowa Medicaid Member Services at 1-800-338-8366 or 1-515-256-4606 in the Des Moines area
- Complete the Iowa Health Link MCO Change form on the HHS website
  - Email Iowa Medicaid Member Services at: imemember@hhs.iowa.gov
    Mail the form to: Member Services
    PO Box 36510
    Des Moines, IA 50315

If you would like to change your MCO due to “Good Cause,” you must first contact your current MCO to go through the MCO's grievance process for resolution.

If your issue has not been resolved following the decision of your grievance, you may call Iowa Medicaid Member Services at 1-800-338-8366.

When will the change be effective?

Your change in MCO will not happen right away. It will take effect the month after your annual Open Choice period has ended. You will get a letter saying when your new MCO will begin. You will continue to receive coverage from your current MCO until that date. For the specific dates related to your MCO change, contact Iowa Medicaid Member Services.

Example: Your effective coverage date will depend on the date that you requested to make your change. It is always best to contact Iowa Medicaid Member Services to verify when your coverage is in effect. If you request to change your MCO on January 8, your coverage with your new MCO will begin February 1. If you request to change your MCO after the middle of the month, January 21, for example, your coverage with your new MCO will begin March 1.

Rights and Responsibilties

What are my rights as a member?

It is important to know your rights and responsibilities as a managed care member. Your rights are listed in your member handbook. They are in a place to protect you. You have the right to:

- Get the accessible medical care you need when you need it
- Get a second opinion regarding your health care needs
- Choose the provider from the providers available within your MCO
- Change your MCO as allowed by program rules
- Appeal a decision that you do not agree with
- Be treated with respect and dignity
- Be treated without discrimination regarding race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status
- Be part of the choices about your health care, including saying no to treatment

You may request a Waiver of Administrative Rules, also known as an Exception to Policy (ETP), for an item or service that Medicaid would not otherwise cover. A Waiver of Administrative Rules may be granted at the discretion of the Iowa Department of Health and Human Services (HHS). The Iowa Department of Health and Human Services issues written decisions for all requests for a Waiver of Administrative Rules.

Waivers of Administrative Rules may only be granted if HHS is responsible for the rule you are asking to be waived. Waivers cannot be granted to rules that are based on federal policy or state law and those for program eligibility requirements, such as income guidelines or resource limits. You should know there are no appeal rights on a Waiver of Administrative Rules decision. A member who does not agree with the decision can ask for the request to be reconsidered by HHS by writing a letter or completing the online Petition for Exception to Policy form.

Learn more about the process at: https://hhs.iowa.gov/programs/appeals/how-appeal/exceptions-policy, or complete the online Petition for Exception to Policy form.

What are my responsibilities as a member?

It is very important to be involved in your care to make sure you get the help you need when you need it. Your responsibilities are to:

- Learn/know about Medicaid services available to you
- Get regular checkups and care from your provider in their office
- Contact your provider before emergency room visits unless the situation requires emergency care. An emergency is defined as any condition that could endanger your life or cause permanent disability if not treated immediately. Refer to your MCO member handbook or your Iowa Health Link Member Handbook.
- Always carry your current medical assistance card and MCO card. Present it when accessing medical care
- Call the number on the back of your medical cards if you move or have incorrect information printed on your medical cards
- Confirm that your provider is enrolled with Medicaid and is within your MCO's network. Know you could be responsible for payment if a provider is not a Medicaid provider, not contracted with your MCO, or if prior authorization is not received when required

It is also a good idea to:

- Keep important paperwork related to your services and care
- Tell your MCO of any changes in your health
- Open your mail as soon as you get it
- Keep all mail including letters and the envelopes in which the letters were sent from Iowa Medicaid and your MCO
- Update your contact information as needed with Iowa Medicaid and your MCO
- Talk to your providers about what you might need in the future to help plan ahead

Important Topics as a Member

Understanding the managed care system can be tricky. You should understand what to expect from your managed care organization (MCO). If you need help, it is a good idea to have someone you trust help you make sure you get the care you need.

Person-Centered Service Plan

As a member, the care you receive should focus on you, your needs, goals, and likes. You are the most important part of your person-centered service plan (PCSP). This means that any assessments done to determine your care needs and build your service plan should accurately reflect you.

Your person-centered service plan should include:

- People you choose (legal or authorized representative, physician, family, case manager, etc.)
- Making sure, as much as possible, that you direct your plan and can make your own choices and decisions
- Planning at times and locations that work for you
- Including your cultural choices and likes
- Getting information that is understandable to you
- Tips for resolving conflict
- Choice of services and supports you receive and who provides them.
- How to request updates to your care plan.
- Other home and community-based settings you looked into

Person-centered planning helps to make sure you get the services you need and that your MCO checks your services to see if they meet your needs, goals, and preferences. Your MCO should help you coordinate your Medicaid services. Your MCO should also help you fix any problems with your services or providers. If you switch MCOs, your current MCO should talk to your providers, so your services are not delayed or stopped.

