**Section 4000, Complaints, Internal MCO Appeals and State Fair Hearings**

Revision 19-2~~18-0~~; Effective December 2, 2019~~September 4, 2018~~

**4100 Managed Care Organization Procedures**

Revision 11-4; Effective December 1, 2011

The managed care organization (MCO) must develop, implement and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations, including Code of Federal Regulations 42, §431.200, 42 CFR Part 438, Subpart F, Grievance System, and the provisions of Texas Administrative Code 1, Chapter 357, relating to Medicaid managed care organizations.

The MCO's complaint and appeal systems must include:

* a complaint process;
* an appeal process; and
* access to the Health and Human Services Commission fair hearing process.

**4110 MCO Complaint Procedures**

Revision 14-1; Effective March 3, 2014

The Health and Human Services Commission's (HHSC) Uniform Managed Care Contract Terms and Conditions, Attachment A, defines a complaint as:

"an expression of dissatisfaction expressed by a Complainant, orally or in writing to the managed care organization (MCO), about any matter related to the MCO other than an Action. As provided by 43 CFR §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights."

The complaint procedure does not apply to situations described in "Appeal Procedures."

When a managed care organization (MCO) member wants to file a complaint, he or she must first contact the MCO, following procedures specified in the MCO's member handbook. The MCO must provide a designated member advocate to assist the member in using the complaint system. The advocate must assist members in writing or filing a complaint, and monitor the complaint throughout the process until the issue is resolved.

If the member is not satisfied with the outcome of the MCO complaint process, he or she sends a written request to HHSC to investigate the complaint. The request is sent to:

Texas Health and Human Services Commission Managed Care Operations – STAR+PLUS Mail Code H-320 P. O. Box 13247 Austin, TX 78711

If a STAR+PLUS member contacts any HHSC employee with a complaint regarding an agency licensed by HHSC, the member is referred to 1-800-458-9858 to file a regulatory complaint.

Members may also call the Medicaid hotline at 1-800-252-8263 to file a complaint not related to licensure issues.

**4120 MCO Appeal Procedures**

Revision 14-1; Effective March 3, 2014

The Health and Human Services Commission's Uniform Managed Care Contract Terms and Conditions, Attachment A, defines an appeal as the formal process by which a member or his or her representative requests a review of the managed care organization’s (MCO’s) action. An action is:

* the denial or limited authorization of a requested Medicaid service, including the type or level of service;
* the reduction, suspension or termination of a previously authorized service not caused by loss of eligibility;
* denial in whole or in part of payment for service;
* failure to provide services in a timely manner;
* failure of an MCO to act within the time frames set forth in the contract and 42 Code of Federal Regulations (CFR) §438.408(b); or
* for a resident of a rural area with only one MCO, the denial of a Medicaid member's request to obtain services outside of the network.

The member may file an appeal by contacting the MCO following the procedures specified in the MCO's member handbook. The MCO is contractually required to regard any oral or written expression of dissatisfaction or disagreement as a request to file an appeal. The MCO must provide a designated member advocate to assist the member in filing an appeal. The advocate must also assist members by monitoring the appeal throughout the process until the issue is resolved.

During the appeal process, the MCO must provide the member a reasonable opportunity to present evidence and any allegations of fact or law in person, as well as in writing. The MCO must inform the member of the time available for providing this information and that in the case of an expedited resolution, limited time will be available.

The MCO must provide the member and his or her representative the opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents considered during the appeal process.

As required by 42 CFR §438.420, the MCO must continue the individual's benefits pending the outcome of the appeal if all the following criteria are met:

* appeal is filed by the effective date of action;
* appeal involves termination, suspension or reduction of a previously authorized course of treatment;
* services were ordered by an authorized provider; and
* original period covered by the authorization has not expired.

**4121 Expedited MCO Appeals**

Revision 11-4; Effective December 1, 2011

In accordance with 42 Code of Federal Regulations §438.410, and [Uniform Managed Care Contract](https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/UniformManagedCareContract.pdf) (UMCC) Attachment B-1, Section 8.2.7.3, the managed care organization (MCO) must establish and maintain an expedited review process for service-related appeals when the MCO determines (for a request from a member) or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life or health. The MCO must follow all appeal requirements for standard member appeals as set forth in UMCC Attachment B-1, Section 8.2.7.2, except where differences are specifically noted. The MCO must accept oral or written requests for expedited appeals.

After the MCO receives a request for an expedited appeal, the MCO must notify the member of the outcome of the expedited appeal request within three business days. However, the MCO must complete investigation and resolution of an appeal relating to an ongoing emergency or denial of continued hospitalization:

* in accordance with the medical or dental immediacy of the case; and
* not later than one business day after receiving the member's request for expedited appeal.

