Welcome to the CLASS-DBMD Quarterly Webinar!

**Housekeeping Presentation
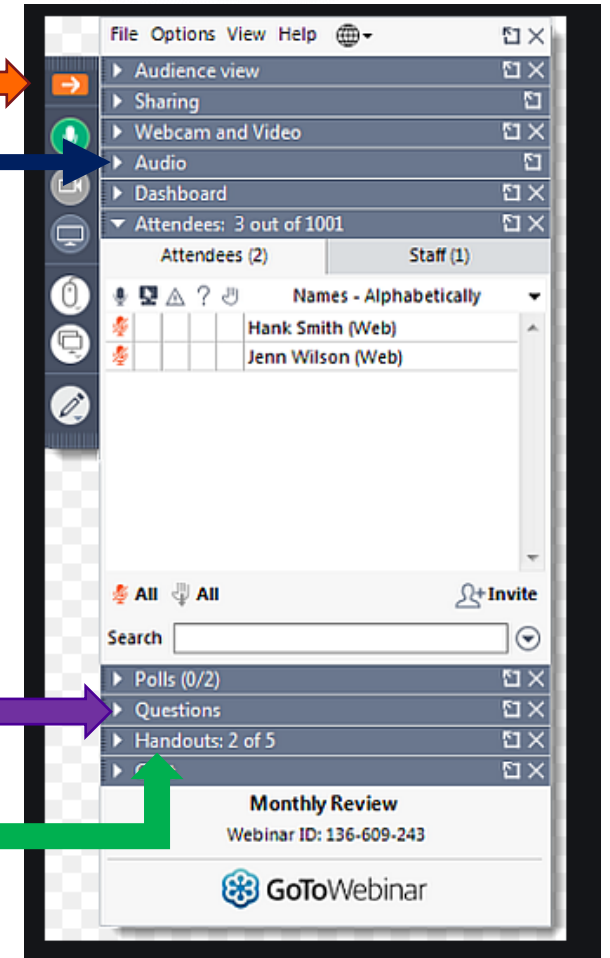Dawn M. Roland, Program Specialist, Program Policy**
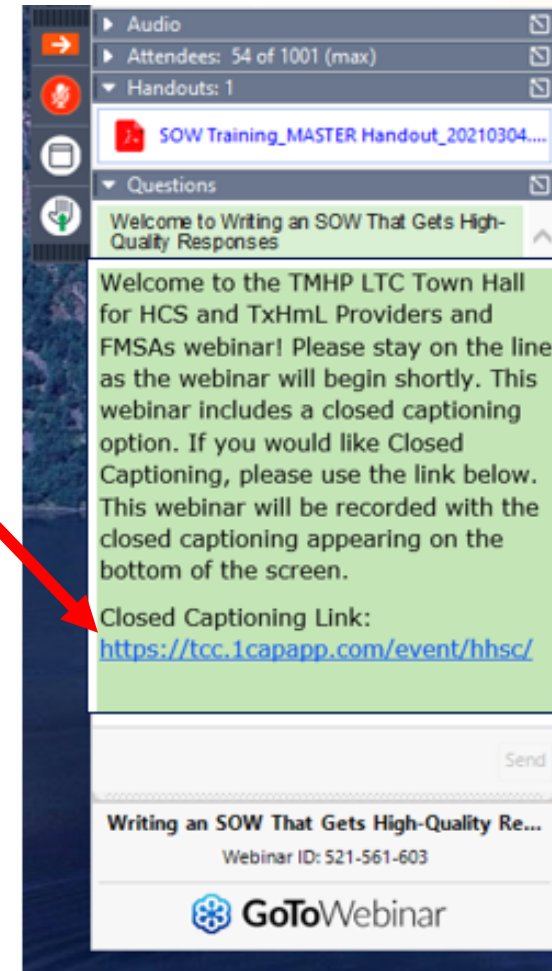
March 20, 2024