If you receive services through one of Medicaid's home and community-based services (HCBS) waivers, federal regulations also say what your service plan should include. These regulations can be read here: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-M/section-441.725 and eCFR :: 42 CFR Part 441 Subpart G -- Home and Community-Based Services: Waiver Requirements.

Important Topics as a Member

Case Management

Your MCO case manager is a main point of contact for you with your MCO. Your case manager is someone who helps make sure you get the services you need to stay healthy and safe. They play an important part in your life. Your case manager will make monthly contact, either in person or by phone and is required to meet with you in your home every three (3) months. Your case manager can help you get resources within your MCO, and community based on your needs and likes.

Your case manager is responsible for working with you to develop a plan to meet your health care needs. Your case manager can help you get in touch with your providers, find services in your community, work with your MCO, and help you fix any problems you have with your care. You can contact your case manager whenever you need to. Do not wait for your case manager to contact you.

Contact your case manager if you have a change in your health or needs. If you have an emergency or are hospitalized, inform your case manager as soon as you are able.

If you are unhappy with your case manager, you have a right to request a new one by calling your MCO's member services. When you make your request, include why you would like a new case manager. Share what you want or need in a new case manager. Your MCO will think about what you want when they choose a new case manager for you.

Medical Necessity

Medicaid only provides services that are considered medically necessary. Medical necessity means that a medical professional, such as your primary care provider (PCP) or another provider, says you need a certain treatment, service, or equipment to help you stay healthy or get better, and by law, you should receive those as long as they are medically necessary. Medically necessary items or services are not just something you want: they are important for your health, so you will need to show there is a medical need.

The request for a needed service must go through an approval process within your MCO. During this process, the MCO reviews the service and amount requested to make sure it is medically necessary specific to your needs.

For children under the age of 21, the Early Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit requires the state to provide treatment and other measures "to correct or ameliorate defects and physical and mental illness" even when those services are not covered by the state plan, when determined to be medically necessary. The determination of whether something is medically necessary for any child is done on a case-by-case basis.

For others, medical necessity is determined by the MCO based on its contract with HHS.

In Iowa, covered services are reviewed by the MCO to be sure they are:

- Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member
- Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment

- Within standards of professional practice and given at the appropriate time and in the appropriate setting
- Not primarily for the convenience of the member, the member's physician or other provider; and
- The most appropriate level of covered services that can safely be provided

The MCO must be fair when deciding medical necessity. They depend on information you, and the people helping you, give to them. To show that a service is medically necessary, it is important to explain why you need it and show proof or documents to support your needs. Usually, a provider will explain why you need a covered service because of your health or disability. The MCO will look at information related to your health and check for providers available to meet your needs.

Medical Necessity Checklist:

- ☐ Include letters from all relevant healthcare and service providers about why you need the service.
- ☐ Talk about the treatments you have tried before, how they worked or did not work for you, and why you are asking to try something different. Include dates.

Prior Authorization

Prior Authorization (PA) is the process of getting approval from the MCO for a service, equipment, or medicine. Not all your services will need PA. If you have questions about PAs, it is best to first contact your MCO member services or case manager.

If you and your provider decide that you would benefit from a service, equipment or prescription drug that requires a PA, it is the provider's responsibility to request a PA. The process includes:

- Your provider gives your MCO information to show that the service, equipment or medicine is medically necessary
- The MCO has a team that reviews the information using rules and guidelines from the Iowa Department of Health and Human Services (HHS)
- If the request is approved, your MCO will let you and your provider know
- If the request is denied or you are approved for less than what was requested, your MCO must send you and your provider a letter explaining:
  - The MCO's decision on the PA request
  - The MCO's reasons for their decisions
  - Your right to file an appeal with the MCO
  - How to file an appeal with the MCO and related information

Prior authorizations must be decided within 14 calendar days from when all necessary information is received. Urgent requests, which are those necessary to treat an injury, illness, or condition that could seriously jeopardize your life, health or ability to regain maximum function, must be decided within 72 hours of receipt. Pharmacy PAs will be processed within 24 hours of the provider's PA request being submitted.

Important Topics as a Member

Level of Care

Some people may need long-term services and supports. Long-term services and supports may include home health, nursing, community living supports, and transportation. To receive long-term services and supports through your managed care organization (MCO), you need to meet a nursing facility, skilled nursing facility, hospital, or intermediate care facility for the intellectually disabled level of care. The process to decide if you meet this level of care is called a Level of Care assessment. This process also helps figure out the services and supports you need.

The level of care assessment for facility is completed prior to facility admission. For HCBS, the level of care assessment is completed when the waiver slot is assigned to determine waiver eligibility and then annually after that. If your needs have changed and you need more services or a change in care setting, a reassessment may also be completed. Your MCO case manager should be involved in your level of care assessment. Your case manager and someone you trust can help you communicate your needs. You should be present at your assessment.

The individual completing the assessment will ask you a variety of questions about your health and ability to complete daily tasks. It is very important that you answer the questions correctly and fully describe your health status and abilities. For example, if you can dress yourself, but it takes several hours to do so on your own, it is important to say that during your assessment.