Members must exhaust the MCO’s expedited appeal process before making a request for an expedited state fair hearing.

Except for an appeal relating to an ongoing emergency or denial of continued hospitalization, the time frame for notifying the member of the outcome of the expedited appeal may be extended up to 14 calendar days if the member requests an extension or the MCO shows (to the satisfaction of the Health and Human Services Commission (HHSC), upon HHSC’s request) that there is a need for additional information and how the delay is in the member’s interest. If the time frame is extended, the MCO must give the member written notice of the reason for delay if the member did not request the delay.

If the decision is adverse to the member, the MCO must follow the procedures relating to the notice in UMCC Attachment B-1, Section 8.2.7.5. The MCO is responsible for notifying the member of his/her right to access an expedited fair hearing from HHSC. The MCO is responsible for providing documentation to the state and the member, indicating how the decision was made, prior to HHSC’s expedited fair hearing.

The MCO is prohibited from discriminating or taking punitive action against a member or his/her representative for requesting an expedited appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution, nor supports a member’s request.

If the MCO denies a request for expedited resolution of an appeal, the MCO must:

* transfer the appeal to the time frame for standard resolution; and
* make a reasonable effort to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

**4200 Appeal Procedures for Program Support Staff**

Revision 14-1; Effective March 3, 2014

**4210 PSU Specialist Procedures**

Revision 19-2; Effective December 2, 2019

When a request for a fair hearing is received from an applicant or member, orally or in writing, Program Support Unit (PSU) staff must refer the request to the hearings officer within five calendar days from the date of the request. Upon receipt of the fair hearing request, the PSU specialist completes [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary. The PSU specialist sends the form to the regional data entry representative (DER) and the supervisor within **three** calendar days of the request for a hearing. The three-day time frame allows the DER two days to enter the information into the Texas Integrated Eligibility Redesign System.

When PSU staff complete Form 4800-D, all questions in Section 3, Appellant Details Programs, must be answered. In Subsection D, Summary of Agency Action and Citation, staff must always answer “No” to the question, “Is there a good cause for non-timely?” as this question applies only to Texas Works programs.

PSU staff must indicate the Individual Service Plan (ISP) or Individual Plan of Care (IPC) begin and end dates, as applicable, in Section 3.D., Summary of Agency Action and Citation. The begin and end dates must also be mentioned during the fair hearing so the hearings officer is aware of when the ISP or IPC year ends when rendering a decision for STAR+PLUS Waiver.

The Form 4800-D format follows the data entry screens. See the Form 4800-D instructions for more specific directions for completion and transmittal.

**4211 Designated DER Procedures**

Revision 19-2; Effective December 2, 2019

Within two calendar days of receipt of [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary, the data entry representative (DER) enters the information into the Fair Hearings and Appeals system in the Texas Integrated Eligibility Redesign System. When entry of all information is complete, the system assigns the appeal identification (ID) number. The DER notes the appeal ID number on the bottom of the form and in the designated space on the front of the form, and sends a copy back to the PSU specialist and his supervisor.

When an applicant or member requests a fair hearing, the burden of proof to uphold the PSU decision rests with the PSU. The hearings officer is a neutral party and is restricted by law from presenting the agency’s case. It is crucial that staff complete and organize all fair hearing packets in order to support the agency’s decision.

**4212 Fair Hearings and Appeals Procedures**

Revision 14-1; Effective March 3, 2014

The Texas Integrated Eligibility Redesign System generates a hearing packet, which includes:

* [Form H4803](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4803-notice-hearing), Notice of Hearing; and
* [Form H4800](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4800-fair-hearing-request-summary), Fair Hearing Request Summary.

The Program Support Unit (PSU) coordinator and his/her supervisor receive a copy of Form H4800 and Form H4803, identifying the fair hearings officer assigned to the appeal and the date, time and location of the hearing. PSU staff are not expected or required to attend fair hearings.

**4213 Hearing Packet**

Revision 19-2; Effective December 2, 2019

Use [Form H4800-A](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4800-a-fair-hearing-request-summary-addendum), Fair Hearing Request Summary (Addendum), to submit all supporting documentation to the fair hearings officer. Be sure documentation on the form clearly states this is a STAR+PLUS Program appeal. The appeal identification number assigned by the Texas Integrated Eligibility and Redesign System must be written on the top of Form H4800-A.

Use [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary, to record the names, titles, addresses and telephone numbers of all persons, or their designees, who should attend the hearing. For appeal issues related to service delivery, enter the names of the designated managed care organization (MCO) staff and the designated backup. Program Support Unit (PSU) staff should contact the MCO if there is doubt as to who should be listed on Form 4800-D.