Control Panel Features

Closed Captioning Option

1. Open your Questions tab located in your navigation pane.

2. Click on the closed captioning link provided.

3. Link will open a new internet browser window displaying more lines of text.

Note: Closed Captioning Link today: https://tcc.1capapp.com/event/ltss/

Telephone Audio Option

1. Click Audio tab

2. Select Phone Call
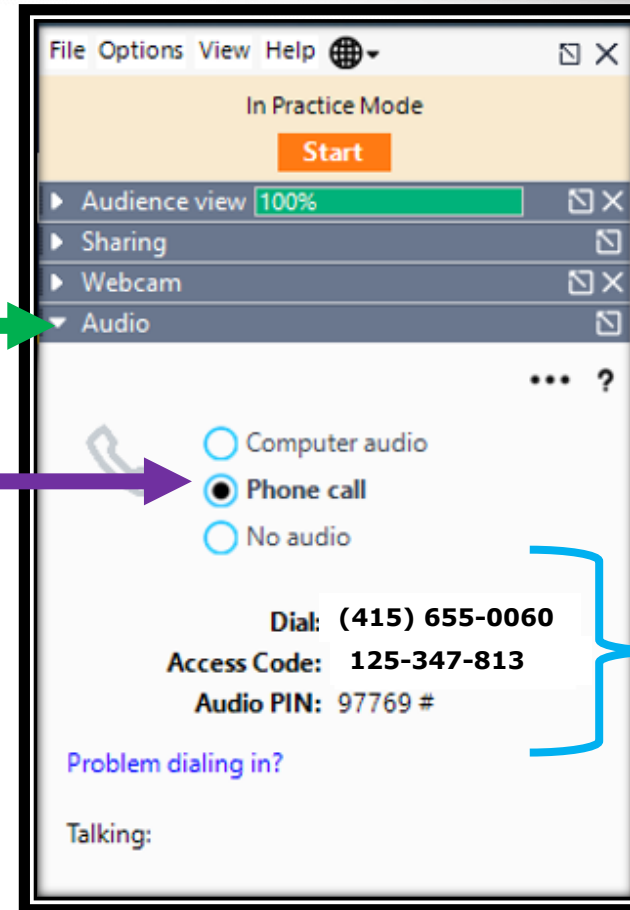
3. Dial-in Information

File Options View Help

In Practice Mode

Start

Audience view 100%

Sharing

Webcam

Audio

• • •   ?

○ Computer audio
● Phone call
○ No audio

Dial: **(415) 655-0060**

Access Code: **125-347-813**

Audio PIN: 97769 #

Problem dialing in?

Talking:

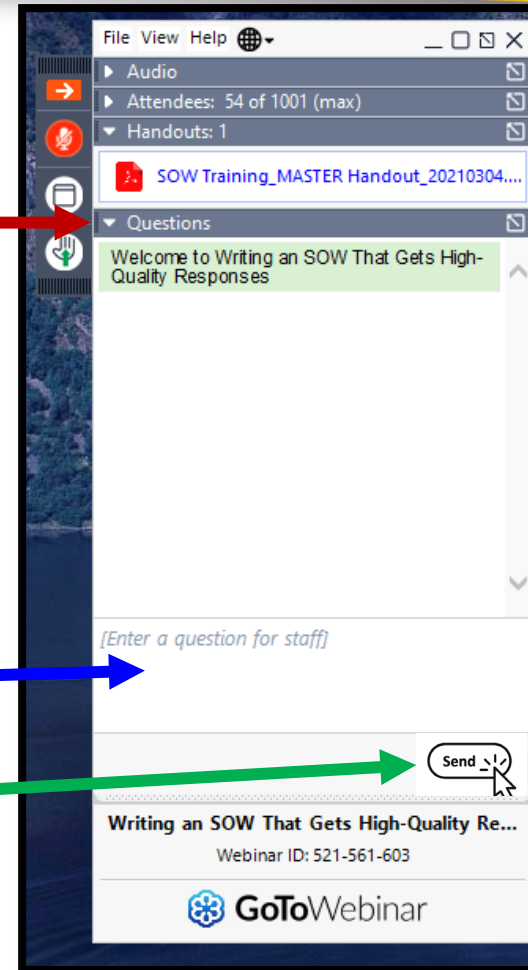# Have a Question?

1. Open your Questions Tab

2. Type your question in the box provided.
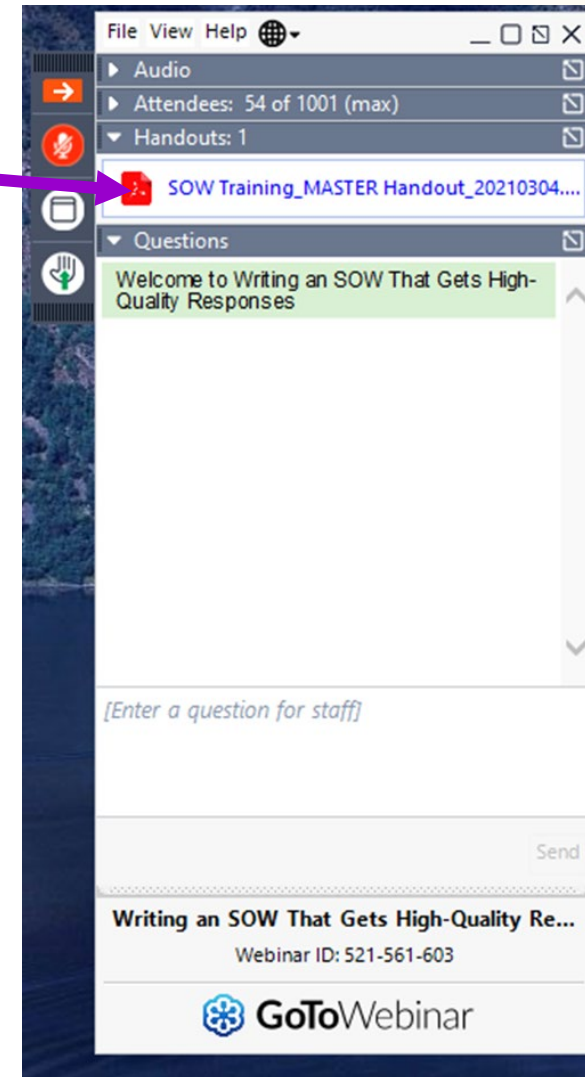
3. Click **Send**

Where can I get a copy of the presentation or handouts?

