



# **Medically Dependent Children Program Monitoring Report**

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**As Required by  
Texas Government Code, Section  
531.06021**

**Texas Health and Human Services  
September 2023**



**TEXAS**  
Health and Human  
Services

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# Executive Summary

The 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 2023, quarter four.

## **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 611 unduplicated individuals were enrolled in MBIC for fiscal year 2023, quarter four.

## **Requests relating to interest list placements**

Section 531.06021 sets forth processes for individuals who are enrolled in MDCP but subsequently found ineligible for the program. These processes allow for individuals to request different options related to placement on the waiver interest list for MDCP or another waiver. HHSC implemented this provision on December 14, 2020.

Under this process, HHSC received zero requests for interest list placement through the end of quarter four of fiscal year 2023.

## **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 Independent Review Organization (IRO). To implement this initiative,

HHSC must contract with IROs to conduct the External Medical Review (EMR). IROs began conducting EMRs effective May 1, 2022.

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

For fiscal year 2023 quarter four the Health and Human Services Office of the Ombudsman received 21 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 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.

## 2. Background

HHSC implemented the State of Texas Access Reform (STAR) Kids program on November 1, 2016, 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 through a managed care model.

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.

### 3. 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 2023, quarter four, 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 2023 Quarter Four and Unduplicated Number of Individuals Eligible for Fiscal Year 2023 Quarter Four**

Month/Year	MBIC Eligible Individuals
June 2023	577
July 2023	519
August 2023	472
Unduplicated	611

Data source: HHSC Office of Data, Analytics and Performance

## 4. Interest List Placement

Section 531.06021 sets forth processes for individuals (referred to as members) who are enrolled in MDCP but subsequently found ineligible for the program. A member may lose eligibility due to denial of medical necessity. If a member lost eligibility because of denial 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 another 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 placed their name on the MDCP interest list as the date of interest list placement for any interest list on which the individual is currently included. HHSC implemented this provision on December 14, 2020.

In fiscal year 2023, through quarter four, HHSC has received a total of zero 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.



## 5. 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 2023, Quarter Four**

Month/Year	Complaints	Inquiries
June 2023	4	59
July 2023	3	73
August 2023	3	69
<b>Total</b>	10	201

The helpline received 211 total contacts for fiscal year 2023, quarter four (ten complaints and 201 inquiries). This is an increase of 17 contacts from the previous quarter, during which HHSC received 194 contacts. Of the 211 total contacts, 57 contacts were specific to MDCP services, including:

- Fifty-four related to Member Enrollment,
- One related to Access to Care,
- One related to Policy/Procedures, and
- One related to Prescription Services.

This was a decrease of five MDCP contacts from the 62 MDCP contacts for fiscal year 2023, quarter three. There was no trend found regarding the decrease of contacts specific to MDCP.

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.

Table 3 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 2023, Quarter Four**

Category	Sub-Category	Number of Complaints	Number of Inquiries
Access to Care	Access to Care	0	1
Access to Care	Coordination of Benefits	0	1
Access to Care	Enrollment/Cancellation/Renewal of Enrollee	0	13
Access to Care	In-Network: Specialty Care/Provider Access	0	1
Access to Care	Urgent Care Accessibility	1	0
Claims/Payment	Enrollment/Cancellation/Renewal of Enrollee	0	1
Customer Service/Quality	Customer Service	0	1
Customer Service/Quality	Representative Not Responding/Follow-up	1	0
Member Enrollment	Accessibility-Other	0	1
Member Enrollment	Balance Billing	0	4
Member Enrollment	Benefit Issues	4	158
Member Enrollment	Enrollment/Cancellation/Renewal of Enrollee	2	11
Member Enrollment	Loss of Eligibility	0	3
Member Enrollment	Member Enrollment Issues	1	2
Member Enrollment	MDCP	0	1
Non-Medicaid Services	Access to Care	0	1
Policies/Procedures	Home Modifications	0	1
Prescription Services	Denial/Non-Payment MN Prescription	1	0
Provider Contracting	Provider Enrollment Issues	0	1
<b>Total</b>	<b>N/A</b>	<b>10</b>	<b>201</b>

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.

