Attachment F
HCBS Fair Hearing Procedures

The material presented in Attachment F corresponds to the contents of Appendix F of the Application for a §1915(c) Home and Community-Based Services Waiver, Version 3.5.

I. Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated and have exhausted the managed care organization (MCO) internal appeal process. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing

The MCO must develop, implement and maintain an MCO internal Appeal process that complies with state and federal laws and regulations. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the MCO must regard the expression of dissatisfaction as a request to Appeal an Action. Unless the Member or his or her authorized representative requests an MCO expedited internal appeal, the Member or his or her authorized representative are notified they must file a written MCO internal appeal. If the Member does not follow up on an oral request for appeal in writing, the MCO decision is upheld after 30 days from the notice and the Member may request a state fair hearing.

A Member must file a request for an MCO internal Appeal with the MCO within 60 days from receipt of the notice of reduction, denial or termination of services.

The MCO's internal Appeal process must be provided to Members in writing and through oral interpretive services.

The MCO must send a letter to the Member within five (5) business days acknowledging receipt of the MCO internal Appeal request. Except for the resolution of an Expedited MCO Appeal, the MCO must complete the entire standard MCO internal Appeal process within 30 calendar days after receipt of the initial written or oral request for an MCO internal Appeal. The timeframe for a standard MCO internal Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the MCO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended and the Member had not requested the delay, the MCO must give the Member written notice of the reason for delay. The MCO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the MCO's written policies.

In accordance with 42 C.F.R. § 438.420, the MCO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the MCO internal Appeal, if all of the following criteria are met:

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1. The Member or his or her representative files the MCO internal Appeal timely as defined in this Contract;
2. The MCO internal Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If the MCO fails to meet the timeliness requirement for notification or at the Member's request, the MCO continues or reinstates the Member's benefits while the MCO internal Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the MCO internal Appeal;
2. Ten (10) days pass after the MCO mails the notice resolving the MCO internal Appeal against the Member, unless the MCO did not provide adequate notice or the Member, within the 10-day timeframe, has requested a state Fair Hearing with continuation of benefits until a state Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member.

In accordance with 42 C.F.R.§ 438.420(d), if the final resolution of the MCO internal Appeal is adverse to the Member and upholds the MCO's Action, then to the extent that the services were furnished to comply with the Contract, the MCO may recover such costs from the Member only with written permission from the state.

If the MCO or state fair hearings officer reverses a decision to deny, limit, or delay services that were not furnished while the MCO internal Appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no more than 72 hours from the decision.

If the MCO or hearings officer reverses a decision to deny authorization of services and the Member received the disputed services while the MCO internal Appeal was pending, the MCO is responsible for the payment of services.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for MCO internal Appeals, when the MCO determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The MCO must follow all MCO internal Appeal requirements for standard Member MCO internal Appeals except where differences are specifically noted. The MCO must accept oral or written requests for MCO Expedited internal Appeals.

Members must exhaust the MCO Expedited internal Appeal process before making a request for an expedited state Fair Hearing. After the MCO receives the request for an Expedited MCO internal Appeal, it must hear an approved request for a Member to have an MCO Expedited internal Appeal and notify the Member of the outcome of the MCO Expedited internal Appeal

within 72 hours, except that the MCO must complete investigation and resolution of an MCO internal Appeal relating to an ongoing emergency or denial of continued hospitalization:

1. In accordance with the medical or dental immediacy of the case; and
2. not later than one business day after receiving the Member's request for MCO Expedited internal Appeal is received.

The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an MCO Expedited internal Appeal. The MCO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

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

1. Transfer the Appeal to the timeframe for standard resolution, and
2. Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The MCO must inform Members that they have the right to access the state Fair Hearing process after exhausting the MCO internal Appeal system provided by the MCO. In the case of an expedited Fair Hearing process, the MCO must inform the Member that the Member must exhaust the MCO's internal Expedited Appeal process prior to requesting an Expedited state Fair Hearing. The MCO must notify Members that they may be represented by an authorized representative in the MCO internal Appeal and state Fair Hearing process.

If a Member requests a Fair Hearing, the MCO will enter the request in the Texas Integrated Eligibility Redesign System (TIERS), within five (5) calendar days.

Within five (5) calendar days of notification that the state Fair Hearing is set, the MCO will prepare an evidence packet for submission to the HHSC state Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's state Fair Hearings requirements.

The hearings officer makes an administrative decision on state Fair Hearings. The hearings officers are employees of HHSC that are in a separate division with a separate reporting structure from the State Medicaid Agency. This provides for an independent review and disposition for the member. The MCO sends a letter to the member informing the member that if an appeal is filed timely the member's benefits/services will continue. The member may also contact a member advocate or service coordinator for assistance or clarification. All documentation related to the adverse action and/or requests are maintained by the managed care organization in the member's case file.

II. State Grievance/Complaint System

The State operates a grievance/complaint system that affords participants the opportunity to register grievances, which HHSC refers to as complaints, concerning the provision of services.

A. Operational Responsibility

HHSC, the State Medicaid agency, and the MCO operate the complaint system.

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The State Medicaid Agency operates and maintains an electronic complaint system that provides information to HHSC staff on any complaints related to members of the MCOs. The MCO is required by contract to develop, implement and maintain a member complaint and appeal system specific to their members.

The member is informed at enrollment that filing a complaint is not a pre-requisite or substitute for a state Fair Hearing. The member is also informed that they can contact a Member Advocate or their service coordinator if they need assistance for issues related to making complaints or filing a grievance.

B. Description of System

The MCO must develop, implement, and maintain a Member Complaint and MCO internal Appeal system that complies with the requirements in applicable federal and state laws and regulations.

The Complaint and MCO internal Appeal system must include a Complaint process, an MCO internal Appeal process, and access to HHSC's state Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and MCO internal Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

The MCO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. The MCO must resolve Complaints within 30 days from the date the Complaint is received. The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The MCO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the MCO's complaint process.

The MCO's Complaint procedures must be provided to Members in writing and through oral interpretive services. The MCO must include a written description of the Complaint process in the Member Handbook. The MCO must maintain and publish in the Member Handbook, at least one local and one toll-free telephone number with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The MCO's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the managed care organization resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

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The MCO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

If the Member makes a request for disenrollment, the MCO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The MCO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees. The MCO must provide a designated Member Advocate to assist the Member in understanding and using the MCO's Complaint system until the issue is resolved.