Medically Dependent Children Program Monitoring Report

As Required by
Texas Government Code Section 531.06021

Health and Human Services Commission
June 2022

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Health and Human Services

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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 for fiscal year 2022, quarter three. 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 in the following sections.

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 that 779 unduplicated individuals were enrolled in MBIC for fiscal year 2022, quarter three.

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.

Under this process, HHSC has received five requests for interest list placement through the end of quarter three of fiscal year 2022.

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 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. These IROs began conducting EMRs effective May 1, 2022.

Complaints relating to the MDCP waiver program, categorized by disposition

For fiscal year 2022 quarter three, the Health and Human Services (HHS) Office of the Ombudsman received 15 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 executed two contracts for the planned EMR implementation.

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 5,829.

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 fiscal year 2022, quarter three, 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 Fiscal Year 2022 Quarter Three (Q3) and Unduplicated Number of Individuals Eligible for Fiscal Year 2022 Quarter Three (Q3)

Month/Year	MBIC Eligible Individuals
March 2022	761
April 2022	703
May 2022	756
Unduplicated	779

Data source: HHSC Office of Data, Analytics and Performance Interest List Placement

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 included. HHSC implemented this provision on December 14, 2020.

Fiscal year 2022, through quarter three, HHSC has received a total of five requests for first position placement on the MDCP interest list.

Waiver release slots are offered on a first-come-first-served basis, based on legislative funding allotted to the program. Members electing first position are informed they will be reassessed as MDCP slots become available.

4. MDCP/DBMD Escalation Helpline

Texas Government Code Section 533.00253 requires HHSC to implement a MDCP/DBMD Escalation Helpline for recipients in the MDCP and DBMD waiver programs.

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

Table 2: Total Number of Inquiries and Complaints Received by the MDCP/DBMD Escalation Helpline by Month for Fiscal Year 2022 Q3

Month/Year	Complaints	Inquiries
March 2022	6	35
April 2022	5	36
May 2022	10	45
Total	21	116

The helpline received 137 total new contacts for fiscal year 2022 quarter three (21 complaints and 116 inquiries). This is an increase of 22 contacts from the previous quarter, during which HHSC received 95 contacts. Ten (10) of the 137 contacts were specific to MDCP services.

Complaints are contractually defined as an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Adverse Benefit Determination. Inquiries are defined as a request by a consumer (Member or Provider) for information about HHS programs or services.

The table below depicts the total number of complaints and inquiries by category and subcategory for the Escalation Helpline.

Table 3: Total Number of Complaints and Inquiries by Category and Subcategory Received and Resolved by Escalation Helpline in Fiscal Year 2022 Q3

Category	Sub-Category	Number of Complaints	Number of Inquiries
Access to Care	Accessibility	0	1
Access to Care	Benefit Issues	0	1
Access to Care	Continuity of Care	0	1
Access to Care	Covid - 19	0	1
Access to Care	Delay of Referral or Authorization	1	0
Access to Care	Enrollment/Cancellation/Renewal of Enrollee	1	5
Access to Care	Health Coverage/Copay/Limits	0	1
Access to Care	Home Health	1	2
Access to Care	In Network Specialty Care Provider Access	1	0
Access to Care	MDCP	0	1
Access to Care	Member Enrolment Issues	0	1
Access to Care	Quality of Care	1	0
Access to Care	Therapy – Availability of Services	0	1
Claims/Payment	Coordination of Benefits	0	1
Claims/Payment	Customer Service	1	0
Claims/Payment	Denial/Delay of Payment	1	0
Claims/Payment	Enrollment/Cancellation/Renewal of Enrollee	0	1
Claims/Payment	Health Coverage/Copay/Limits	0	1
Customer Service/Quality	Accessibility / Availability	0	1
Member Enrollment	Access to care	1	0
Member Enrollment	Benefit Issues	4	52
Member Enrollment	Delay of Referral or Authorization	1	0
Member Enrollment	Denial of Claim	0	1

