# Medically Dependent Children Program Monitoring Report

**As Required by**

**Texas Government Code Section 531.06021**

**Health and Human Services Commission**

**June 2021**

# Table of Contents

**Executive Summary ........ 2**

**2. Introduction ........ 4**

**3. Medicaid Buy-In Enrollment ........ 5**

**4. Interest List Placement ........ 6**

**5. MDCP/DBMD Escalation Helpline ........ 7**

**6. External Medical Review ........ 9**

**7. Complaints relating to the MDCP waiver program ........ 10**

**8. Conclusion ........ 13**

**List of Acronyms ........ 14**

# Executive Summary

Health and Human Services Commission (HHSC) submits the Medically Dependent Children Program (MDCP) monitoring report in compliance with Texas Government Code Section 531.06021. This section requires HHSC to provide a report containing, for the most recent state fiscal quarter, information and data related to access to care for Medicaid recipients receiving benefits under the MDCP waiver program.

This report contains information through the end of quarter three (Q3) of the fiscal year 2021. Some provisions are in the process of implementation and information is not available as of the drafting of this report. This includes the availability of the Independent Review Organization (IRO) to perform external medical reviews (EMRs). In those instances, information regarding implementation status is provided. The following information is included:

*Enrollment in the Medicaid Buy-in for Children (MBIC) program*

HHSC is required to provide enrollment numbers for individuals participating in MBIC. The data included in this report indicates 793 unduplicated individuals were enrolled in MBIC for the fiscal year 2021 Q3.

*Requests relating to interest list placements*

Texas Government Code Section 531.06021 sets forth processes for individuals who are enrolled in MDCP but found ineligible for the program. HHSC implemented this provision on December 14, 2020.

Starting, December 14, 2020, HHSC notified denied MDCP members of interest list options to request MDCP first position, advanced placement, and placement on another interest list. Individuals have 120 days from the denial notification sent date to request these options.

HHSC continues to collect interest list data. A report containing this information through the end of Q3 is expected in quarter four (Q4) of the fiscal year 2021.

*Use of the MDCP escalation helpline*

[Texas Government Code Section 533.00253] requires HHSC to implement an escalation helpline for recipients in MDCP and the Deaf-Blind with Multiple Disabilities (DBMD) waiver program. Information on the use of the helpline is included in this report.

*Use of, requests for, and outcomes of the external medical review procedure*

[Texas Government Code Section 531.024164] requires HHSC to implement a process for review of managed care organization (MCO) or dental maintenance organization (DMO) benefit denials or reductions and medical necessity eligibility denials by an IRO. To implement this initiative, HHSC must contract with IROs to conduct the EMRs. HHSC is using an open enrollment process to contract with IROs which meet specified criteria. To date, HHSC has received two applications from IROs and is determining when it is feasible to implement based on these responses.

*Complaints relating to the MDCP waiver program, categorized by disposition*

For the fiscal year 2021 Q3, the HHS Office of the Ombudsman received 22 complaints from individuals in MDCP that have been resolved at the time of this report. The agency data is included by the resolution, categories, and subcategories of the complaints.

# 1. Introduction

This report contains information and data related to access to care for Medicaid recipients receiving benefits under the MDCP waiver including:

- Enrollment in the MBIC program;
- Requests relating to interest list placements under a provision in Texas Government Code (Section 531.06021);
- Use of the Medicaid escalation helpline;
- Use of, requests for, and outcomes of the EMR procedure; and
- Complaints relating to the MDCP waiver program, categorized by disposition.

Certain provisions are not fully implemented at the time of this report. HHSC has received two proposals for the planned EMR implementation and is in process of executing contracts.

**Background**

On November 1, 2016, HHSC implemented the State of Texas Access Reform (STAR) Kids program at which time, MDCP enrollees began receiving their acute care and long-term services and supports (LTSS) through STAR Kids. STAR Kids provides all medically necessary or functionally necessary Medicaid services and benefits of the MDCP waiver to eligible individuals.