Depending on the issue being appealed, the following staff must attend:

* MCO and Texas Medicaid & Healthcare Partnership (TMHP) (for medical necessity/level of care (MN/LOC) denials);
* MCO (for denials of individual service plans (ISPs) over the cost ceiling); and
* Medicaid for the Elderly and People with Disabilities (MEPD) (for financial denials).

All related documentation necessary to support the decision taken on an Home and Community-based (HCBS) STAR+PLUS Waiver (SPW) case must be sent to the fair hearings officer within 10 business days prior to the hearing. Each entity involved in the fair hearing is responsible for preparing its packet and forwarding it to both the hearings officer identified on [Form H4803](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4803-notice-hearing), Notice of Hearing, and the appellant. Be sure documentation on the form clearly states this is a STAR+PLUS Waiver Program appeal. All documentation must be neatly and logically organized, and all pages numbered.

Examples of additional information and who is responsible for submitting that information to the state fair hearings office include, but are not exclusively limited to:

* MCO:
	+ MCO policy handbook, *STAR+PLUS Handbook* and/or *Uniform Managed Care Contract/Uniform Managed Care Manual*;
	+ summary of events;
	+ other documentation supportive of the decision, such as documentation of telephone calls, visit summaries, etc.; and
	+ copies of the signed [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan — SPW (Pg. 1) and [Form H1700-2](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-2-individual-service-plan-pg-2), Individual Service Plan — SPW (Pg. 2), Individual Service Plan, and all relevant attachments;
* MEPD:
	+ documentation supportive of the financial decision, including official documentation forms, telephone calls, etc.; and
	+ a copy of the original signed denial form;
* TMHP:
	+ a copy of the MN/LOC; and
	+ other documentation supporting the decision; and
* PSU — a copy of the original signed [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services (if available, use the signed copy of the form returned by the applicant/member when the appeal was filed).

After the data entry representative (DER) has added information from Form 4800-D into the Texas Integrated Eligibility Redesign System (TIERS), PSU may learn of subsequent changes such as address changes, withdrawal forms or additional supporting documents needed for a fair hearing. When this occurs, PSU staff complete Form H4800-A with the updated information and submit it to the designated DER who will check TIERS to identify if a fair hearings officer has been assigned to the case. In the event the participant updates need to be communicated to the fair hearings officer, PSU staff complete and forward Form 4800-D to the DER.

If a fair hearings officer is not yet assigned, the DER must wait until one is assigned to send the additional information. When sending information, the DER completes the following activities according to the situation:

* When PSU staff submit Form H4800-A or Form H4800-D to the DER, the DER sends the form(s) directly to the hearings officer’s email address with the appeal ID number in the subject line.
* If the PSU staff submission to the DER includes additional supporting documentation for an appeal, the DER not only emails Form H4800 to the assigned hearings officer, but also uploads the supporting documentation directly into TIERS. The email sent by the DER must include the appeal ID number in the subject line, as referenced above, and inform the hearings officer that supporting documentation listed in Section 2 of Form H4800-A has been uploaded to TIERS.

PSU staff and the DER must follow current time frames and procedures to ensure supporting documentation is uploaded into TIERS no later than 10 calendar days prior to the fair hearing date.

**4220 Special Procedures for Cases MEPD or TW Determined Financial Eligibility**

Revision 14-1; Effective March 3, 2014

**4221 Centralized Representation Unit**

Revision 14-1; Effective March 3, 2014

The Health and Human Services Commission (HHSC) Office of Eligibility Services (OES) maintains a Centralized Representation Unit (CRU) to handle all hearings for Medicaid for the Elderly and People with Disabilities (MEPD) and Texas Works (TW) staff. CRU replaces the MEPD specialist in specific steps related to the denial of MEPD applications and ongoing cases. CRU:

* represents HHSC OES in fair hearings, which includes both TW and MEPD;
* completes and implements all TW/MEPD case actions based on fair hearing decisions; and
* coordinates actions required with regional TW/MEPD staff and Program Support Unit (PSU) staff.

PSU staff must coordinate all appeals involving TW/MEPD-related eligibility with CRU. This includes HCBS STAR+PLUS Waiver (SPW) cases. The procedures in [Section 4222](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-4000-complaint-appeal-procedures#4222), Centralized Representation Unit Procedures, must be used to coordinate appeal actions with CRU in cases for which MEPD staff determine financial eligibility.

Staff must remember CRU replaces the local TW/MEPD specialist in the following steps and that notices must not be sent to the local MEPD specialist, except as specified. All correspondence on appeals will go to the CRU supervisor and the CRU administrative assistant.