1. Find a copy of the presentation under the "Handouts" tab.

2. Double-click on the presentation handout to download it to your computer.

3. Open the presentation, click "File"> "Save As"

4. Select desired location you wish to save this presentation (Ex: Desktop)

5. Click "Save" when done.

Please Complete Our Survey.

- **Questions?**

  - **Suggestions?**

    - **Comments?**

- Let us know!

- Please take a moment to complete the Post Survey! Your responses will provide valuable input to the development of future webinars!

Thank you

Technical questions?
Please email: Dawn.Roland@hhs.texas.gov

CLASS and DBMD Quarterly Webinar

Rachel Perez, CLASS/DBMD Lead &
Lorenza Martinez, DBMD Policy Specialist
Long-Term Services and Supports Policy
March 20, 2024

Agenda

Policy
- DBMD Region 1

EVV
- EVV Updates

UR
- Rate Changes
- DBMD Financial Eligibility

PES
- Fair Hearing Process

DBMD Region 1 Providers Needed

DBMD Program

HHS Regional Map

Thank You

CLASSPolicy@hhs.texas.gov

DBMDPolicy@hhs.texas.gov

Electronic Visit Verification (EVV)

Tracie Teague
EVV Contract Specialist, CLASS/DBMD

EVV Claims Matching Resources for FMSAs

Best Practices to Avoid EVV Claim Mismatches (PDF)
For all FMSAs except those submitting EVV claims for HCS and TxHmL EVV-required services.

HCS and TxHmL Best Practices to Avoid EVV Claim Mismatches (PDF)
For FMSAs submitting EVV claims for HCS and TxHmL EVV-required services.

EVV Claims Matching Bypass from Jan. 1 to March 31

- HHSC implemented a claim matching bypass on Feb. 1, 2024 for EVV claims with dates of service from Jan. 1 through March 31 to be paid without a matching EVV visit.

- Program providers, FMSAs, and CDS employers must enter missing EVV visits not entered during the EVV claims matching bypass period within the 95-day visit maintenance period.

- Payers will not allow the entry of missing EVV visits after the 95-day visit maintenance timeframe has passed. Failure to use the EVV system to record visits may result in recoupments.

- Program providers and FMSAs who received a "No EVV Visit Match" denial for claims with dates of service beginning Jan. 1 can submit adjustment claims after Feb. 1. **EVV claims matching will begin with dates of service on April 1.**

EVV Claims Matching Bypass from Jan. 1 to March 31 (cont.)

Billing Claims

- **If billing through the HHAeXchange system**, you must ensure you have a valid, accepted visit on file or you will not be able to invoice and bill your claim.

- Program providers and FMSAs using HHAeXchange, who need to bill but **don't have a valid visit on file** in the HHAeXchange system, may submit their claims through TexMedConnect.

- Claims paid without a valid matching visit are subject to recoupment.

EVV Claims Matching Bypass from Jan. 1 to March 31 (cont.)

Reminders

- EVV claims for EVV required services must be submitted to the Texas Medicaid & Healthcare Partnership (TMHP). MCOs will reject any managed care claims with EVV services and dates of service on or after Dec. 1, 2023, back to the program provider and FMSA, directing them to submit the claim to TMHP for EVV claims matching.

- Providers listed in *Home Health Care Services Required to Use EVV*, including providers of physical therapy, occupational therapy, or nursing services in the home who bill service codes listed in *EVV Home Health Care Services Bill Codes Table*, should have begun submitting claims to TMHP as of Dec. 1, 2023.

EVV Claims Matching Bypass from Jan. 1 to March 31 (cont.)

Resources

- For information on submitting EVV claims to TMHP, refer to *Prepare for EVV Cures Act Home Health Care Services Implementation*, found on the EVV webpage.

TMHP EDI Help Desk:

800-626-4117 – select option 3 or

888-863-3638 – select option 4

Email EVV Operations for questions.

Visit Maintenance Reminder

- Starting April 1, 2024, the EVV Aggregator will reject visit transactions that don't have the **Bill Time In and Bill Time Out** fields populated.

- A missing clock in time on a visit should be entered in the Bill Time In field and a missing clock out time on a visit should be entered in the Bill Time Out field; **not documented in the free text**. These fields may be called something different, depending on the EVV system you're using e.g., Visit Start Time, Visit End Time, Punch In, Punch Out, etc.

- These fields can also be edited during visit maintenance to accurately reflect service delivery.