Category	Sub-Category	Number of Complaints	Number of Inquiries
Member Enrollment	Denial/Delay of Payment	0	1
Member Enrollment	Enrollment/Cancellation/Renewal	2	31
Member Enrollment	Health Coverage/Copay/Limits	0	1
Member Enrollment	Incorrect Enrollee information/Eligibility	0	1
Member Enrollment	Loss of Eligibility	0	1
Member Enrollment	MDCP	0	1
Member Enrollment	Member Enrollment Issues	0	2
Member Enrollment	Member Requested Disenrollment	1	1
Member Enrollment	Accessibility / Availability	0	1
Non-Medicaid Services	Miscellaneous Complaints	1	0
Non-Medicaid Services	Customer Service	0	1
Policies/Procedures	Durable Medical Equipment	0	1
Policies/Procedures	Home Health	1	0
Prescription Services	Denial/Non-Payment Medically Necessity Prescription	1	0
Prescription Services	Prescription Coverage/Copay/Limits	2	1
Therapy	Therapy – Availability of Services	0	1
Total		21	116

Current call volume does not support a 24/7 implementation. Staff are on call between the hours of 8:00 p.m. and 8:00 a.m. Monday through Friday, including holidays, and 24-hours a day on weekends. 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 and weekends.

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

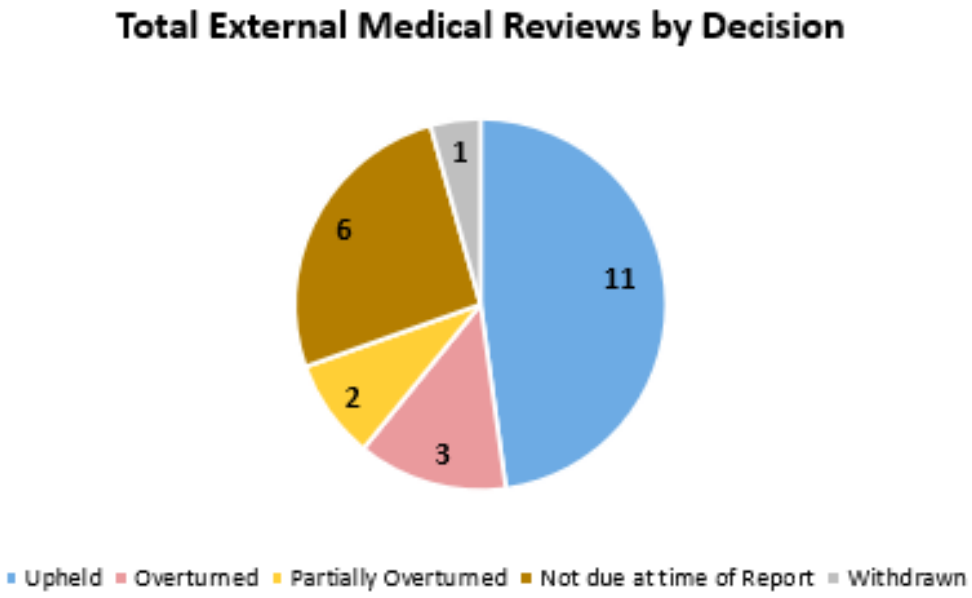
Government Code Section 531.024164 requires HHSC to implement a process for review of MCO or DMO benefit denials or reductions and medical necessity eligibility denials by an EMR. To implement this initiative, HHSC must contract with IROs to conduct the EMRs. HHSC is using an open enrollment process 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 I implemented May 1, 2022.
- Phase II includes eligibility denials based on the Medicaid member's medical or functional needs. Implementation is to be determined.

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.

IROs were assigned 23 external medical reviews: 11 decisions were upheld, three decisions were overturned, two decisions were partially overturned, six decisions were not due at the time of this report, and one request was withdrawn. Eight EMR requests were from MDCP Members.