You have the right to request a copy of your level of care assessment. Be sure to review your assessment and make sure it is correct before the assessor leaves. If there is something you do not agree with, talk with your case manager and the person who completed the assessment to discuss how to correct it. Iowa Medicaid Medical Services reviews Level of Care assessments and determines if you meet the level of care for any waiver.

Nurse Line

If you have a medical question or would like advice about whether you need emergency care, you can contact your MCO's nurse line or on-call physician. The nurse line or on-call physician are resources available to give medical advice 24 hours a day, seven (7) days a week from trained medical professionals. You can also contact your primary care provider (PCP). The phone numbers for your MCO's nurse line, on-call physician, and PCP are listed on your MCO ID card. These numbers are specific to your MCO and can also be found in your MCO member handbook under or near the emergency care section.

Urgent Care

Urgent care is when you are not in a life-threatening situation and have time to call your MCO or provider. If you have an urgent care situation, you should call your provider or MCO to get instructions. The following are examples of urgent care:

- Fever
- Earaches
- Upper respiratory infection
- Stomach pain
- Sore throat
- Minor cuts and lacerations

Emergency Care

How do I know if I need emergency care? What if I have an emergency, and the hospital is not in my MCO's network?

An emergency is when you need to get care right away for trauma, serious injury, and life-threatening symptoms. If you need emergency care, call 911 or go to the nearest hospital, regardless of whether the hospital is in your MCO's provider network. If it is an emergency, you do not need to call your MCO first. Once you have received medical attention and when you are able, let your MCO and primary care provider (PCP) know that you visited the emergency room. Examples of emergencies:

- chest pain
- choking
- severe wound or heavy bleeding
- breathing problems
- severe spasms or convulsions
- loss of speech
- broken bones
- severe burns
- drug overdose
- sudden loss of feeling or not being able to move
- severe dizzy spells, fainting or blackout

Should I go back to the emergency room for follow-up care?

No. Contact your MCO for all follow-up care. Do not return to the emergency room. Your provider will either provide or authorize this care.

Second Opinions

Figuring out and diagnosing a difficult health problem can be hard for any provider, but it is important to get it right. Sometimes, you or someone helping you might have questions about a diagnosis or the options for surgery or treatment. You can ask your provider to submit a request for a second opinion for you.

A second opinion is when you get another provider's opinion about a health service that was recommended for you. The goal is to see if a health service is the right choice for you. Typically, second opinions are given by providers contracted by your MCO. If your MCO does not have a provider for a second opinion, they must arrange for you to get one from a provider outside your network at no cost to you.

Once a second opinion is approved, you will hear from your provider who will:

- Let you know the date and time of the appointment
- Send copies of all related records to the provider who will be giving the second opinion
- Let you and your MCO know the outcome of the second opinion

Grievances, Appeals and State Fair Hearings

The care and services you receive are important to your overall health. Sometimes you might not get the customer service or quality of care you expect from your managed care organization (MCO) or provider. You may also disagree with a decision made about your care. It is important to know how you can share when you are unhappy or concerned about how you were treated. This section will provide an overview of filing a grievance, appealing a decision and requesting a state fair hearing.

It is important to stay in touch with your case manager and share any concerns or issues. You can also share your issue directly with your MCO by contacting your MCO's member services.

File a Grievance

You can only file a grievance about issues such as quality of care, concerns, poor customer service and untimely care. Grievances can be filed at any time. The MCO must acknowledge receipt within three (3) business days and must decide within thirty (30) calendar days.

File an Appeal

You can only appeal a decision that was made about your care, such as a decrease in services or when your request for a service or prescription drug is not approved. Appeals must be filed within 60 calendar days from the date printed on the MCO's adverse benefit determination. If you would like to continue receiving a service that is being reduced or ending while your appeal is processed, you can request continuing services in your appeal. The request for continuing services must be made within 10 days of the date of the MCO's adverse benefit determination or before the date the changes take effect, whichever is later (42 CFR 438.420). The MCO must let you know that they got your appeal within three (3) business days. They must decide within thirty (30) calendar days.

Request a State Fair Hearing

You can request a state fair hearing if you have used the MCO's internal appeal process and are still dissatisfied with the MCO's decision on your appeal. This means you cannot have a hearing until you have filed an internal appeal and your MCO makes its final decision on the appeal. Requests for a fair hearing must be made within 120 calendar days of the date that the MCO made the decision on your appeal.

The following pages outline when and why you might file a grievance or appeal or request a state fair hearing.

Grievances

My services have not been reduced or denied, but I am unhappy with my service or have other concerns. What can I do?

File a grievance. A grievance is a complaint about something other than a change or reduction in your services. Examples may include:

- A rude provider or employee
- The quality of your care or how you were treated
- Not respecting your member rights
- You are unhappy with the time it takes for authorization decisions
- You disagree with the decision to extend an appeal timeframe
- You want to disenroll from your current MCO and request to change MCOs
- Any other problems you may have getting health care and services

As a member, you may file a grievance with your MCO at any time. If someone else files a grievance on your behalf, you must give written consent. If you need help filling out forms or completing other parts throughout the grievance process, your MCO must give you the help you need.