EVV Visit Maintenance Process on Hold for Dates of Service Prior to Go-Live Date with Current EVV System

- Program providers, FMSAs and CDS employers should **not submit** Visit Maintenance Unlock Requests (VMURs) for dates of service prior to going live with HHAeXchange or their EVV proprietary system. HHSC is actively working with TMHP to develop a solution to allow for visit maintenance.

- Once the hold has lifted, HHSC and TMHP will notify users of HHAeXchange and EVV Proprietary System Operators (PSOs) that they may resume visit maintenance, including submitting VMURs, for dates of service prior to their go-live date with their current EVV system.

- The go-live date is the "System Start Date" for your current EVV system. Program providers and FMSAs can determine their go-live date by reviewing the EVV Provider Report in the TMHP EVV Portal.

EVV Visit Maintenance Processes on Hold for Dates of Service Prior to Go-Live Date with Current EVV System

Note:

All required visit maintenance, for dates of service on or after the go-live date with HHAeXchange or an EVV proprietary system, can be performed in your current EVV system. VMURs for dates of service on or after the go-live date can be sent to your payer.

Email TMHP for assistance with the TMHP EVV Portal.
EVV@tmhp.com

Email HHSC EVV Operations for questions.
EVV@hhs.Texas.gov

Updates to HHAeXchange Training Resources

HHAeXchange has updated its training resources available for Electronic Visit Verification (EVV) program providers and FMSAs that use the HHAeXchange Portal as their EVV system.

The updated training resources, located on the HHAeXchange webpage: (https://www.hhaexchange.com/info-hub/Texas)

- **HHAX Provider Portal FAQs (PDF)**
- **HHAX EVV Aggregation Transaction Manager Rule Holds and Resolutions (PDF)**

Updates to HHAeXchange Training Resources (cont.)

For more information, or to view additional HHAeXchange resources, refer to TMHP's published *Updates to HHAeXchange EVV Training Resources Now Available*, on TMHP's EVV webpage. https://www.tmhp.com/topics/evv

Email questions to:
HHAeXchange@TXsupport@hhaexchange.com

EVV Geo-Perimeter Expansion

- HHSC was accepting comments on the proposed geo-perimeter increase from 250 feet to 1320 feet (1/4 mile) of the members service delivery location.
  - The geo-perimeter is the distance from the member's home address to the service provider or CDS employee's location, when clocking in or out of the EVV mobile app.

- This proposal is to reduce administrative burden by limiting the need to manually update and verify visits that are out-of-range.

- Feedback survey is closed, any feedback can be sent to EVV@hhs.texas.gov

TMHP Published EVV Known Issues and Resolutions, Vol. 3

TMHP published a table that highlights the most frequently occurring issues EVV users have experienced with the HHAeXchange system. The table also features a resolution for the issues that were identified.

For more information, refer to *EVV Known Issues and Resolutions, Vol. 3* on TMHP's EVV webpage.

https://www.tmhp.com/news/2024-02-06-evv-known-issues-and-resolutions-volume-3

EVV Resources Summary

HHSC EVV webpage

https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification-evv

- Sign up to receive EVV email updates
- Personal Care Services Required to Use EVV
- Home Health Care Services Required to Use EVV
- HHSC EVV Policy Handbook
- Policies Effective Oct. 1, 2023 (PDF)
- HHSC EVV Training Resources webpage
- FAQs about the EVV HHCS Implementation (PDF)

Thank you

Please submit questions to EVV@hhs.texas.gov

Rate Changes

Casey Zwerneman, Manager

CLASS/DBMD Utilization Review

Rate Change Submissions

- Per IL 2023-38, the deadline to submit revised IPCs related to September 2023 rate increases was December 31, 2023.

- Following that deadline, Service Planning Teams (SPTs) can submit revised IPCs requesting rate increases in alignment with 26 TAC §259.79 (related to renewal and revision of an IPC) and Section 2330 of the CLASS Provider Manual (related to revisions).

26 TAC §259.79

(d) – *Within 5 business days of becoming aware that a person's need for a service has changed, the case manager must convene an SPT meeting to develop a proposed revised IPC.*

(g)(3) - *The revised IPC and supporting documentation must be submitted to HHSC at least 30 calendar days before the proposed effective date.*

26 TAC §259.79 (cont.)

Does not allow an IPC revision with a retroactive effective date (for example, September 1, 2023).

Revised IPCs requesting rate increases must now include an effective date that is at least 30 days after the submission date.

- The SPT must calculate the number of units requested at the old and new rates based on the IPC effective date.

- These IPCs may include revisions to other services if needed.

CLASS Provider Manual Section 2330

The following submission standards apply when submitting revision paperwork requesting rate increases to HHSC:

- Form 3621 (Individual Plan of Care/IPC)
- Form 8606 (Individual Program Plan/IPP) for each service being revised
- Form 3596 (PAS/HAB Plan), if this service is marked "N" or "C" on the IPC
- Form 3598 (Individual Transportation Plan), if this service is marked "N" or "C" on the IPC
- Form 8598 (Non-Waiver Services)
- Form 6515 (Nursing Assessment)

Rate Change Submissions (cont.)