Image 1: Total Number of External Medical Reviews By Decision Received Fiscal Year 2022 Q3



6. Complaints Relating to the MDCP Waiver Program

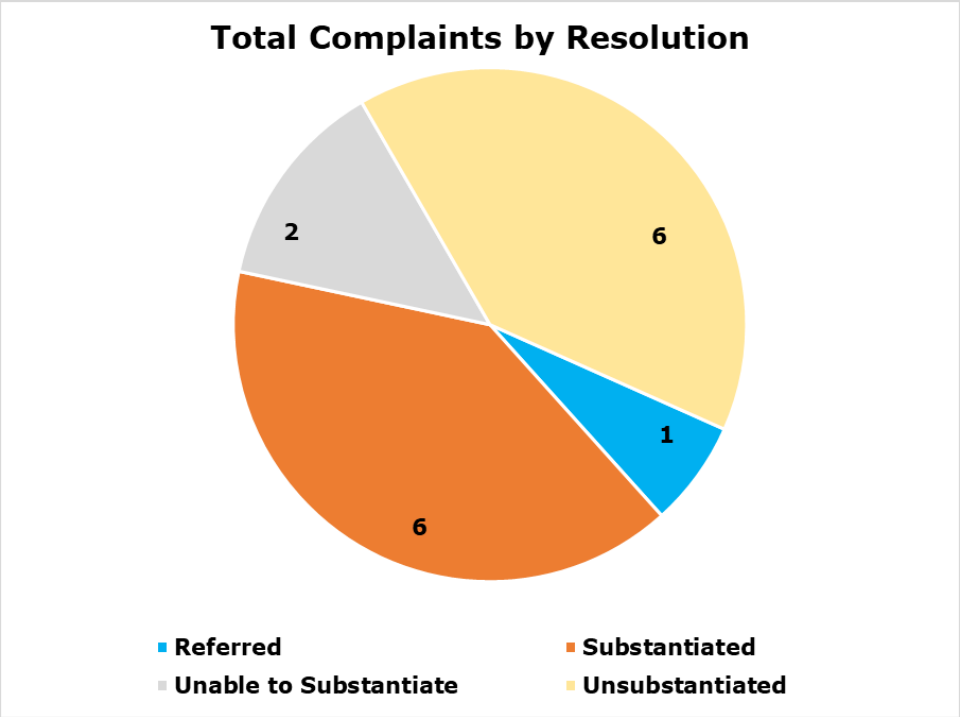
The HHS Office of the Ombudsman was established in state law to have authority and responsibility for providing dispute resolution services, performing consumer protection and advocacy functions, and collecting data on inquiries and complaints.

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 fiscal year 2022 Q3 and resolved at the time of this report. MCOs are required to submit complaints data to HHSC. HHSC posts MCO self-reported data compiled with agency data on the HHSC website in a standalone report on complaints data.

The Ombudsman received and resolved 15 total complaints related to MDCP. Image 1 below shows that, of the complaints received and resolved, six were substantiated, six were unsubstantiated, two were unable to substantiate, and one was referred.

Image 2: Total Number of Complaints by Resolution of Substantiated, Unsubstantiated, and Unable to Substantiate Received and Resolved by Ombudsman in Fiscal Year 2022 Q3



Ombudsman uses 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.
- *Referred* - a complaint neither fully researched nor investigated because the complaint needs to be resolved elsewhere (a referral to another area to address the complaint).

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 Fiscal Year 2022 Q3

Complaint Category	Complaint Sub-Category	Number of Complaints
Access to Care	Access to DME	3
Access to Care	Continuity of Care	1
Access to Care	Home Health	2
Access to Care	Reduction/Suspension/Termination of Services	1
Member Enrollment	Application/Case Denied	1
Member Enrollment	Case Information Error	1
Policies/Procedures	Disagree with Policy	1
Prescription Services	Prescription Services - Member Not Showing Active	1
Prescription Services	Prescription Services - Other	1
Prescription Services	Prescription Services - Refill Too Soon	1
Quality of Care	Service Coordination/Service Management	1
Transportation Issues	NEMT-Individual Transportation Participant Claims	1
Total		15

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
DBMD	Deaf Blind and Multiple Disabilities
DMO	Dental Maintenance Organization
EMR	External Medical Review
HHS	Health and Human 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
STAR	State of Texas Access Reform