Medically Dependent Children Program Monitoring Report

As Required by
Texas Government Code Section 531.06021

Health and Human Services Commission
December 2021

TEXAS
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 through the end of quarter one of fiscal year 2022. 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 787 unduplicated individuals were enrolled in MBIC for fiscal year 2022 quarter one.

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 four requests for interest list placement through the end of quarter one 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. Implementation is scheduled to occur May 1, 2022.

Complaints relating to the MDCP waiver program, categorized by disposition

For fiscal year 2022 quarter one, the Health and Human Services (HHS) Office of the Ombudsman received 28 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 5,467.

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 one, 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 One (Q1) and Unduplicated Number of Individuals Eligible for Fiscal Year 2022 Quarter One(Q1)

Month/Year	MBIC Eligible Individuals
September 2021	765
October 2021	764
November 2021	772
Unduplicated	787

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

Fiscal Year 2022, Quarter One, HHSC has received a total of four 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 Q1

Month/Year	Complaints	Inquiries
September 2021	1	8
October 2021	3	40
November 2021	5	27
Total	9	75

The helpline received 84 total contacts for fiscal year 2022 quarter 1 (nine complaints and 75 inquiries). This is an increase of 63 contacts from the previous quarter, during which HHSC received 21 contacts. HHSC attributes the increase in calls, specifically inquiries, to the helpline contact information being placed above other member-facing hotline numbers on the Contact Us | Texas Health and Human Services webpage.

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 Q1

Category	Sub-Category	Number of Complaints	Number of Inquiries
Access to Care	Appointment Assistance	0	2
Access to Care	Denial of Services	2	0
Access to Care	Home Health	1	1
Access to Care	Home Modification	1	0
Access to Care	Non-Medicaid Local Resource	0	1
Member Enrollment	Cancellation/Renewal	0	10
Member Enrollment	Member Benefit	3	37
Member Enrollment	Interest List	0	6
Policies/Procedures	Adaptive Aid	0	1
Policies/Procedures	Member Benefit	1	3
Policies/Procedures	General Inquires	0	11
Policies/Procedures	Disagree with Policy	1	3
Total		**9**	**75**

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. Implementation for Phase I is scheduled to occur 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.

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 received two IRO applications. Both applicants met HHSC requirements and contracts have been executed.

6. Complaints Relating to the MDCP Waiver Program

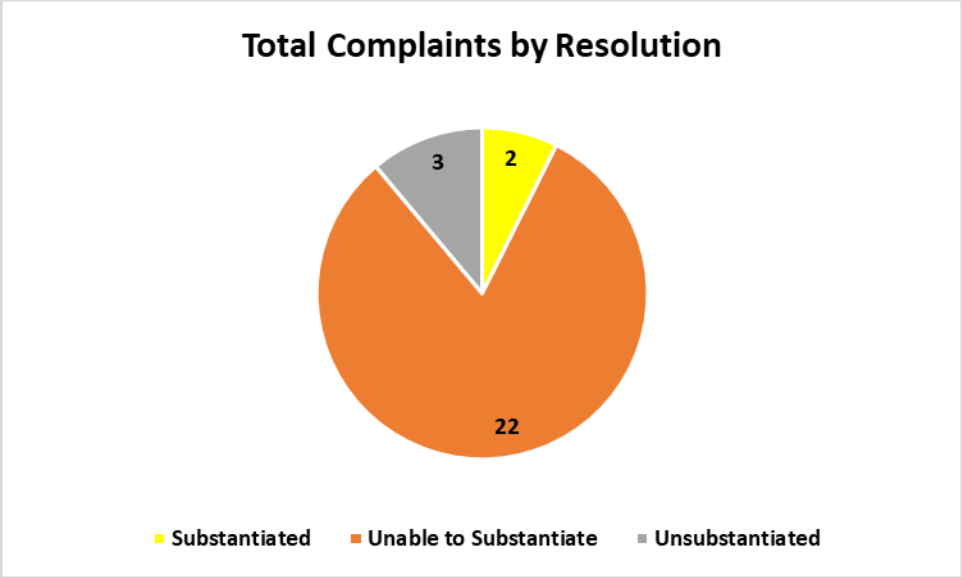
The HHS Office of the Ombudsman was established in state law to have authority and responsibility for providing dispute resolution services, performing consumer protection and advocacy functions, and collecting data on inquiries and complaints.

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 Q1 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 28 total complaints and resolved 27 complaints related to MDCP. The table below shows that, of the complaints received and resolved, two were substantiated, three were unsubstantiated, and 22 were unable to substantiate. One complaint was pending at the time of this report.

Image 1: Total Number of Complaints by Resolution of Substantiated, Unsubstantiated, and Unable to Substantiate Received and Resolved by Ombudsman in Fiscal Year 2022 Q1



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.

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 Q1

Complaint Category	Complaint Sub-Category	Number of Complaints
Access to Care	Denial of Services	3
Access to Care	Access to Durable Medical Equipment	3
Access to Care	Home Health	3
Access to Care	Access to In-Network Provider (non-Primary Care Physician)	1
Access to Care	Continuity of Care	1
Customer Service	Incorrect Information or Guidance	1
Member Enrollment	Client Notice	2
Member Enrollment	Medicaid Eligibility/Recertification	1
Member Enrollment	Case Information Error	1
Member Enrollment	Changes Not Processed Timely	1
Policies/Procedures	Fair Hearing/Appeals	5
Policies/Procedures	Disagree with Policy	2
Quality of Care	Service Coordination/Service Management	1
Therapy	Therapy - Availability of Services	1
Transportation Issues	NEMT-Client was not transported	1
Total		**27**

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