Please continue to show the breakdown of units being requested at the old and new rates on the IPC and IPP using formats discussed in the December 7, 2023 Quarterly Webinar.

Thank you

DBMD – Financial Eligibility

Patrick Koch, Manager

CLASS/DBMD Utilization Review

DBMD – Eligibility

DBMD identifies nine eligibility components. Today we will focus on the first component:

26 TAC §260.51 *Eligibility Criteria for DBMD Program Services and CFC Services*

(a) An individual is eligible for DBMD Program services if:

(1) the individual meets the financial eligibility criteria as described in Appendix B of the DBMD Program waiver application approved by CMS and available on the HHSC website;

DBMD – Eligibility (cont.)

How to check Medicaid Eligibility Service Authorization Verification (MESAV):

Verifying Eligibility for an Individual

https://www.youtube.com/watch?v=ui2_GGphd4s

When to check MESAV:

Financial eligibility for DBMD services may change frequently. Best practice is to check MESAV at the beginning of each month to identify changes in financial eligibility status and to determine if the reported type coverage code and Medicaid type is in fact meeting financial eligibility for the DBMD program.

DBMD – Eligibility (cont.)

Printed on: 8/14/2023 9:26:33 AM

General Disclaimer	Payment is not based solely on any single piece of information listed below. This data may change. Outstanding claims may affect the number of units. Nursing Facility clients with managed care eligibility segments must have service authorizations verified by the appropriate MCO.

Client Information

Client No./Trainee SSN	xxx xxx xxx
DOB	1/26/1234
Gender	F
SSN	
Name	
Address	123 Somewhere BLVD APT 13, UNIVERSAL TX
County	
Medicare No.	
Medicaid Recert Review Due Dt	

Inquiry Information

NPI/API	
Eligibility From	8/1/2023
Eligibility Through	8/1/2023
Medicaid /Client No.	
Social Security Number	
Date of Birth	1/26/1234
Last Name	
First Name	
M.I.	
Suffix	

Service Authorization Information/Details

Effective Date	End Date	Referral Number	Status	Svc Grp	Svc Grp Desc	Svc Code	Svc Code Desc	Client Control No.	Units Paid	Unit Type	Units	Proc. Code	Proc. Type	NPI/API	Provider Number
8/1/2023	7/31/2024	12397168	Active	16	DEAF BLIND MULTIPLE DISABILITIES (DBMD) PROGRAM	13C	SPECIALIZED NURSING RN				5.00				00101xxxx
8/1/2023	7/31/2024	12397168	Active	16	DEAF BLIND MULTIPLE DISABILITIES (DBMD) PROGRAM	12	Case Management				20.00				00101xxxx

Agent

-No Data-

Authorization Message

-No Data-

Monthly Units

-No Data-

Eligibility

Begin Date	End Date	Coverage Code	Secondary Coverage Code	Program Type	Coverage Category
11/1/2015	12/31/9999	R		13	4

DBMD – Eligibility (cont.)

Interpreting MESAV eligibility data:

- Begin date
- End date
- Coverage Code
- Secondary Coverage Code
- Program Type
- Coverage category

DBMD – Eligibility (cont.)

Interpreting MESAV eligibility data
Defining start and end date per report

Inquiry Information	
NPI/API	
Eligibility From	8/1/2023
Eligibility Through	8/1/2023

Begin date & End date

Eligibility		
Begin Date	**End Date**	
11/1/2015	12/31/9999	

DBMD – Eligibility (cont.)

Interpreting MESAV eligibility data

Coverage Code

Coverage Code
R

This Coverage Code may be:

- "**R**" – **R**egular Medicaid or
- "**P**" - three months **P**rior coverage

DBMD – Eligibility (cont.)

Interpreting MESAV eligibility data

Program Type

Program Type
13

While Program Type 13 and 14 are the types most commonly reported for a DBMD individual, any Program Types listed on the following slides will establish financial eligibility for the DBMD program.

DBMD – Eligibility (cont.)

- Different data systems use different ways to describe various Medicaid types.

- While Type Of Assistance (TOA) in the left column of the table may be a method used by a HHSC Medicaid Eligibility Worker to distinguish Medicaid types, your MESAV will show numerical values as captured in the right column of the table.

DBMD – Eligibility (cont.)

Medicaid Eligibility (ME) by Program Type

TOA	Description of Medicaid Type	MESAV TP
TA02	ME - Supplemental Security Income Waivers	13
TA10	ME - Waivers	14
TA22	ME - Manual Supplemental Security Income (SSI)	12
TA27	ME - Prior Medicaid Institutional - Waiver	14
TA78	PCA Medicaid - Federal Match - No Cash	78
TA79	PCA Medicaid - No Federal Match - No Cash	79
TA80	PCA Medicaid - Federal Match - With Cash	80
TA81	PCA Medicaid - No Federal Match - With Cash	81
TA82	MA - Former Foster Care Children (FFCC)	82

DBMD – Eligibility (cont.)

