



Continuous Medicaid Coverage Unwinding Operational Plan

**Texas Health and Human
Services Commission**

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Executive Summary

To prepare for the end of continuous Medicaid coverage, the Texas Health and Human Services Commission (HHSC) has pursued a set of strategies to manage the higher-than-normal caseload during the unwinding period and the return of normal operations once HHSC redetermines eligibility for all clients on Medicaid after March 31, 2023.

This operational plan reflects more than two years of work by hundreds of staff, external partners and stakeholders to review the Centers for Medicare & Medicaid Services' (CMS) guidance and recommended strategies, best practices in other states, and HHSC's operational needs. HHSC devised a phased, population-based approach for redetermining eligibility for more than 5.9 million Texans enrolled in Medicaid and the Children's Health Insurance Program (CHIP) as of April 2023. The approach best carries out the goals of:

- Maintaining coverage for people who are still eligible and minimizing client impact.
- Prioritizing redeterminations for those most likely to no longer be eligible for Medicaid or to be eligible for another program.
- Balancing the workload of our eligibility staff.
- Establishing a sustainable redetermination schedule for future years.

Over the last two years, HHSC has implemented dozens of strategies to manage workload, increase workforce capacity and protect clients during the unwinding period. HHSC has emphasized staff recruitment and retention, process improvement, and proactive communications to prepare for the expected volume of work and ensure success for the goals listed above. Additionally, HHSC developed a monitoring center involving a cross-functional team of experts to oversee the unwinding process, monitor trends, and address issues during the unwinding period.

Staff continue to monitor federal guidance to ensure HHSC is following federal regulations, state statutes, and CMS policies related to unwinding continuous Medicaid coverage.

1. Background

Families First Coronavirus Response Act

In March 2020, HHSC took the following actions in response to the Families First Coronavirus Response Act (FFCRA), which required states to maintain Medicaid eligibility during the COVID-19 public health emergency (PHE) to receive enhanced Federal Medical Assistance Percentage (FMAP):

- Re-opened eligibility for denied Medicaid clients who were active as of March 18, 2020, and had an eligibility end date of March 31, 2020.
- Notified Medicaid clients who were expected to renew their coverage from March 2020 through August 2020 that their redetermination would be delayed because of the federal PHE; and
- Made system updates to the eligibility system in:
 - ▶ May 2020 and June 2020 to ensure Medicaid coverage was maintained, even if a reported change or other case action indicated the person was ineligible, except as federally allowed.
 - ▶ September 2020 to allow HHSC to resume processing Medicaid redeterminations while maintaining continuous Medicaid coverage.

In September 2021, further system changes were made to allow staff to automatically request information needed to redetermine eligibility while still maintaining Medicaid coverage if the information was not provided.

Interim Final Rule (CMS-9912-IFC)

In accordance with the CMS Interim Final Rule (CMS-9912-IFC with Comment) and the subsequent CMS approval of the agency's implementation plan¹, HHSC implemented system changes in December 2020 to allow eligible individuals to transition between Medicaid programs that provided the same tier of coverage

¹ CMS requested that HHSC provide a timeline for implementing the changes needed to comply with the IFC.

effective February 1, 2021.² This change ensured eligible individuals were certified for their appropriate eligibility category.

As directed in the State Medicaid Directors Letters dated February 6, 2023, and March 7, 2023, HHSC ceased moving individuals from full Medicaid to Medicare Savings Programs only and changed the eligibility system in April 2023 to prevent future transitions from full Medicaid to Medicare Savings Program only.

Consolidated Appropriations Act, 2023

Following the Consolidated Appropriations Act, 2023 (CAA 2023) and CMS guidance, HHSC ended continuous Medicaid coverage on March 31, 2023. HHSC will adhere to the updated continuous coverage conditions in section 6008(b)(3) of the FFCRA to continue receiving the temporary FMAP increase that will phase down from April 1, 2023, through December 31, 2023. Under the CAA 2023, states must meet the following additional conditions to receive the increased FMAP, beginning April 1, 2023:

- Compliance with federal renewal requirements.
- Ensure up-to-date contact information before redetermination of eligibility.
- Contact clients using more than one modality prior to terminating enrollment on the basis of returned mail.