**4222 Centralized Representation Unit Procedures**

Revision 19-2; Effective December 2, 2019

Applicants/members may appeal a decision orally, in person or in writing. Program Support Unit (PSU) staff are responsible for completing [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary, to file the appeal through the Texas Integrated Eligibility Redesign System (TIERS) when an applicant/member requests a fair hearing. The method in which the form is completed depends on the action being appealed. Staff must determine if the appealed action is:

* a waiver/service denial (excludes denials based on Texas Works/Medicaid for the Elderly and People with Disabilities (TW/MEPD) denials); or
* a TW/MEPD financial denial (denials based on a TW/MEPD denial action).

If the appealed action is related to a waiver/service denial, PSU staff complete Form 4800-D, entering the managed care organization contact as the Agency Representative. In the Other Participants field, PSU staff enter the Centralized Representation Unit (CRU) supervisor and CRU administrative assistant. The CRU supervisor and assistant names **must** be entered by using the Model Office Resources (MOR) Search function. This will assure that all the correct information is populated in the Texas Integrated Eligibility Redesign System (TIERS) and CRU staff will receive the notice of the appeal. Supplemental Security Income recipient appeals are not handled by CRU.

If the appealed action is a TW/MEPD financial denial, staff complete Form 4800-D and enter the name of the CRU supervisor as the agency representative. This information must be entered through the MOR Search function for CRU to receive the hearing information. List the PSU staff name and title in the Other Participants section. The name of the local TW/MEPD specialist is not entered by staff on Form 4800-D for TW/MEPD financial appeals. PSU staff must include staff title, such as PSU specialist or supervisor. Enter the staff email address and include the CRU administrative assistant in Other Participants. Her information must be entered through the MOR Search function.

If this is a TW/MEPD-related appeal, **select "Yes"** to the question in Section 6 which asks: "Are you an OES Texas Works or MEPD employee?" You are actually responding to this question on behalf of Kristi Rojas, so "Yes" is the correct response. On the Agency Representative page, select "Yes" in the drop-down menu. Failure to answer "Yes" to this item will result in CRU not being notified of the hearing. **This paragraph only applies to TW/MEPD financial denials.**

When Form 4800-D is sent to the designated data entry representative, PSU staff send an email notification regarding the request for an appeal to CRU. PSU staff will send the email to the HHSC Office of Eligibility Services (OES) Fair Hearings mailbox, which can be found in the Outlook Global Address List search box by typing HHSC OES Fair Hearings. In the subject line of the email, include the following: Request for Continued Benefits-MEPD Appeal ID-XXXXXXX. In an attachment to the email, staff must also include a copy of the notification form sent to the applicant or member.

The email must include:

* applicant's/member's name;
* Medicaid number (if available);
* type of service (HCBS STAR+PLUS Waiver (SPW)); and
* specific information requesting the TW/MEPD financial case remain active/open during the appeal, if the member appealed in a timely manner and requested continued benefits.

For example, the financial case may need to remain open pending an appeal decision regarding medical or functional eligibility. PSU staff must notify CRU to keep the TW/MEPD case open pending the fair hearing decision.

Upon receipt of notification of an appeal, CRU requests the TW/MEPD evidence packet from the local TW/MEPD specialist and completes any necessary actions required during the appeal process. The CRU supervisor assigns CRU staff to represent TW/MEPD at the hearing, if required, and takes steps to ensure the appropriate TW/MEPD financial case action is taken once a fair hearings officer's decision is rendered.

When a waiver/service denial hearing decision is rendered by the fair hearings officer, the PSU staff entered as "Agency Representative" is notified via email of the decision by the fair hearings officer. Based on the hearing decision, PSU staff determine the appropriate action for the waiver/services according to program-specific time frames. For more information, refer to [Section 4500](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-4000-complaint-appeal-procedures#4500), Hearing Decision Actions.

PSU staff may need to coordinate effective dates of reinstatement with CRU and must email the CRU supervisor (with a copy to the CRU administrative assistant) for the coordination. PSU staff report the implementation of the hearing decision through TIERS on [Form 4807-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4807-d-action-taken-hearing-decision), Action Taken on Hearing Decision, according to current procedures.

The local TW/MEPD specialist notifies PSU staff if an appeal is filed by TW/MEPD regarding a financial eligibility decision, and refers the TW/MEPD case to CRU to handle during the appeal process. Once the appeal decision regarding the MEPD financial case is rendered by the hearings officer, CRU must notify PSU staff via email of the hearing decision, including decisions that are sustained, reversed or withdrawn. Based on the hearing decision, staff determine the appropriate action for the waiver/service. The email sent by CRU includes:

* applicant's/member's name;
* Medicaid number;
* a copy of the hearing decision; and
* the effective or denial date of Medicaid eligibility.