MDCP provides services to support families caring for children and young adults age 20 and younger who are medically dependent and to encourage de-institutionalization of children and young adults who reside in nursing facilities. MDCP provides respite, flexible family support services, minor home modifications, adaptive aids, transition assistance services, employment assistance, supported employment, and financial management services through STAR Kids and STAR Health MCOs. The average number of clients served per month is 5,155.

# 2. Medicaid Buy-In for Children Enrollment

The MBIC program offers low-cost Medicaid services to children with disabilities in families who exceed Medicaid financial eligibility criteria. Eligibility for MBIC includes:

- Age 18 and younger
- Have a disability
- Are a U.S. citizen or qualified non-citizen living in Texas

MBIC provides the same services, both acute and LTSS, as Medicaid. Unlike traditional Medicaid eligibility, MBIC may require monthly payments. The requirement and amount vary based on income or if a member has other insurance.

The table below includes the monthly counts for enrollment in the MBIC program for the fiscal year 2021 Q3, as well as an unduplicated count of clients for the same time period. The unduplicated number represents the number of individuals served over the reporting period.

**Table 1. Number of Individuals Eligible for MBIC by Month for the Fiscal Year 2021 Q3 and Unduplicated Number of Individuals Eligible for the Fiscal Year 2021 Q3**

| Month/Year | MBIC Eligible Individuals |
|---|---|
| **March 2021** | 764 |
| **April 2021** | 767 |
| **May 2021** | 769 |
| **Unduplicated** | 793 |

**Data source: HHSC Center for Analytics and Decision Support**

# 3. Interest List Placement

Texas Government Code Section 531.06021 sets forth processes for individuals (referred to as members) who are enrolled in MDCP but found ineligible for the program. If a member lost eligibility because of medical necessity, the member can request to be placed in the first position on the MDCP interest list. The member can also request to use the original date they applied for the MDCP interest list as the interest list placement date for an existing waiver interest list. If a member lost MDCP eligibility due to a denial of medical necessity or because they have exceeded the age requirement for the program, the member can request to use the date they applied for the MDCP interest list as the date of interest list placement for any interest list on which the individual currently resides. HHSC implemented this provision on December 14, 2020.

To date, HHSC received a total of six requests for interest list placement with the following options selected:

- two requests received for first position placement for the MDCP interest list;
- three requests received for another waiver interest list using the date of their original MDCP request date; and
- one request received for placement on an interest list with the current request date.

Waiver release slots are offered based on legislative funding allotted to the program. Members electing the first position are aware they will be reassessed as MDCP slots become available.

Reporting measures through May 2021 are expected in Q4.

# 4. MDCP/DBMD Escalation Helpline

Texas Government Code Section 533.00253 requires HHSC to implement an escalation helpline for recipients in the MDCP and DBMD waiver programs.

The escalation line implemented in a phased approach. October 15, 2020, the helpline became available Monday through Friday 8:00 a.m. to 5:00 p.m. On December 1, 2020, the helpline expanded its hours to Monday through Friday 8:00 a.m. to 8:00 p.m.

**Table 2: Total Number of Inquiries or Complaints by the MDCP/DBMD escalation line by Month for the Fiscal Year 2021 Q3**

| Month/Year | Number of Calls Received | Complaints | Inquiries |
|---|---|---|---|
| **March 2021** | 37 | 10 | 13 |
| **April 2021** | 28 | 3 | 9 |
| **May 2021** | 20 | 1 | 6 |
| **Total** | 85 | 14 | 28 |

The MDCP/DBMD Escalation line received 85 calls generating 28 total cases. This is a 54 percent (30 more calls) increase from the previous quarter. In February 2021, HHSC began including the escalation line number in monthly member packet mailings. Many of the calls received were asking about the letter. Callers were educated on the purpose of the escalation line and a case was not generated.

All complaints or inquiries were resolved within an average of two days from receipt to closure. Eight cases were confirmed (five required enrollment updates within HHSC, three cases were sent to health plans to assist with prior authorization of services).