Example: Beth's transportation provider was late to pick her up many times in one month. When Beth talked with the driver, she was told there were too many people to take places, and she would just have to deal with being late. Beth's MCO did not ensure her services were received on time, and the provider was rude. Beth submits a grievance to her MCO.

How do I file a grievance?

1. Review your member handbook. Your member handbook will include how to file a grievance with your MCO. You may submit your grievance at any time.
2. Know what you want to tell your MCO: be as detailed as you can. Include dates, times and names if you remember them. If you have a letter from your MCO related to your reason for the grievance, keep it in a safe place to maintain the record. Make sure the information you send is only about your complaint.
3. Pick how you want to submit your grievance. Refer to your MCO's member handbook for details on how you can file your grievance with your MCO. How you share your grievance (online in an email or in your member portal, by telephone, fax or mail, for example) will depend on which MCO you are with.

4. Submit your grievance. Refer to the process in your member handbook. Be as detailed as you can. If you choose to call, make a record of the date, time and name of the individual you spoke with. If you choose to mail, keep a copy of your letter and write down what day you sent it.
5. You will receive a letter from your MCO acknowledging your grievance within three (3) business days from the date the MCO received your grievance.
6. Your MCO will decide on your grievance within 30 calendar days from the date they received the grievance. MCO grievance decisions must be made in writing. You or your MCO can have an extra 14 days if more information is needed, and it is in your best interest. If your grievance is urgent, your MCO must decide as quickly as needed.

Appeals

I disagree with a decision my MCO made about the services I receive. What can I do?

File an appeal. An appeal is when you ask your MCO to reconsider a decision about your care. For example, if your MCO says they will cut back, deny, or stop your services, and you don't agree with that, you can appeal the decision.

When your MCO decides to deny, decrease or otherwise limit your services, they must send you a written notice informing you of the decision. That decision may be called an "adverse benefit determination," a "prior authorization notification" or a "notice of proposed action." If the MCO's action affects services you were previously authorized to receive, then the MCO must mail you notice of their decision at least 10 days before the decision is implemented.

Appealing an MCO decision can be hard. As a member, you, your provider or your authorized representative may submit an appeal on your behalf with your written consent. You have the right to legal help, though assistance from a lawyer is not required. It is recommended to have an advocate assist you if possible. The MCO must provide you with any reasonable assistance in completing forms and taking other steps in the appeal process.

Example: John receives care in his home to help him remain independent. A home health aide visits John three times weekly to assist with bathing and personal care. John gets a letter from his MCO saying that his home health aide will be visiting only once every week instead. John submits an appeal with his MCO.

How do I file an appeal?

Follow the steps below to submit an appeal with your MCO. A sample letter is provided in Appendix A: MCO Member Appeal Sample Letter.

1. Review the notice letter from your MCO describing their decision and their reasoning. This notice will tell you how to appeal and will include important deadlines. Your member handbook also states how to file an appeal. Note the date of the MCO letter and the postmark date on the envelope to determine when you need to submit your appeal. Your appeal must be submitted within 60 calendar days of the date on the notice of decision. If you want to keep your services while you appeal, you need to act quickly. You must ask to

keep your services within 10 days after the MCO sent you the decision, or before the change starts, whichever gives you more time. Otherwise, the MCO's decision can be implemented during your appeal. Always save important letters from your MCO, including the envelopes showing when the letters were mailed to you.

2. Know what you want to tell your MCO and be as detailed as you can. The notice of decision from your MCO should state the reason for their decision. Gather information that shows why the reason is wrong and add it to your appeal. For example, include copies of medical records that indicate your medical service is medically necessary. Include dates, times and names if you can remember them. If you have a letter from your MCO related to your appeal, keep it in a safe place.
3. Pick your method for submission. Your appeal may be submitted to your MCO by telephone or mail. Refer to your MCO's member handbook for telephone and mailing address contact information. It is always recommended to file your appeal in writing. If you choose to submit your appeal by telephone, you will need to follow up with a written appeal.
4. Submit your appeal. Look at the instructions in your notice of decision or member handbook. Keep a copy of your written appeal and write down the day you sent it. As a member, you have the right to examine your case file, including medical records and any other documents or records, during the appeal process. You also have the right to present evidence in person or in writing. Save any documentation showing when you submitted your appeal, such as postage receipts, certified mail receipts, or fax confirmations.
5. You will receive a letter from your MCO acknowledging your appeal within three (3) business days from the date the MCO received your appeal request. Keep a copy of the letter and the envelope with the date it was mailed to check the dates.
6. Your MCO will decide on your appeal within 30 calendar days from the date they receive the appeal. MCO appeal decisions must be in writing and must describe the action taken and the reason for the action taken. You or your MCO can have an extra 14 calendar days if more information is needed, and it is in your best interest.

Expedited (Fast) Appeal

If the normal appeal process could make your health worse or make it harder for you to get better, you can ask for an expedited appeal, also called a fast appeal. To file an expedited appeal, call your MCO. You do not have to submit anything in writing for an expedited appeal; however, you may submit documents to support your appeal by sharing them with your MCO. Your MCO must give you a decision within 72 hours of receiving your expedited appeal.