Medicaid Eligibility (ME) by Program Type

TOA	Description of Medicaid Type	MESAV TP
TP03	ME - Pickle	3
TP07	MA - Earnings Transitional	7
TP08	Parent/Caretaker Relatives	1
TP11	ME - Supplemental Security Income Prior	11
TP13	ME - Supplemental Security Income	13
TP17	ME - Nursing Facility/	14
TP18	ME - Disabled Adult Child	18
TP20	MA - Alimony/Spousal Support Transitional	20
TP21	ME - Disabled Widow(er)	22
TP22	ME - Early Aged Widow(er)	22

DBMD – Eligibility (cont.)

Medicaid Eligibility (ME) by Program Type

TOA	Description of Medicaid Type	MESAV TP
TP37	MA - EID Transitional	37
TP38	ME - SSI Nursing Facility	13
TP40	MA - Pregnant Women	40
TP43	MA - Children Under 1	43
TP44	MA - Children 6-18	44
TP45	MA - Newborn Children	45
TP47	MA - Children denied TANF w/Applied Inc	47
TP48	MA - Children 1-5	48
TP55	MA - Medically Needy	55
TP56	MA – Medically Needy w/Spend Down	55

DBMD – Eligibility (cont.)

Medicaid Eligibility (ME) by Program Type

TOA	Description of Medicaid Type	MESAV TP
TP70	Medicaid for Transitioning Foster Care Youth	9
TP87	ME-Medicaid Buy In	2
TP91	Adoption Assistance - Federal Match - No Cash	21
TP92	Adoption Assistance - Federal Match - With Cash	21
TP93	Foster Care - Federal Match - No Cash	9
TP94	Foster Care - Federal Match - With Cash	8
TP95	Adoption Assistance - No Federal Match - No Cash	15
TP96	Adoption Assistance - No Federal Match - With Cash	15
TP97	Foster Care - No Federal Match - No Cash	9
TP98	Foster Care - No Federal Match - With Cash	10

DBMD – Ineligibility

Examples of eligibility concerns

Eligibility

-No Data-

Loss of Medicaid eligibility at the end of February and with that loss of financial eligibility for the DBMD program

Eligibility				
Begin Date	**End Date**		**Coverage Code**	**Program Type**
10/1/2023	02/29/2024		R	44

Open-ended Medicaid, but of a Program Type that does not establish financial eligibility for the DBMD waiver program

Eligibility				
Begin Date	**End Date**		**Coverage Code**	**Program Type**
11/1/2023	12/31/9999		Q	24

DBMD – Ineligibility (cont.)

26 TAC §260.89 *Termination of DBMD Program Services and CFC Services With Advance Notice Due to Ineligibility or Leave from the State*

(a) Except as provided in subsection (c) of this section, HHSC terminates:

[…]

(b) Within two business days after becoming aware that a situation described in subsection (a) of this section exists, the program provider must request, in writing, that HHSC terminate DBMD Program services and CFC services, or DBMD Program services, or CFC services for the individual.

DBMD – Ineligibility (cont.)

Ineligibility – Next steps:

- Follow 26 TAC §260.89 and report loss of financial eligibility to HHSC within the set time period.

- Assist individuals regaining financial eligibility.
  - Help individuals / LARs navigating yourtexasbenefits.com.
  - Assist individuals / LARs with 2-1-1 calls.
  - Reapply per Form H1200 Application for Assistance - Your Texas Benefits.
  - File Form H1746-A MEPD Referral Cover Sheet.

- Monitor TMHP - MESAV for status changes.

Thank you

Fair Hearing Process

Due to Denial of CLASS Enrollment or Proposed CLASS Termination

Eric Peña, Program Manager
CLASS, CFC Non-Waiver

Fair Hearing Process

Proposed CLASS Termination due to Loss of Financial Eligibility

- On the third week of every month, the Fair Hearing Coordinator (FHC) generates a report detailing which individuals lost or will lose financial eligibility.

- FHC contacts CMA and supplies them the notice of proposed termination, appeal request, Form 4800D, and H1003.

- CMA contacts the individual, DSA, and FMSA (if applicable).

- If individual/LAR wants to appeal, they sign the appeal request and return it to the CMA.

Fair Hearing Process (cont.)

- CMA completes Form 4800D and returns it with the signed appeal request to FHC.

- FHC enters the appeal request in TIERS.

- The Fair Hearing Office schedules the hearing and sends the Hearing Notice (H4803) to the FHC and the appellant/LAR.

- A CLASS Reviewer is invited to the hearing, and the fair hearing evidence packet is distributed to all stakeholders.

- If individual is already enrolled in CLASS, they can continue to receive services until a hearing officer issues a formal decision, if individual/LAR or CMA requests an appeal within 10 days of the day the notice of proposed termination is completed.

Fair Hearing Process (cont.)