## 6. External Medical Review

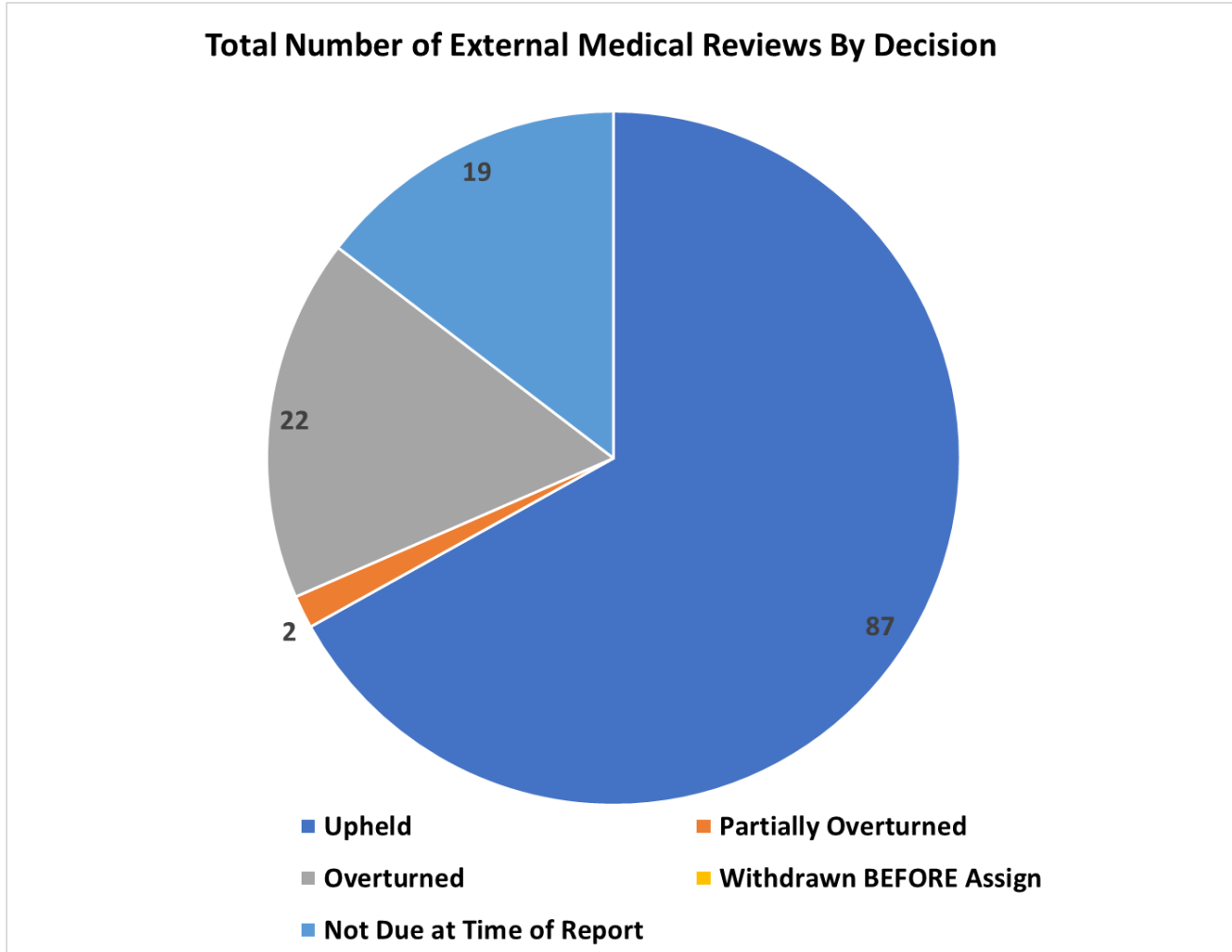
Section 531.024164 requires HHSC to implement a process for review of MCO or DMO benefit denials or reductions. To implement this initiative, HHSC must contract with IROs to conduct the EMRs. HHSC is using an open enrollment process to contract with IROs which meet specified criteria. MCO and DMO benefit denials and service reductions subject to the EMR process implemented May 1, 2022.

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.

The HHSC EMR Intake Team received 130 EMR requests for fiscal year 2023, quarter four. Of the 130 EMRs requested:

- Eighty-seven decisions were upheld,
- Twenty-two decisions were overturned,
- Two decisions were partially overturned,
- Nineteen decisions were not due at the time of this report.
- Eleven EMR requests were from MDCP Members.