Continued Benefits

MCOs must continue to provide your benefits while an appeal is being reviewed if the appeal is about stopping, cutting back, or pausing services you were already approved for, and you have requested your services to continue within the required timeframe.

If you would like to continue to receive your service(s) during an appeal, you must:

- Ask to keep getting your services within 10 calendar days after you get the decision from your MCO, or before the change is supposed to start
- File your appeal with the MCO within 60 calendar days from the date of the notice of decision (if the appeal is filed separately from the request for continuation of benefits)

If your MCO's decision to stop, cut back, or limit your services is supported after your appeal, you may be responsible to pay for the services that were provided to you solely because of a request for continuation during your appeal.

Deemed Exhaustion

If your MCO fails to follow the notice and time standards in the appeal process, you have the right to move on to request a state fair hearing with the Iowa Department of Health and Human Services without first appealing at the MCO level. This is called "deemed exhaustion."

Next Steps

If you still do not agree with the final outcome of your MCO appeal, you have the right to request a state fair hearing.

State Fair Hearings

I am still dissatisfied with my managed care organization's (MCO) decision on my appeal. What can I do?

Request a state fair hearing. A state fair hearing is an appeal to the Iowa Department of Health and Human Services (HHS), as it is the agency that oversees the Medicaid program. In a state fair hearing, you make your case before an administrative law judge (ALJ). The ALJ does not work for HHS and is a neutral decision maker. You and your MCO will have the opportunity to show proof, including documents and witness testimony. Your goal is to show that there is a medical need for the service or equipment you requested. The ALJ will review the evidence provided and will decide on your case. The decision will be mailed to you approximately 30 days after the hearing.

How do I request a state fair hearing?

You have 120 calendar days from the date on the MCO appeal decision to ask for a hearing. The written notice from the MCO should advise you about the right to request a hearing and how to do so. Most hearings are on the phone. If you would like to have an in-person hearing in Des Moines, you should include this in your request for a hearing.

To request a hearing, follow the steps below. A sample letter is provided in Appendix B: Request for State Fair Hearing Member Sample Letter.

1. **Request to continue service(s).** Your MCO must keep giving you your services while they look at your appeal if your appeal is about stopping, lowering, or pausing services you were already told you could have, the time you were approved for isn't over yet, and you ask for the services to keep going. If you would like to continue receiving your services during the hearing appeal, you must request this within 10 calendar days of the date of the MCO decision on your appeal or before the date the change is set to take effect (42 CFR 438.420). Remember, if the ALJ upholds the MCO's decision, you may be responsible for paying for the service you received during the hearing process. This is called "recoupment" of benefits.
2. **Pick your method of filing and submit your request.** It is recommended that you explain the service or issue you are appealing to. Also state that you have either completed the MCO level of appeal or that you are entitled to "deemed exhaustion" due to notice or timing issues with the MCO appeal process. A sample written request for a state fair hearing can be found in Appendix B. Keep a copy of your written request and write down what day you submitted your request to the HHS Appeals Section.

Your request for a hearing may be submitted to the HHS Appeals Section

Phone: 1-888-723-9637

Email: appeals@hhs.iowa.gov

Mail or in-person: 321 E. 12th Street, 4th Floor
Des Moines, IA 50319

Online: https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest
Spanish version: https://secureapp.dhs.state.ia.us/dhs_titan_public/appeals/appealrequest/1

3. **Receive confirmation that your request for a state fair hearing has been received.** This letter will come from the HHS Appeals Section. Review of your request. The HHS Appeals Section will review your request to determine if a hearing can be granted. If a hearing is granted, you will receive notice of hearing. The notice of hearing will include the hearing date and time and include the name of the administrative law judge (ALJ) involved in your appeal.

4. **Prepare for the hearing.** Anyone you trust, such as providers, medical professionals, case managers, family, and friends, can help you during your hearing. You are also entitled to have legal representation at your hearing. It is important to stay organized, understand your rights, and show that you need the medical service or equipment you asked for. The Iowa Department of Inspections, Appeals, and Licensing (DIAL) website provides helpful information regarding hearings. To prepare for your hearing, you should:

   Gather documents. Gather any information or records that show why you need the medical service or equipment you asked for. If the service was taken away or reduced before and it made your health worse, be sure to have papers that can help prove that. These papers are called “exhibits” in a hearing. If you want to use exhibits in your hearing, you must send them to the ALJ and your MCO at least five (5) business days before the hearing. The hearing notice you receive will tell you how to send in your exhibits.

   Request documents. You have the right to see all the information in your file, including any information the MCO used when they made the decision to deny, end, or reduce your service. Contact your MCO to request a copy of your entire file. You want the entire file because, although your MCO would have used your most recent assessments to make their decision, the file may include past assessments that may help you show that the newest assessments do not reflect your needs today.

   Share documents you plan to use. You and your MCO are both required to share documents with each other before your hearing if they will be used at the hearing. The notice of hearing you get will tell you when and how to file any documents. HHS may also submit an appeal summary. These documents are usually shared within five (5) business days before the hearing date.