Current call volume does not support a 24/7 implementation. HHSC continues to assess options to efficiently respond to member needs while considering current call volumes. Staff are on call between the hours of 8:00 p.m. and 8:00 a.m. Monday through Friday and on weekends and holidays. As required, the helpline staff return voice messages no later than two hours after receiving the call during standard business hours; and return a telephone call not later than four hours after receiving the voice message during evenings, weekends, and holidays.

HHSC will continue to review helpline call data to determine the feasibility of expanding the helpline to other Medicaid programs that serve medically fragile children and young adults as well as extending the hours to 24/7.

# 5. External Medical Review

Government Code Section 531.024164 requires HHSC to implement a process for review of MCO or DMO benefit denials or reductions and medical necessity eligibility denials by an external medical reviewer. To implement this initiative, HHSC must contract with IROs to conduct the EMRs. HHSC is using an open enrollment process to contract with IROs which meet specified criteria. Implementation is occurring in two phases:

- Phase I includes MCO and DMO benefit denials and service reductions subject to the EMR process.
- Phase II includes eligibility denials based on the Medicaid member's medical or functional needs.

Contracted IROs must provide objective, unbiased medical necessity determinations. The determinations must be conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules. The IRO must also be overseen by a medical director. The medical director must be a physician licensed in Texas and employ, or be able to consult with, staff experienced in providing private duty nursing services and LTSS.

HHSC developed several training modules for MCOs, DMOs, and IROs. Additionally, system changes are complete and HHSC continues to engage with the MCOs to prepare for implementation. As of this report, HHSC has received two IRO applications and is determining when it is feasible to implement based on these responses.

# 6. Complaints relating to the MDCP waiver program

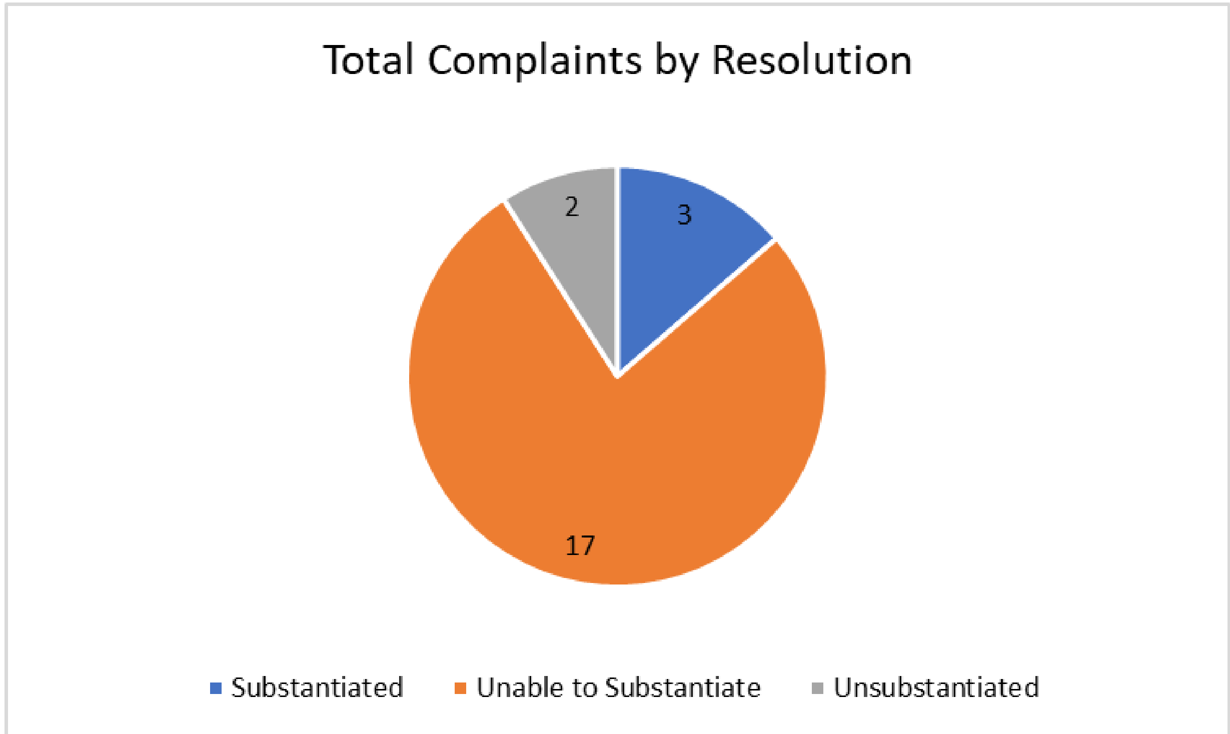
The HHS Office of the Ombudsman was established in state law to have authority and responsibility for providing dispute resolution services, performing consumer protection and advocacy functions, and collecting data on inquiries and complaints.