The following sections outline the approach HHSC will take to redetermine eligibility for all clients enrolled in Medicaid and CHIP, as directed by the CAA 2023 and CMS guidance.

Approach to Different Case Types

HHSC organizes work based on program type, action needed, and the complexity of the task using an eligibility workload management system (EWMS). This allows

² On October 28, 2020, CMS published CMS-9912-IFC, which establishes a new section 433.400 in Part 433 of Title 42 of the Code of Federal Regulations (CFR). The regulation reinterprets the condition in section 6008(b)(3) of the FFCRA under which states claiming the temporary FMAP increase must maintain client enrollment through the end of the month in which the PHE for COVID-19 ends and includes additional safeguards to protect clients. [CMS-9912 Interim Final Rule with Comment Factsheet on Updated Policy for Maintaining Medicaid Enrollment during the Public Health Emergency for COVID-19](#)

HHSC to assign eligibility workers casework based on their skillset and the priority of the work.

Redeterminations

HHSC assigns redeterminations processing based on program type and complexity of work using EWMS. Redeterminations are prioritized based on certification end date, and workers process them based on the client's last benefit month to avoid any gap in coverage.

HHSC resumed processing Medicaid redeterminations in September 2020 after pausing redeterminations in March 2020 at the onset of the PHE. Clients who are determined eligible at their redetermination receive a new 12-month certification period. Clients who were not determined eligible or who did not return their redetermination packet were flagged as part of the continuous enrollment population and had their Medicaid coverage maintained due to the continuous coverage requirement.

For Medicaid, redetermination packets are sent in the ninth month of the person's 12-month certification period. If eligibility can be determined through the administrative renewal (*ex-parte*) process, clients only need to return information if they need to report a change. Clients whose eligibility cannot be determined through the administrative renewal process must return the renewal form and any required verification within 30 days of the date of the notice. Redeterminations for Medicaid are processed by a specified date in the twelfth month of the certification period.

Clients in the continuous enrollment population will have their redetermination initiated in the first six months of the unwinding period.

2. Unwinding Approach

HHSC's phased, population-based unwinding approach staggers Medicaid redeterminations over multiple months for clients whose coverage was maintained due to the continuous coverage requirement. These clients, for whom Medicaid coverage has been sustained, are referred to as the "continuous enrollment population."

The HHSC staggered approach best carries out the goals of:

- Maintaining coverage for people who are still eligible and minimizing client impact.
- Prioritizing redeterminations for those most likely to no longer be eligible for Medicaid or to be eligible for another program.
- Balancing the workload of our eligibility staff.
- Establishing a sustainable redetermination schedule for future years.

HHSC will stagger redeterminations for each group in the first six months of the unwinding period. The continuous enrollment population was divided into three groups.

- The first cohort includes those clients most likely to be ineligible for all benefits (e.g. a person who has aged out of Children's Medicaid or an adult relative under age 65 without a Medicaid-eligible dependent in the household), and children who are ineligible for Medicaid, but may be eligible to be transitioned to CHIP.
- The second cohort includes those likely to transition to a different Tier 1 Medicaid eligibility group (e.g., Children's Medicaid, Medicaid for Parents and Caretaker Relatives, and waiver programs) and those who are moving to a lower tier of coverage.
- The third cohort includes anyone remaining from the previous groups and includes the populations most likely to remain eligible for Medicaid, such as children in Medicaid, older adults and people with disabilities.

In the event household members are assigned to different cohorts, HHSC will redetermine eligibility for all household members according to the earliest cohort designation. For example, all household members included with a client assigned in the first cohort will have their redetermination initiated with the first cohort in April 2023.