Staff must not put an applicant/member back on waiver/service-specific interest lists while a TW/MEPD denial is in the appeal process. PSU staff must take appropriate action to certify or deny the case, or resume services once the TW/MEPD hearing decision is rendered. The individual may choose to be added back to the waiver/service-specific interest list once staff deny the waiver/service.

**4230 Regional Responsibilities**

Revision 14-1; Effective March 3, 2014

**4231 Uploading the Appeals Evidence Packet into the TIERS Application**

Revision 14-1; Effective March 3, 2014

All evidence packets must be scanned into the Texas Integrated Eligibility Redesign System (TIERS) Appeals application using the process described below. The regional data entry representative (DER) uses [Form H4800-A](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4800-a-fair-hearing-request-summary-addendum), Fair Hearing Request Summary (Addendum), to submit all supporting documentation (also referred to as the appeals packet) to the fair hearings officer. The appeal identification number assigned by TIERS must be written on the top of Form H4800-A.

At least 12 business days prior to the fair hearing date, the case manager or Program Support Unit (PSU) specialist must:

* go to the multi-function office Workcenter and scan in the documentation;
* save the document by either allowing the default document name or entering a name of the user's choosing;
* retrieve the scanned document and attach it to an email; and
* send the document to the regional DER.

**Within two business days after receipt, the DER must:**

* save the attachment to the appropriate network drive, as assigned by regional management;
* go into the TIERS portal and select the Appeals tab, without launching TIERS;
* ensure the appeal has been entered in TIERS (this requirement must be met before the next step can be completed);
* select Hearing Evidence Packets Upload and enter the Appeal ID;
* select Document Type: Agency Evidence Packet (items entered in any other selection will not be included in the evidence packet);
* select Validate;
* check the details to ensure the right person has been selected;
* browse for the document; and
* select Upload.

Users who make mistakes they are unable to reverse may contact the state office Document Maintenance manager to assist in correcting the error and uploading the appropriate information.

**4232 Presentation of the Hearing Packet**

Revision 14-1; Effective March 3, 2014

The Texas Integrated Eligibility Redesign System generates a hearing packet that includes [Form H4803](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4803-notice-hearing), Notice of Hearing, and [Form H4800](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4800-fair-hearing-request-summary), Fair Hearing Request Summary. The Program Support Unit (PSU) specialist and his/her supervisor receive a copy of Form H4800 and Form H4803, identifying the hearings officer assigned and the date, time and location of the hearing. PSU staff are not expected or required to attend fair hearings.

**4233 Presentation of the Evidence**

Revision 14-1; Effective March 3, 2014

Documentation contained in the fair hearing packet is not considered in the case decision unless the packet is offered into evidence. To accomplish this requirement, the agency representative must present the packet, ask that it be submitted as evidence and summarize what the packet contains.

**Example:** "I want to offer the following packet as evidence in the appeal filed on the behalf of Ned Flanders. Pages 1-10 contain information relating to the completion of Form H2060, Needs Assessment Questionnaire and Task/Hour Guide. Pages 11-15 contain policy from the *STAR+PLUS Handbook* that relates directly to the issue in question. Pages 16-20 contain documents signed by the applicant related to individual rights. Page 21 contains Form H2065-D, Notification of Managed Care Program Services, which was mailed to the applicant on March 2, 2011."

The fair hearings officer then asks for objections and admits the documents into evidence. If any documents are not admitted, the fair hearings officer explains the reasons for excluding the material. Any documents admitted by the fair hearings officer are considered when a decision is rendered.

**4234 Hearing Decision**

Revision 14-1; Effective March 3, 2014

After the hearing is held, the fair hearings officer sends a decision letter to the appellant and copies to the Program Support Unit (PSU) specialist and his/her supervisor. If the decision is sustained, the PSU specialist takes the appropriate action. If the member requested continued services during the appeal period, follow procedures as described in [Section 4500](https://hhs.texas.gov/laws-regulations/handbooks/sph/section-4000-complaint-appeal-procedures#4500), Hearing Decision Actions.

If the action is reversed, the fair hearings officer also sends [Form H4807](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4807-action-taken-hearing-decision), Action Taken on Hearing Decision. The fair hearings officer specifies the corrective action to be taken and a 10-day time frame for completion of the action. The PSU specialist actions required by the hearings officer must be reported back through the Texas Integrated Eligibility Redesign System within the 10-day time frame designated by the hearings officer.