**Image 1: Total Number of External Medical Reviews By Decision Received Fiscal Year 2023, Quarter Four**



## **7. Complaints Relating to the MDCP Waiver Program**

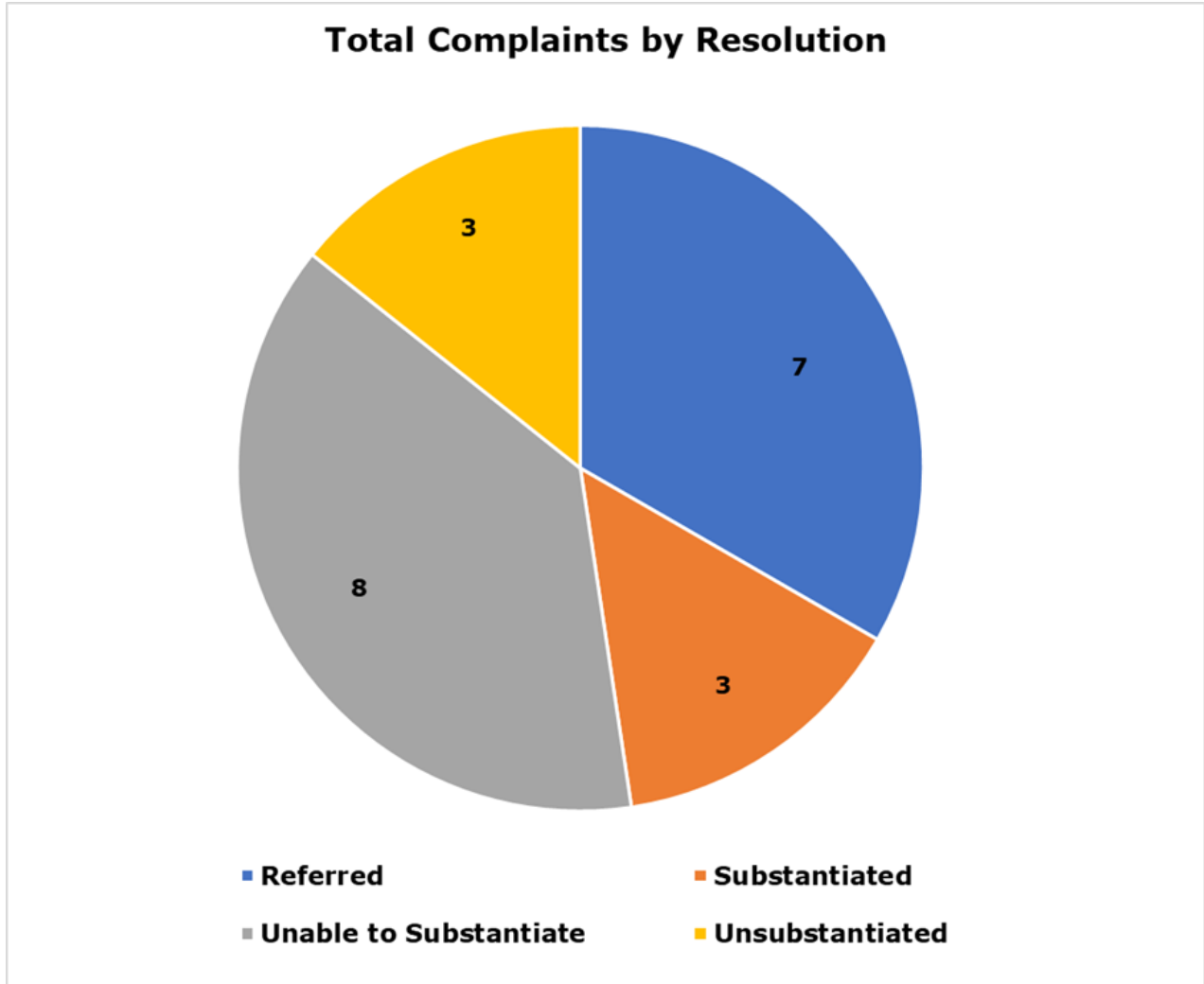
The HHS Office of the Ombudsman was established in state law to have authority and responsibility for providing dispute resolution services, performing consumer protection and advocacy functions, and collecting data on inquiries and complaints.

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 2023, quarter four 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 21 total complaints related to MDCP. Image 2 shows of the complaints received and resolved, three were substantiated, three were unsubstantiated, eight were unable to substantiate, and seven were referred.

**Image 2: Total Number of Complaints by Resolution of Substantiated, Unsubstantiated, and Unable to Substantiate Received and Resolved by Ombudsman in Fiscal Year 2023, Quarter Four**



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 2023, Quarter Four**

<b>Complaint Category</b>	<b>Complaint Sub-Category</b>	<b>Number of Complaints</b>
<b>Access to Care</b>	Access to DME	1
<b>Access to Care</b>	Authorization Process/Denial	2
<b>Access to Care</b>	Home Health	1
<b>Member Enrollment</b>	Application Not Completed	2
<b>Member Enrollment</b>	Application/Case Denied	4
<b>Member Enrollment</b>	Case Information Error	1
<b>Member Enrollment</b>	Medicaid Eligibility/Recertification	4
<b>Policies/Procedures</b>	Disagree with Policy	1
<b>Policies/Procedures</b>	Fair Hearing/Appeals	1
<b>Policies/Procedures</b>	HIPAA	1
<b>Quality of Care</b>	Coordination of Care (Provider)	1
<b>Therapy</b>	Therapy - Denial of Authorization	2
<b>Total</b>	<b>N/A</b>	<b>21</b>



## List of Acronyms

<b>Acronym</b>	<b>Full Name</b>
DBMD	Deaf-Blind with Multiple Disabilities
DMO	Dental Maintenance Organization
EMR	External Medical Review
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