When CMA has learned an individual has lost or is pending loss of eligibility:

- CMA emails Form 2067 to FHC PesFairHearingNotifications@hhs.texas.gov.

- FHC confirms loss of CLASS eligibility.

- FHC provides the CMA with the notice of proposed termination, appeal request, 4800D, and H1003 if applicable.

Fair Hearing Process (cont.)

Objectives

1. Types of CLASS Fair Hearings for IDD PES
2. Submitting an Appeal Request
3. Appeal Process
4. Evidence Packets
5. Time Frames
6. Ex-Parte Communication

Types of CLASS Appealable Actions for IDD PES

Adverse Actions taken by HHSC

- Denial of CLASS Enrollment (e.g.; ID/RC)
- CLASS Termination (e.g. Loss of Financial Eligibility)
- Suspension

Submitting an Appeal Request

- PES notifies the CMA's of the adverse action with an appeal instructions included

- The CMA notifies the individual, DSA, and, if selected, FMSA.

- The appellant or authorized representative must sign and date the appeal request and return it to the CMA.

- CMA receives appeal request and completes Form 4800D - *Fair Hearing Request Summary*

- The CMA sends the fair hearing request along with Form 4800D to IDD PES via IDD Operations Portal, fax (512-438-5693) or pesfairhearingnotifications@hhs.Texas.gov

Appeal Process

- PES enters information from the signed appeal request and the completed H4800-D into HHSC's system.

- A Fair Hearings officer is assigned the appeal and schedules the fair hearing with the appellant and/or authorized representative.

  o After the Fair Hearing is scheduled the appellant and/or authorized representative will receive an evidence packet.

Appeal Process (cont.)

- Fair Hearings are conducted at the scheduled time by conference call.

- The appellant and/or authorized representative and witness(es) are responsible for calling during the scheduled time.

Evidence Packets

IDD PES/MEPD

The appellant and/or authorized representative may receive, one or more, evidence packet(s) that consists of information supporting the adverse action by the agency.

Evidence packets may include, but are not limited to:

- Notices sent
- TAC rules
- Any additional information supporting why the agency took the adverse action

Note: Appellant and/or authorized representative has the right to submit any documentation that may assist in the hearing's outcome.

Evidence Packets (cont.)

Hearings Office

Form H4803 *Notice of Hearing*

- H4803 consists of:
  - The scheduled date and time of the hearing
  - The phone number and code that must be dialed.
  - The hearing officer's name, phone, and fax number

- **Form H4805 *Fair Hearing Procedures***

Evidence Packets (cont.)

Hearings Office (cont.)

Form H4806 Request for Another Appointment – Request to Withdraw

- The appellant or authorized representative must complete, sign and fax Form H4806 if they cannot or do not want to attend the scheduled hearing to the Hearing Officer.

- Form H4800 Fair Hearing Request Summary

Note: The appellant or authorized representative must call the phone number and use the code provided to participate in the hearing. Appellant failure to call into the hearing will result in dismissal.

Time Frames

Appellant has 90 days to request a fair hearing.

If the appeal request for the fair hearing, excluding enrollments, is received on or before the 10th day of the letter date, the appellant will continue to receive CLASS Program services at the currently authorized amounts until after the fair hearings officer has made a final decision about CLASS Program services.

Time Frames, cont.

Hearing officer has 90 days from the date the appeal request is received by the agency to issue a decision based exclusively on testimony and evidence introduced at the hearing.

Decisions by Hearings Officer

- Dismissals

- Withdrawals

- Sustained

- Reversals

Time Frames (cont.)

- Appellant or authorized representative has 30 days from the decision date to request an administrative review (when the appellant or authorized representative does not agree with the hearing officer's decision).

- If appellant or authorized representative does not agree with the administrative review decision, they can request a judicial review with the courts in Travis County within 30 days of the date of the administrative review decision.

Ex-Parte Communication

- HHSC employees and the fair hearing officer are not allowed to communicate in any way with the individual or their representatives/witnesses after the request for fair hearing has been received.

- HHSC will not accept any documents or additional information regarding the appeal outside of the hearing.

Ex-Parte Communication (cont.)

Some examples of communication which **would be allowed** under federal rules are:

- Providers or individuals may contact HHSC employees to request a mailing address to send the evidence packet.

- Providers may ask if the request for a fair hearing was received.

- Providers may ask for the date/time of the fair hearing or for the hearing officers contact information.

Ex-parte Communication* (cont.)

- The Hearing Officer is prohibited from engaging in ex-parte (private) communication relating to matters to be adjudicated.

- Any information considered by the Hearing Officer in deciding the appeal must be shared with the appellant and/or their authorized representative.

- Ex-parte consultations, whether oral or written, about the issues of the appeal are allowed only if they are shared with all parties.

*1 TAC, Part 15, Chapter 357, Subchapter A, Rule 357.5(c)(1)

Loss of Financial Eligibility: Termination Sustained

- If a hearing is for Loss of Financial Eligibility, the reviewer will reach out to the CMA.