Clients who cannot be renewed in their current eligibility category and whose eligibility must be redetermined on another basis are not assigned to one of the three cohorts. These clients include:

- Women enrolled in Medicaid for Pregnant Women who have completed their two-month postpartum coverage period.
- Women enrolled in Medicaid for Breast and Cervical Cancer.
- Transitional Medicaid recipients whose transition periods have ended
- Deemed Eligible Medicaid newborns.
- People categorically eligible for Medicaid based on receiving Social Security Income benefits.
- Children no longer in conservatorship of the Department of Family and Protective Services .
- Clients who have aged out of Children’s Medicaid, Medicaid for Former Foster Care Children and Medicaid for Transitioning Foster Care Youth.

HHSC will redetermine eligibility for these clients throughout the first six months of the unwinding period.

Redeterminations for clients who have renewed their coverage while continuous Medicaid coverage was in effect or are newly eligible will be processed based on their regular redetermination date during the unwinding period. These clients are not included in the cohorts described above.

HHSC anticipates there will be months where the volume of redeterminations initiated will exceed the recommended one-ninth of the total caseload.³ During the unwinding period, HHSC will maintain Medicaid coverage for all clients in the continuous enrollment population until their redetermination has been completed. This will allow HHSC to manage the redetermination workload without negatively affecting clients. HHSC has taken other steps to safeguard against negative client impact, as discussed in Section 6 of this plan.

HHSC developed a monitoring center involving a cross-functional team of experts to oversee the unwinding process, monitor trends and address issues during the

³The projected distribution of Medicaid and CHIP redeterminations can be found in the State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions (April 2023), <https://www.hhs.texas.gov/sites/default/files/documents/state-report-plans-prioritizing-distributing-renewals.pdf>

unwinding period. Baselines for key metrics were established to identify, escalate and resolve issues quickly. The monitoring center will also review feedback from external partners to ensure successful implementation of the unwinding operational plan.

3. Reducing Eligibility Workload

HHSC uses the Texas Integrated Eligibility Redesign System (TIERS) and an integrated eligibility workforce to determine eligibility for Medicaid, CHIP, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF).

Because Texas' eligibility system is integrated and staff determine eligibility for all programs, any reduction in workload for SNAP or TANF increases staff capacity to support Medicaid and CHIP work.

Implemented Strategies

In preparation for the end of continuous Medicaid coverage, HHSC has implemented, and continues to evaluate, strategies to improve the efficiency of eligibility determinations and to mitigate the impact of redetermining eligibility for 5.9 million Texans on the HHSC eligibility workforce. These strategies include:

- Implemented "No Action" changes by using clerical team members to review change tasks to determine if action is needed, or if the task can be cleared in the event no action is required. This allows eligibility staff to focus on processing applications and redeterminations.
- Implemented updates to the system used to assign tasks to eligibility staff to combine similar tasks. Previously, these tasks were processed individually.
- Prioritized specific types of reported changes in the workload management system that have faster processing times or that are considered critical, increasing the number of changes and cases processed per day.
- Implemented additional automation for MAGI Alerts. The MAGI Alert prompts staff to reevaluate the client's eligibility for other medical programs and are processed promptly to prevent a gap in coverage. During the continuous Medicaid coverage unwind, clients are automatically evaluated for other medical programs. If more information is needed to complete the determination, the client is mailed a redetermination notice, a redetermination form, and a request for information.
- Implemented improved sharing of client's preferred method of contact with Medicaid and CHIP managed care organizations (MCOs).
- As required by Senate Bill 1059 (87th Legislature, Regular Session, 2021) HHSC implemented self-attestation of Texas residency for Medicaid for

Former Foster Care Children, eliminating the need to request and wait for residency verification.