   Invite others to your hearing. Ask medical professionals, like your primary care provider (PCP) or other providers involved in your care, to help explain why you need the service you are asking for. Other people who help with your care, like direct care workers, can also be good witnesses. If they can’t come to the hearing, they can write a letter explaining why the service is needed.

5. **Attend your hearing**. Your hearing will likely occur by telephone conference unless you request an in-person hearing. It is your responsibility to call in for the hearing on the date and time it is scheduled. You may call in as early as five (5) minutes before your hearing is scheduled to begin. The ALJ will lead the hearing. You and the MCO will each be given a chance to state your case.
6. **Make your case.** This is your chance to explain to the judge why you need the service or equipment. It is important that you:
   - Prove medical necessity
   - State the type and amount of service you need
   - Discuss how the service will or has helped you
   - Show how your health gets worse if you do not receive the service

You will need to show proof and talk about your needs. You should share evidence that will help the judge understand what the requested service or equipment is and why you need it. Remember that any evidence needs to be shared with the ALJ before your hearing. Evidence can include:

- Statements from yourself or others who support you
- Records (medical, school, etc.)
- Documents (letters from your primary care provider (PCP), information about the service or equipment, etc.)
- Pictures of items or equipment you use or would like to use to help meet your needs. For example, if you requested certain equipment, you could show the judge a picture of it

It is important to stay focused on the reason for your appeal during the hearing. A Medicaid state fair hearing is to talk only about the service or equipment that was denied, stopped, reduced, or taken away. This is not the time to bring up other issues you have with your MCO or your service provider or share other frustrations. Bringing up other issues can distract the judge from your appeal.

Witnesses can include anyone who can speak to your medical need for the service or equipment. A witness should be able to describe the service and amount requested, its impact on your health, and the negative effects of not having the service or equipment. Consider the following to be witnesses:

- Primary care provider (PCP)
- Medical professional
- Other provider
- Case manager
- Family
- Friends

7. **Check with your witnesses to make sure they are available on the day and time of your hearing.** If they are not available at the scheduled day and time, you can let the ALJ know this and of their availability before the hearing date. If one of your witnesses is not available, that may be “good cause” for requesting an extension, which is a later hearing date. A decision is not made during your hearing. The ALJ will decide about your case and issue a proposed decision, which you will be notified of within approximately thirty (30) days of the hearing. Both parties have appeal rights from the ALJ’s proposed decision, so read the decision carefully for additional appeal rights and the process.

Building Your Support System

A support system and advocates can help you understand and work through the managed care system. Your support system should include people who help you with everyday things and give you emotional support. This can be family, friends, helpful groups, case managers, and your managed care organization (MCO). They all work together to help you live a better life.

Anyone helping you should be someone you can trust, who shows up when needed, and who understands you and your needs. The people helping you might change depending on what you need and what you've been through. You might include your support system when you are:

- Identifying resources
- Needing help with IA Health Link and MCO communications
- Explaining your needs
- Making decisions about your managed care experience
- Participating in your health care

What is an advocate, and what do they do?

An advocate can be a lot of different people. Pick someone:

1. Who knows you well, understands you, and understands what you like and don't like
2. Who will help you but knows you must be involved in decisions about your life
3. Who can help you build positive relationships with people who serve you
4. Who will help you learn new skills and let you use them

In your managed care experience, an advocate is someone who helps you make decisions and explains complicated information so you can understand it better. You are the primary decision-maker.

Why would you want to have an advocate?

- You don't understand something well enough to decide
- You would like to talk about a decision you need to make before you make a final decision
- You would like to find more information
- You would like help talking with others
- You need help keeping track of papers and records

An advocate can do a lot that might be helpful for you, such as:

- Write things down for you
- Help you decide what questions to ask
- Explain things to you
- Find more information for you
- Go to meetings with you
- Talk to others with you, not for or without you

What are other ways you can be involved in your managed care?

There are other ways you can give input and speak up for yourself and others during your managed care experience.

You can attend Medicaid Town Halls.

Town halls are virtual monthly meetings for Medicaid members and providers to learn about the Medicaid program, receive updates and voice any questions or concerns directly to the Iowa Medicaid state team. Town halls are also a way for Iowa Medicaid to hear suggestions from members and providers and work toward solutions. Visit Medicaid Town Halls to learn more.

You can be part of your MCO's Stakeholder Advisory Board (SAB).

Each MCO meets regularly with a group of members to discuss the MCO, member experiences and various topics. This is a chance to learn more about the MCO, ask questions, and give suggestions to the MCO. Call your MCO member services and ask about the Stakeholder Advisory Board.

You can be involved with the Iowa Developmental Disabilities Council (Iowa DD Council).

The Iowa DD Council works to create change with and for people with developmental disabilities so they can live, work, learn, and play in the community of their choosing. Visit https://www.iowaddcouncil.org/ to learn more.

You can be selected for the Beneficiary Advisory Council (BAC).

The Beneficiary Advisory Council (BAC) is made up of Medicaid members and people who support them. You must be chosen for this council. The BAC is federally required, and the purpose is to share about your Medicaid experience, problems with Medicaid policies, and ways to make Medicaid better. More information is on HHS's website at https://hhs.iowa.gov/advisory-groups/beneficiary-advisory-council-bac.