For the Medicaid managed care programs, a specialized team of Ombudsman staff are authorized by statute to work with HHSC Medicaid program staff, MCOs, and health care providers on behalf of consumers. Ombudsman staff educate consumers so they understand the concept of managed care, understand their rights under Medicaid, including grievance and appeal procedures, and are able to advocate for themselves. Ombudsman staff also collect and report statistical information on inquiries and complaints relating to MCOs by region and the Medicaid managed care program. Quarterly reports are posted on the agency's website.

The data included in this report includes all MDCP complaints received by the Ombudsman for the fiscal year 2021 Q3 and resolved at the time of this report. This report does not include complaints submitted directly to the MCOs. MCOs are required to submit complaints data to HHSC. HHSC is working to post MCO self-reported data compiled with agency data on the HHSC website in a standalone report on complaints data.

The Ombudsman received 23 total complaints and resolved 22 complaints related to MDCP at the time of this report. The table below shows, of the complaints, received and resolved, three were substantiated, two were unsubstantiated, and 17 were unable to substantiate.

**Table 3: Total Number of Complaints by Resolution of Substantiated, Unsubstantiated, and Unable to Substantiate Received and Resolved by Ombudsman in the Fiscal Year 2021 Q3**




Ombudsman utilizes the following definitions for these terms:

- *Substantiated* – a complaint where research clearly indicates agency policy was violated or agency expectations were not met.
- *Unable to Substantiate* – a complaint where research does not clearly indicate if agency policy was violated or agency expectations were met.
- *Unsubstantiated* – a complaint where research clearly indicates agency policy was not violated or agency expectations were met.

The table below depicts the total number of complaints by category and subcategory.

**Table 4: Total Number of Complaints by Category and Subcategory Received and Resolved by Ombudsman in the Fiscal Year 2021 Q3**

| Complaint Category | Complaint Sub-Category | Number of Complaints |
|---|---|---|
| Access to Care | Home Health | 4 |
| | Denial of Services | 3 |
| | Access to DME | 3 |
| | Access to PCP | 1 |
| Claims/Payment | Authorization Issue | 1 |
| Customer Service | Incorrect Information or Guidance | 2 |
| | Correspondence/ID Card | 1 |
| Member Enrollment | Client Notice | 2 |
| | Application/Case Denied | 1 |
| Policies/Procedures | Fair Hearing/Appeals | 2 |
| Prescription Services | Other Insurance | 1 |
| | Other | 1 |
| Total | | 22 |

# 7. Conclusion

HHSC continues to work towards fully implementing all items outlined in Texas Government Code Section 531.06021(b). Certain provisions are in the process of being implemented. HHSC anticipates more detailed reports in the future.

# List of Acronyms

| Acronym | Full Name |
| --- | --- |
| CSIL | Community Services Interest List |
| DBMD | Deaf Blind and Multiple Disabilities |
| DME | Durable Medical Equipment |
| DMO | Dental Maintenance Organization |
| EMR | External Medical Review |
| FY | Fiscal Year |
| HCBS | Home and Community Based Services |
| HHSC | Health and Human Services Commission |
| IRO | Independent Review Organization |
| LTSS | Long Term Services and Supports |
| MCO | Managed Care Organization |
| MDCP | Medically Dependent Children's Program |
| MBIC | Medicaid Buy In for Children |
| PCP | Primary Care Physician |
| PHE | Public Health Emergency |