**4300 Post Hearing Actions**

Revision 14-1; Effective March 3, 2014

**4310 Action Taken on the Hearing Decision**

Revision 19-2; Effective December 2, 2019

The Program Support Unit (PSU) specialist completes [Form 4807-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4807-d-action-taken-hearing-decision), Action Taken on Hearing Decision, recording case actions taken and sends it to his/her supervisor and the designated data entry representative (DER). The PSU specialist must send Form 4807-D within the time frame to allow at least two days for the DER to enter the information into the system. If the action cannot be taken by the time frame designated by the hearings officer, Form 4807-D is completed and sent to the supervisor and DER, providing the reason for the delay. Acceptable reasons are listed on the form; the begin delay date and end delay date must be included. See the instructions for Form 4807-D for detailed information on completion of the form.

**4400 Continuation of Services**

Revision 14-1; Effective March 3, 2014

**4410 Continuation of STAR+PLUS Waiver Services During an Appeal**

Revision 15-1; Effective September 1, 2015

HCBS STAR+PLUS Waiver (SPW) services must continue until the hearings officer makes a decision regarding the appeal of an active SPW member, if the appeal is filed by the effective date of the action pending the appeal. If an appeal was requested by the effective date of the action, Program Support Unit (PSU) staff must promptly notify the managed care organization (MCO).

SPW services must continue to be provided until the hearings officer renders a decision by posting to TxMedCentral [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication.

If the hearings officer's decision will not be made until after the individual service plan (ISP) expiration date, PSU staff must extend the current ISP for four calendar months or until the outcome of the appeal is determined. PSU does not extend the medical necessity/level of care records in the Service Authorization System (SAS). Do not send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, to the member notifying of continued eligibility related to the reassessment action taken to continue services until the appeal decision is made.

If an appeal is initially dismissed and subsequently re-opened, the Health and Human Services Commission (HHSC) continues/restarts services pending the appeal outcome, if the member requests continued services. When the hearing officer sets a date for a new hearing, he/she, in effect, voids the prior decision. Because services are continued until a decision is rendered, and the hearing officer is stating there is still a hearing to be held, HHSC continues/re-starts services again.

**4420 Discontinuation of HCBS STAR+PLUS Waiver Services During an Appeal**

Revision 14-1; Effective March 3, 2014

If the appeal is not filed by the effective date of the action, HCBS STAR+PLUS Waiver (SPW) services continue until the effective date of denial notated on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, which is usually the expiration date of the current individual service plan (ISP). If an appeal was not requested by the effective date of the action, the Program Support Unit must complete [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication.

* For Medical Assistance Only (MAO) members, Form H2067-MC is:
	+ posted to TxMedCentral to inform the managed care organization (MCO) SPW services must continue until the end of the ISP period or the Medicaid denial date, as notated on Form H2065-D; and
	+ emailed to Operations Coordination to disenroll from STAR+PLUS following the disenrollment policy effective the day immediately following the ISP expiration date.
* For Supplemental Security Income (SSI) members, Form H2067-MC should be posted to TxMedCentral to inform the MCO that SPW services should continue until the end of the ISP period.

SSI members are still enrolled in STAR+PLUS services and are still eligible for State Plan services, which include acute care and long-term services and supports, such as Primary Home Care and Day Activity and Health Services.

**4500 Hearing Decision Actions**

Revision 14-1; Effective March 3, 2014

**4510 Sustained Appeal Decisions**

Revision 14-1; Effective March 3, 2014

When the hearings officer’s decision sustains the denial of HCBS STAR+PLUS Waiver (SPW) services, Program Support Unit (PSU) staff must:

* notify the member via telephone or letter (if the individual does not have a telephone) of the hearings officer's decision and the termination effective date;
* notify the managed care organization via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, to deliver services through the SPW termination effective date if services were continued during the appeal process;
* terminate SPW (service group 19) services in the Service Authorization System effective the SPW termination effective date (see Section 4511 below);
* notify the Medicaid for the Elderly and People with Disabilities (MEPD) specialist of the hearings officer's decision and the termination effective date for non-Supplemental Security Income (SSI) recipients. MEPD terminates Medicaid eligibility for non-SSI recipients; and
* notify Managed Care Operations of the hearings officer's decision and the termination effective date for non-SSI recipients. Managed Care Operations disenrolls non-SSI recipients from STAR+PLUS.