You can contact your legislators.

Legislators want to know what is important to you. It helps them understand what you want or need so that they can assist you better. You can find your legislator at www.legis.iowa.gov/legislators/find.

Further Assistance

It is important you understand the managed care system and how to advocate for yourself and your rights. Additional resources are available to help you as a managed care member.

MCO Member Services

As a managed care member, you have access to your case manager and the managed care organization's (MCO) member services. If you have an issue, concern or question about your care, your MCO should be your first point of contact. Your MCO's member services department includes a dedicated helpline staffed with trained individuals who know about your MCO and can handle many questions you may have. If member services cannot help you with your question or you would like to be connected with another MCO service, member services can transfer you directly. Member services are also available by email and mail and has services to communicate if you do not speak English, are deaf or are hard of hearing. Your MCO member services can answer questions, such as those about:

- Nurses (available 24/7)
- Vision
- Non-Emergency Medical Transportation (NEMT)
- Medical Management
- Health Education
- Care Management
- Physical and Behavioral Health
- Waiver and Facility-Based Services
- Interpreter Requests

Communication with your MCO is an ongoing process that helps ensure you receive the necessary long-term services and supports you need. Your MCO should be aware of any changes in your health and providers as well as life changes and emergencies. If you have a question or problem or need help, contact your MCO. If they are not able to help, ask them to connect you to the right source or help you find the answer.

Iowa Medicaid Member Services

Although your MCO manages and coordinates your health care, Iowa Medicaid still has a role. Iowa Medicaid Member Services is a customer service line which can help you with questions specifically related to Medicaid. Customer service representatives are trained to help with billing, address changes, Medicaid information, Medicaid ID cards, MCOs and third-party liability. If you have questions related to Medicaid, Iowa Medicaid Member Services can be a great resource to use. If they are unable to help answer your question directly, they will refer you to the right resource(s). Iowa Medicaid Member Services can be reached by phone at 1-800-338-8366, by email at imemember@hhs.iowa.gov, or by mail and has services to communicate if you do not speak English, are deaf or are hard of hearing.

Further Assistance

Iowa Aging and Disability Resource Center

Aging and Disability Resource Center Network Aging and Disability Resource Centers (ADRCs) help make it easier for older adults and people with disabilities in Iowa to find the services and support they need. They work with different partners to make sure people get the right help in a simple and easy way. Disability Access Points (DAPs) and Area Agencies on Aging (AAAs) are part of the ADRC network. Iowa's ADRCs can be reached by phone at 1-800-779-2001 or online at https://hhs.iowa.gov/health-prevention/aging-services/aging-and-disability-resource-center-adrc-network.

Office of the State Long-Term Care Ombudsman

The Office of the State Long-Term Care Ombudsman (OSLTCO) advocates for the rights and needs of Medicaid managed care members who live or receive care in a long-term care facility as well as members enrolled in one of Iowa Medicaid's home and community-based services (HCBS) waiver programs.

The OSLTCO provides:

- Education and information regarding your rights as a Medicaid managed care member
- Advocacy and complaint resolution when you are unable to resolve an issue with your MCO
- Appeals assistance when you are dissatisfied with a decision made by your MCO about your care

The OSLTCO can be reached by phone at 1-866-236-1430, by email at sltco@hhs.iowa.gov, or online at https://hhs.iowa.gov/aging-services/ltcombudsman.

Office of Ombudsman

The Office of Ombudsman services as an independent and neutral agency to which citizens can submit their grievances about government. The Ombudsman helps people communicate with the government and suggests ways to make the government better. The Ombudsman has authority to investigate complaints about the Iowa state and local government, with certain exceptions. The Ombudsman attempts to resolve most problems informally. Following an investigation, the Ombudsman may make findings and publish a report. The Ombudsman may provide the following:

- Look into complaints about an agency, worker, or official in Iowa government privately, as much as the law allows
- Accept complaints about Iowa Medicaid or your MCO after you've gone through all the grievance and appeal steps, unless it's an emergency or crisis
- Work with an agency to fix a problem if it's found that the agency broke the law, acted unfairly, or made a mistake
- Suggest changes to rules or policies, if needed
- Answer questions about the government or help you find someone else who can answer questions

The Office of Ombudsman can be reached by phone at 1-515-281-3592 or online at https://ombudsman.iowa.gov/.

Further Assistance

Iowa Developmental Disabilities Council

The Iowa Developmental Disabilities Council (DD Council) was established under the federal Developmental Disabilities Assistance and Bill of Rights Act. This important legislation ensures that individuals with developmental disabilities get the help they need and choose and control their services.

The DD Council advocates for Iowans with disabilities so they can live and be part of their communities. The DD Council, made up of volunteers appointed by the Governor, includes individuals with disabilities, family members, state government leaders, and representatives from advocacy organizations. This network of Iowans works to create meaningful change through advocacy. The Iowa DD Council can be reached by phone at 1-800-452-1936 or online at www.iowaddcouncil.org.