- Implemented improvements to the YourTexasBenefits.com platform, including:
 - ▶ an online password reset process to reduce call volumes and support a better client experience.
 - ▶ an electronic signature option for clients to sign certain forms.
 - ▶ improvements to the mapping of client data to application fields to save staff time during the eligibility processing stage.
- Implemented changes to the Electronic Benefit Transfer system to automate tasks previously performed manually.
- Implemented a strategy to create multiple monthly eligibility files when individual transactions exceed 500,000 to ensure all downstream enrollment systems can successfully complete enrollments, disenrollments, and changes to enrollment for the enrollment broker, managed care plans, payment systems and Medicaid management information systems.
- Implemented the use of robotic process automation to receive updated address information from the U.S. Postal Service (USPS) and MCOs to reduce manual staff workload related to address updates.
- Automated the scheduling of SNAP appointments and made system changes that allowed other staff to help in scheduling interviews.
- Implemented system changes that allow staff to initiate redeterminations for the continuous enrollment population when processing an initial application or redetermination for SNAP or TANF. The verified income received for SNAP or TANF is used to process the Medicaid redetermination, which prevents the client from having to reverify their household income.
- Updated YourTexasBenefits.com and its mobile application to automatically process certain address change requests when a client reports a change.
- Suspended interviews for TANF and Medicaid for Parents and Caretaker Relatives.
- Effective September 2022, established a direct connection to The Work Number data through the CMS Federal Data Services Hub to obtain employment and income information for Medicaid and CHIP eligibility determinations.
- Increased the age of quarterly income information used from the Texas Workforce Commission during the administrative redetermination process.
- Expanded and enhanced the Community Partner Program to increase the number of community organizations that can provide application and redetermination assistance to clients.

Temporary Waivers

To reduce the need for staff to manually verify addresses by contacting clients or sending correspondence, HHSC has implemented CMS-approved 1902(e)(14) waivers in Medicaid and CHIP to accept updated in state client contact information from the USPS, National Change of Address (NCOA) system database and MCOs without requiring HHSC to seek additional verification from the client.

Through March 2024, HHSC is using 1902(e)(14) waiver authority to use SNAP income data, verified within the last six months, to determine a client Medicaid income eligible without a separate MAGI income determination. The eligibility system will compare a client's verified SNAP gross income to the appropriate MAGI Medicaid federal poverty limit to determine whether the client is income-eligible for Medicaid. Under this waiver, if the client is found ineligible using the SNAP verified income, the client will have an opportunity to provide updated income verification as part of the Medicaid redetermination process.

HHSC received approval from the federal Food and Nutrition Service to extend SNAP recertifications for six months for recertifications due through June 2023 and to waive interviews for SNAP at application and recertification through May 2024.

Periodic Income Checks

A periodic income check (PIC) is an automated process using electronic data sources to identify changes in a client's household income that could potentially make them ineligible for Medicaid or CHIP. Prior to the PHE, HHSC processed PICs in months five through eight for Children's Medicaid and months three through eight for Medicaid for Parents and Caretaker Relatives. Children enrolled in CHIP with an income above 185 percent of the federal poverty limit had one income check in month six of their 12-month certification period.

HHSC has suspended PICs during the PHE and through the unwinding period. As a result of the CAA 2023, children enrolled in Medicaid or CHIP will receive 12 months of continuous eligibility beginning January 1, 2024, ending PICs for children when the state's unwinding period ends in May 2024.

4. Expanding Workforce Capacity

While reducing workload will help manage the volume of redeterminations over the unwinding period, HHSC still expects a significant increase in workload during this time. HHSC has made expanding hiring, improving training and increasing retention of eligibility staff top priorities over the last year. HHSC has experienced a net gain of nearly 1,000 eligibility advisors between April 2022 and March 2023, and as of March 31, 2023, the vacancy rate for eligibility workers is 4.4 percent (down from a high of 21 percent in March 2022).

Implemented Strategies

HHSC has taken the following steps to increase the number and capacity of eligibility staff able to process cases:

- Adjusted the eligibility advisor initial and pre-hire screening criteria to increase the pool of qualified full and part-time candidates.
- Reduced the time between the date of hire and the start of training.
- Streamlined the web-based prerequisites and designed the training to be more self-directed.
- Launched on-the-spot hiring to all offices statewide.
- Conducted job fairs in high retention areas.
- Targeted hiring of part-time eligibility workers who have prior experience processing Medicaid eligibility.
- Recruited military spouses.
- Implemented virtual basic skills training for eligibility staff, which increases class options and results in faster training for new team members.
- Assigned specific regions to work specific types of case actions to allow eligibility workers to develop proficiency, while also allowing newer eligibility workers to process simpler types of work sooner.
- Deployed other staff who are qualified to process eligibility (e.g., senior eligibility workers and supervisors) to process cases as needed.
- Trained non-eligibility HHSC staff to process changes.
- Required eligibility staff to work 20 hours of overtime per month, with additional overtime available.
- Engaged the eligibility support services vendor to allow them to assist with:
 - CHIP and Children's Medicaid application processing. Eligibility support services vendor staff ensure all information that is needed for an eligibility

decision is collected and routes the information to agency staff for eligibility determination and disposition.

- ▶ Processing approved change tasks.
- Trained HHSC clerical staff to help with data entering information into cases.
- Implemented workload production goals for team members to increase worker efficiency.
- Issued performance-based one-time merit payments to eligible employees to support staff retention.
- Provided, on an ongoing basis, 3.5 percent salary increases for new eligibility advisors in the 6th and 12th months of their tenure.
- Promoted flexible work schedules for eligibility staff.
- Effective August 1, 2022, HHSC increased base salaries for clerks, eligibility workers, and supervisors. Frontline eligibility worker classifications received up to a 25 percent salary increase.

5. Reducing Client Impact

Throughout the PHE, HHSC has worked to keep clients informed about their Medicaid coverage and has devised strategies to minimize impacts to clients. The protracted nature of the continuous coverage requirement requires multiple layers of change management to remind clients of the Medicaid redetermination process and the need to act when continuous Medicaid coverage ends.

Ambassador Program

To ensure clients receive communications timely and understand when they need to take action, HHSC launched a multi-pronged communication strategy to reach clients with key information and calls to action ahead of the end of continuous Medicaid coverage.

In May 2022, HHSC launched the Ambassador Program and “Don’t Wait, Respond and Update” campaign aimed at MCOs, physicians, health care providers, advocates and other partners who work with Medicaid clients. The toolkit⁴ provides sample communications, flyers and FAQs around actions clients could take before continuous Medicaid coverage ends, such as:

- Creating a YourTexasBenefits.com account (or ensuring they have access to their account) and downloading the YourTexasBenefits mobile app, which is the fastest way to receive information from HHSC.
- Updating their contact information to make sure they receive notices, applications or redetermination packets and other correspondence.
- Responding to HHSC if they received a request for information, an application, or a redetermination packet.

Through the Ambassador Program, HHSC has engaged key stakeholders through targeted meetings and focus groups throughout the first phase of HHSC’s communication plan. During this phase, HHSC held more than 40 public presentations delivered statewide and 15 monthly Ambassador check-in meetings

⁴More information about the Ambassador Program and toolkit can be found at <https://www.hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information/end-continuous-medicaid-coverage-ambassador-toolkit>.

and engaged with nearly 50 Ambassador groups through direct outreach of internal and external stakeholders.⁵

With the federal announcement that continuous Medicaid coverage ended on March 31, 2023, HHSC launched the second phase of the communication plan—direct client outreach. On January 28, 2023, HHSC sent a notice to clients in the continuous enrollment population. The notice encouraged clients to be vigilant for, and respond to, any HHSC communications related to their redetermination and possible requests for additional information. HHSC has used channels such as social media posts, online banner messages, flyers, and text messages (in cases where clients have previously consented to receive text messages) to communicate about the end of continued Medicaid coverage.

Proactive Communications

In addition to the Ambassador Program, HHSC has implemented the following communication initiatives:

- Medicaid MCOs are being provided with the data and scripting needed to effectively engage clients who have not responded to redetermination communications during the unwinding period. This will enable MCOs to contact clients who must provide additional information for an eligibility redetermination to be completed.
- HHSC has coordinated with the enrollment broker vendor, MCOs and dental contractors to conduct outreach to clients identified as being unable to locate through the federally required returned mail processes. This is an additional initiative to locate clients in advance of the unwinding process so they can receive their redetermination packets and other important communication.
- Beginning in April 2023, HHSC began using robocalls for an outbound call campaign to target clients whose Medicaid redetermination has been initiated to remind them of the need to complete their redetermination.