**PSU must not send another**[**Form H2065-D**](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services)**, Notification of Managed Care Program Services, to notify the member of the sustained denial.**

**4511 Sustained Decisions – Termination Effective Dates**

Revision 12-3; Effective October 1, 2012

When services are terminated at reassessment because the member does not meet eligibility criteria and services are continued until the appeal decision is known, the HCBS STAR+PLUS Waiver (SPW) termination effective date will vary depending on the circumstances:

* In cases where the hearings officer's decision is 30 calendar days or more prior to the end of the individual service plan (ISP) in effect when the appeal was filed, SPW termination is effective at the end of the ISP in effect at the time the appeal was filed. See Example 1.
* When the hearings officer's decision date is less than 30 calendar days before the end of the ISP in effect when the appeal was filed, the termination effective date is the end of the month that is 30 calendar days from the hearings officer's decision date (the date the order is signed as recorded on Page 1 of [Form H4807](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4807-action-taken-hearing-decision), Action Taken on Hearing Decision). See Example 2.
* When the hearings officer's decision date is after the end of the ISP in effect when the appeal was filed, and a new ISP was developed to continue services past the ISP end date until the appeal decision was made, the termination effective date is the end of the month that is 30 calendar days from the hearings officer's decision date (as recorded on Page 1 of Form H4807). See Example 3.
* If the hearings officer assigns a specific medical necessity (MN)/ISP expiration date not equal to the last day of the month but after the end of the ISP in effect when the appeal was filed, the termination effective date is the end of the month the hearings officer identified as the expiration month. See Example 4.
* When the hearings officer assigns a specific MN/ISP expiration date equal to the last day of the month, and this date is equal to or after the end of the ISP in effect when the appeal was filed, the termination effective date is the end of that ISP period. See Example 5.
* If the hearings officer assigns a specific MN/ISP expiration date that is before the end of the MN/ISP in effect when the appeal was filed, the termination effective date is the end of the month of the original MN/ISP expiration date. See Example 6.

**Examples**

| **Example** | **Conditions** | **Original MN/ISP Expiration Date** | **New Expiration Date** | **Hearings officer Decision Date** | **Final MN/ISP Expiration Date** |
| --- | --- | --- | --- | --- | --- |
| 1 | hearings officer decision is more than 30 days from the original expiration date. | 1/31/10 | 5/31/10 | 11/30/09 | 1/31/10 |
| 2 | hearings officer decision is less than 30 days from the original expiration date. | 1/31/10 | 5/31/10 | 1/15/10 | 2/28/10 |
| 3 | hearings officer decision is greater than the original ISP expiration date and less than the new expiration date. | 1/31/10 | 5/31/10 | 2/15/10 | 3/31/10 |
| 4 | hearings officer decision assigns a specific expiration date. | 1/31/10 | 5/31/10 | hearings officer decision was for MN/ISP to expire on 2/15/10. | 2/28/10 |
| 5 | hearings officer decision assigns a specific expiration date that occurs in the future. | 1/31/10 | 5/31/10 | hearings officer decision was for MN/ISP to expire on 2/28/10. | 2/28/10 |
| 6 | hearings officer decision assigns a specific expiration date that occurred in the past. | 1/31/10 | 5/31/10 | hearings officer decision was for MN/ISP to expire on 12/31/09. | 1/31/10 |

**4520 Reversed Appeal Decisions**

Revision 14-1; Effective March 3, 2014

When the hearings officer’s decision reverses the denial of an HCBS STAR+PLUS Waiver (SPW) applicant or member, Program Support Unit staff must:

* notify the managed care organization (MCO) via [Form H2067-MC](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2067-mc-managed-care-programs-communication), Managed Care Programs Communication, that SPW services are to continue as directed in the decision and to request [Form H1700-1](https://hhs.texas.gov/laws-regulations/forms/1000-1999/form-h1700-1-individual-service-plan-pg-1), Individual Service Plan — SPW (Pg. 1);
* send [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services, within two business days to the:
	+ SPW member who was terminated at reassessment to notify him the denial decision was reversed and he is eligible for SPW services for the new individual service plan (ISP) year;
	+ SPW applicant who was denied at application to notify him of eligibility for SPW services;
	+ MCO regarding applicants and the SPW effective date; and
	+ Managed Care Operations staff regarding applicants and the SPW effective date and enrollment date;
* ensure the ISP is registered or updated in the Service Authorization System with the correct effective dates; and
* notify Medicaid for the Elderly and People with Disabilities, as appropriate, to continue Medicaid eligibility.

**4521 Reversed Decisions – Effective Dates**

Revision 19-2; Effective December 2, 2019

When the hearings officer’s decision reverses the denial of HCBS STAR+PLUS Waiver (SPW) eligibility, the SPW effective date for:

* reassessment is one day after the end of the individual service plan in effect when the appeal was filed; and
* SPW denied at application is the first of the month following the hearings officer's decision recorded on [Form H4807](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-h4807-action-taken-hearing-decision), Action Taken on Hearing Decision.

When a fair hearing decision reverses a Program Support Unit (PSU) action but PSU staff cannot implement the fair hearing decision within the required time frame, PSU staff must complete Section C, Implementation Delays, on [Form 4807-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4807-d-action-taken-hearing-decision), Action Taken on Hearing Decision. Form 4807-D must be submitted within the required time frame.