Disability Rights Iowa

Disability Rights Iowa (DRI) is an independent nonprofit law firm that provides services to defend and promote the human and legal rights of Iowans who have disabilities and mental illness. The cases DRI accepts are based on the areas of focus set by DRI's board of directors. Disability Rights Iowa may assist with issues such as abuse, discrimination, and denial of services.

Disability Rights Iowa can be reached by phone at 1-800-779-2502, by email at info@driowa.org, or online at www.disabilityrightsiowa.org.

Iowa Legal Aid

Iowa Legal Aid is a nonprofit organization that provides critical legal assistance to low-income and vulnerable Iowans who have nowhere else to turn. Along with volunteer lawyers throughout the state, Iowa Legal Aid helps the legal system work for those who cannot afford help with legal issues.

Iowa legal Aid can be reached by phone at 1-800-532-1275 or online at www.iowalegalaid.org.

Iowa State Bar Association

For additional information and referrals to attorneys who may be able to assist you, contact the Iowa State Bar Association by phone at 1-800-457-3729, by email at isba@iowabar.org, or online at www.iowafindalawyer.com.

Senior Health Insurance Information Program

The Senior Health Insurance Information Program (SHIIP) is a free, confidential service from the Iowa Insurance Division. It provides one-on-one counseling and education to Medicare beneficiaries, their families, and caregivers to help them make informed decisions. SHIIP supports those with limited incomes, individuals under 65 with disabilities, and people eligible for both Medicare and Medicaid. Services are delivered by trained counselors across Iowa. Find a local counselor at https://shiip.iowa.gov/find-resources/find-counselor.

Appendices

Appendix A: MCO Member Appeal Sample Letter

[Date]

[Managed Care Organization]

[Address]

Re: Appeal and Request for Continuation of Benefits

Dear Member Appeals Coordinator:

I am a Medicaid beneficiary and a current member of your managed care organization. This letter is a request for an appeal to [describe what it is you are appealing]. I also request that my benefits be continued while this appeal is considered.

Background

I am diagnosed with [list all your relevant medical conditions]. [Describe how your diagnosed conditions affect you and include what services you receive to assist you with those conditions. Only include information that is relevant to the specific issue(s) you are appealing to].

[Include a short description of the issue(s) you are appealing. Specifically list each decision your MCO has made that you disagree with and include dates if you can. Be sure to list every issue that you are appealing to, or you may forfeit your appeal rights to unlisted issues].

Discussion

[Now describe your argument. Tell the MCO why their decision is wrong. Include detailed information on what negative impact the MCO's decision will have on you. Include information or opinions from your medical providers that support your argument if you have this information. The following are common examples of issues:

- A service reduction or termination will result in harm to your health and safety or will cause you to move into a health care facility
- A service reduction or termination was not based on your medical needs
- An assessment used in the decision was incorrect, or your needs have changed
- Notice provided was insufficient or not timely]

Conclusion

This is a request appealing [the issues described above]. I also request that my benefits be continued during this appeal.

Sincerely,

[Name]

Enc: [Be sure to list any supportive documents you are submitting with your appeal].

Appendices

Appendix B: Request for State Fair Hearing Member Sample Letter

[Date]

Department of Health and Human Services
Appeals Section

321 E. 12th Street, 4th Floor

Des Moines, IA 50319

Re: Request for State Fair Hearing

[Member Name, Medicaid Number]

Dear Member Appeals Coordinator:

I received a written letter dated [insert the date of your letter] from my managed care organization, [list MCO name]. The MCO has reduced, suspended or terminated [state the MCO action here]. This letter is a request for a state fair hearing.

Background and Reason for Appeal

[Describe yourself/person you are writing on behalf of and the factual circumstances here. It is recommended that you list any other reason including inadequacy or timeliness issues with the notice of adverse benefit determination/prior authorization notification/notice of proposed action and appeal rights].

Exhaustion of MCO Appeal Process

I, [include member name], have exhausted the MCO appeal process. On [include month, day and year of initial denial letter from MCO], I received an initial denial letter from MCO [list MCO name]. This decision was appealed in a letter dated [state the date of the letter to appeal]. On [state the month, day and year of denial], MCO [list MCO name] again denied my claim. The reason cited for their decision was that the information reviewed [state reason for denial, e.g., fails to establish medical necessity for the requested service]. I disagree with the finding of the MCO that [restate reason, e.g., this device is not medically necessary. Examples may include:

- Failure to meet language and format requirements, such as not receiving a denial in writing, lack of required content of notice, and the timing of the notice
- Failure by the MCO in handling grievance or appeal. An example is when a reviewer of the MCO appeal was the same person involved in previous level of review or is not a professional with appropriate clinical expertise. Another example is failure to provide you with a copy of your case file when requested]

[State if you want your Medicaid services to continue pending the appeal process (must be requested within a 10 calendar-day timeframe of the date of notice on the MCO letter of decision or before the date the changes take effect, whichever is later).]

Request for State Fair Hearing

I request a state fair hearing.

Sincerely,

[Member Name]

[Address]

[Phone Number]