- The reviewer will need to know if the applicant is still waiting for Medicaid to start after Medicaid application has been submitted.
    - If so, reviewer will wait 30 days.

- After 30 days, the reviewer will contact the CMA and see if Medicaid has started.

- Each case will be reviewed individually to see if we need to wait or request a termination.

- Once the reviewer is informed that Medicaid has started, a <u>2067</u> will be sent to the CMA and DSA to disregard appeal decision letter.

How to Assist the Appellant When Medicaid is Lost

- If the appellant has submitted a Medicaid application and it has been over 45 days, they can call 2-1-1 and request an administrative review.

- If provider needs to escalate the Medicaid case, provider may contact MEPD at OESMEPDIC@hhsc.state.tx.us.

- When the individual/LAR submits a Medicaid application, it is important it is reviewed and completed regarding who can talk with MEPD on behalf of the client.

- If the family requests provider assistance calling MEPD, a H1826 can be completed and sent in with the Medicaid application.

How to Assist the Appellant When Medicaid is Lost (cont.)

- Ask the individual/LAR if they need assistance with the Medicaid application.

- Ask if you could send it for them so you can include Form H1746A.

- If you find out, that the Medicaid application has already been submitted, you still need to send in Form H1746A.

- If the individual receives a denial for Medicaid from the Medicaid office, they can appeal to the Medicaid office. On the denial letter from the Medicaid office will be information on how to appeal.

How to Assist the Appellant When Medicaid is Lost (cont.)

- If the individual was receiving SSI benefits from the Social Security office, they will have Medicaid attached.

- If the individual no longer qualifies for the SSI benefits, Medicaid will end. The individual may be switch over to RSDI and receive a form of Medicare. This happens based on changes in the household.

- If the individual receives a letter stating their Medicaid is ending due to them no longer qualifying for SSI **they can appeal this decision with the Social Security office. There will be information on their denial letter on how to file the appeal.**

How to Assist the Appellant When Medicaid is Lost (cont.)

- If the family receives this type of letter, the Medicaid ending due to no longer qualifying for SSI, this is when the individual/LAR will need to complete application H1200 and submit to the Medicaid office.

- Submission of this application can be done by creating a portal with www.YourTexasBenefits.com, calling 2-1-1 or fax submission to 877-447-2839.

- The CMA must submit Form 1746A as the cover letter. The language for the comments section must state: **Please Test for ME-Waivers with effective date of xx/xx/xxxx. LOC has been approved. MN/ISP questions are not applicable for CLASS Waiver.**

- The date will be when you need the Medicaid reinstated to cover all gaps.

Fair Hearings Resources

Fair Hearing Resources

Section 1000 Fair Hearings

1000, Fair Hearings | Texas Health and Human Services

Fair Hearings TAC (Title 1, Part 15, Chapter 357, Subchapter A)

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=166787&p_tloc=&p_ploc=1&pg=8&p_tac=&ti=1&pt=15&ch=357&rl=11

Form H1003, Appointment of an Authorized Representative

https://www.hhs.texas.gov/regulations/forms/1000-1999/form-h1003-appointment-authorized-representative

Fair Hearing Resources (cont.)

Form 4800-D Fair Hearing Request Summary

Form 4800-DA, 4800-D Addendum | Texas Health and Human Services

HHSC Updates to Communication Related to Enrollment, Denials, Suspensions and Terminations

HHSC Updates to Communication Related to Enrollment, Denials, Suspensions and Terminations | Texas Health and Human Services

Form 2067

Form 2067, Case Information | Texas Health and Human Services

Fair Hearing Resources (cont.)

Section 1000 Fair Hearings

https://hhs.texas.gov/laws-regulations/handbooks/ffhh/section-1000-fair-hearings

Fair Hearings TAC (Title 1, Part 15, Chapter 357, Subchapter A)

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=166787&p_tloc=&p_ploc=1&pg=8&p_tac=&ti=1&pt=15&ch=357&rl=11

CLASS Fair Hearing Forms

Form 4800-D Fair Hearing Request Summary

Form instructions: https://hhs.texas.gov/laws-regulations/forms/4000-4999/form-4800-d-fair-hearing-request-summary

Technical Assistance

CLASS Message Line

Phone: 512-438-2484
IDD PES: Eligibility *(ID/RCs and Programmatic)*
IDD PES: Enrollments *(Enrollment IPCs, Pre-Enrollment Assessments)*
IDD PES: Transfers, Suspensions, Terminations
IDD PES: Fair Hearings related to Eligibility (Denial of CLASS Enrollment & Proposed CLASS Termination) E-mail: PesFairHearingNotifications@hhs.Texas.gov

Thank you!

Contact Information

CLASS: CLASSPolicy@hhs.texas.gov

DBMD: DBMDPolicy@hhs.texas.gov

EVV: EVV@hhs.texas.gov

PES: PesFairHearingNotifications@hhs.texas.gov