**4522 New Assessment Required by Fair Hearing Decision**

Revision 19-2; Effective December 2, 2019

If the hearings officer’s final decision orders completion of a new [Form H2060](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2060-needs-assessment-questionnaire-taskhour-guide), Needs Assessment Questionnaire and Task/Hour Guide, or Medical Necessity and Level of Care (MN/LOC) Assessment, the hearing is closed as a result of this ruling. Program Support Unit (PSU) staff must notify the member of the results of the new assessment on [Form H2065-D](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-h2065-d-notification-managed-care-program-services), Notification of Managed Care Program Services. The member may appeal the results of the new assessment. If the member chooses to appeal, PSU staff must indicate in Section 3.D., Summary of Agency Action and Citation, of [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary, and also during the fair hearing that the new assessment was ordered from a previous fair hearing decision.

If the member requests an appeal of the new assessment and services are continued, the managed care organization (MCO) continues services until the second fair hearing decision is implemented. For example, a STAR+PLUS Waiver (SPW) member is denied medical necessity (MN) at an annual reassessment and requests a fair hearing and services are continued. The MCO would continue services at the level the member was receiving prior to the MN denial. The hearings officer then orders a new MN/LOC Assessment which results in another MN denial. PSU staff send a notice to the member informing him of the MN denial. The member then requests another fair hearing and services are continued pending the second fair hearing decision. The MCO would continue services at the same level services were continued prior to the first fair hearing. If the new assessment results in MN approval but a lower Resource Utilization Group (RUG) level and the member requests a fair hearing due to the lower RUG level, the MCO would continue services at the same level services were continued prior to the first fair hearing.

**4523 Request to Withdraw an Appeal**

Revision 14-1; Effective March 3, 2014

An appellant or appellant representative may request to withdraw his appeal orally by calling the hearings office. An oral request to withdraw may be accepted by the hearings officer’s administrative assistant or the hearings officer. Program Support Unit (PSU) staff should advise the appellant or appellant representative to speak directly to the administrative assistant or hearings officer. If the appellant or appellant representative contacts PSU staff regarding the withdrawal, PSU staff must contact the hearings office via conference call with the appellant or appellant representative on the line so the appellant or appellant representative may inform the hearings office of the withdrawal. If the appellant or appellant representative sends a written request to withdraw to PSU staff, PSU staff must forward this written request to the hearings office. A fair hearing will not be dismissed based on a PSU decision to change the adverse action. All requests to withdraw the hearing must originate from the appellant or appellant representative.

If the appellant or appellant representative requests to withdraw his appeal within 14 calendar days of the fair hearing date, the hearings officer will notify PSU by phone or email and open the conference line to inform participants of the cancellation. If the appellant or appellant representative requests to withdraw his appeal more than 14 calendar days prior to the fair hearing date, the hearings officer will indicate the withdrawal in the Texas Integrated Eligibility Redesign System and a written notice will be sent to participants informing them of the fair hearing cancellation.

**4600 Roles and Responsibilities of HHSC Fair Hearings Officers**

Revision 19-2; Effective December 2, 2019

The Health and Human Services Commission fair hearings officer:

* notifies all persons listed on [Form 4800-D](https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary), Fair Hearing Request Summary, of the date, time and location of the hearing;
* prepares a final order disposing of a case through withdrawal and sends copies of this order to the appellant and Program Support Unit (PSU) upon written notification from the appellant to withdraw an appeal;
* conducts the hearing;
* uses the Texas Medicaid & Healthcare Partnership (TMHP) nurse to determine whether any new medical information introduced at the hearing meets the medical necessity (MN) criteria for nursing facility care;
* reserves the right to hold a case open after a hearing pending medical review by TMHP physicians;
* submits a written request for medical review to TMHP for all new medical information presented at a hearing in situations where the TMHP nurse determines the new medical information presented does not meet the MN criteria;
* renders a decision; and
* sends a written copy of all hearing decisions to the member/applicant, TMHP and the PSU staff within five days of making the decision.

Administrative review of any hearings officer's decision provided in the fair hearings rules must be initiated by the appellant (applicant/member). Program staff may disagree with the decision; however, the hearings officer's decision is final. Disagreements on policy or legal issues may be submitted by program staff to the regional attorney.

**4700 Fair Hearings for MCO Decisions**

Revision 14-1; Effective March 3, 2014

If an applicant wishes a fair hearing with the state of Texas regarding an HCBS STAR+PLUS Waiver (SPW) eligibility denial, he or she must contact the Program Support Unit (PSU) as instructed in the denial notification.

In addition to appealing an adverse action not related to eligibility, the SPW member may also request a fair hearing by contacting PSU.