Maintain Accessibility for Clients

Following agency policies, all end of continuous Medicaid coverage communications and notices are written in plain language and clearly explain how to complete

⁵ Ambassador presentations data as of 01/24/23 and check-in meeting data as of 01/09/23.

redetermination forms, respond to requests for information as well as what information is needed for the state to determine eligibility. The communications also advise clients to keep their contact information up to date.

HHSC also ensures communication is provided in a manner that is accessible to all individuals. Key documents (e.g., notices, applications, forms) are available in English and Spanish and oral translation is available for other languages through access to qualified oral interpreters. HHSC ensures information is accessible to clients with disabilities by providing auxiliary services at no cost to the client, including but not limited to written materials in large print or Braille, and access to sign language interpretation and/or a teletypewriter system, consistent with the Americans with Disabilities Act and section 1557 of the Affordable Care Act. All clients have the same right to request accommodations and the HHSC Civil Rights Office helps ensure compliance with agency policies to protect clients and people applying for benefits.

Redetermination forms and requests for information will be mailed in a yellow envelope to make it easy for clients to identify. The envelope says, "ACTION REQUIRED," in red, in both English and Spanish, and states the enclosed forms are time sensitive and must be submitted by the due date.

HHSC is also using existing agency processes to develop and provide policy training, scripts, and informational materials to call center and eligibility staff that emphasize the importance of providing clear information to help clients maintain coverage.

Up-to-Date Contact Information

HHSC received federal approval to implement 1902(e)(14)(A) waiver authority to temporarily accept updated in-state contact information from the USPS, the NCOA database and MCOs without requiring additional verification from the client. HHSC implemented systems changes to allow for the new address to be automatically included in the case record, once received.

HHSC takes every opportunity to obtain updated contact information from clients prior to sending correspondence. Staff request updated contact information when clients contact HHSC through the statewide 2-1-1 call center or the enrollment broker. Medicaid and CHIP clients who submit only a physical address change through the YourTexasBenefits.com website or mobile app will have the address automatically updated in their case record in the integrated eligibility system.

HHSC has also been encouraging clients to update their contact information through social media, website updates and through the “Don’t Wait, Respond and Update” campaign and Ambassador program launched in May 2022.

Returned Mail Process

Per CMS guidance and the provisions of the CAA 2023, states who receive a redetermination packet through returned mail must make a good faith effort to contact the client using more than one modality prior to terminating eligibility. HHSC has implemented the policies outlined below to ensure compliance with the returned mail requirements. HHSC is also using proactive outreach through “robocalls,” text, and/or email notification when redetermination forms and requests for additional information are mailed. The proactive outreach messages:

- Explain that a redetermination packet was sent by mail.
- Provide information on how to complete the redetermination form.
- Provide information on where to go if the client has additional questions (e.g., the [YourTexasBenefits.com](https://www.yourtexasbenefits.com) or 2-1-1, option 2).

MCOs are conducting additional outreach to clients when their redetermination has been initiated to remind clients to respond timely.

Returned Mail Has Incomplete Information

HHSC will review the address on the returned mail against the information in the client’s case record for accuracy. If the information is not accurate or is missing information, staff will update the case record and mail the returned mail to the complete address. This action will be documented in the client’s case record.

Returned Mail with No Forwarding Address

If the returned mail does not have an address error, staff will attempt to identify a new address using all available electronic data sources. If a new address is not found, staff will try to contact the client by phone to obtain the new address. If a new address is found, the redetermination packet will be remailed and the client will have 30 days to submit their redetermination form and any requested verification.

Returned Mail with a Forwarding Address

HHSC will forward the returned mail to the forwarding address and will attempt to contact the client with an outbound call. This action will be documented in the client's case record.

Case Assistance Affiliate Program

Texas Medicaid MCOs and dental contractors are in a unique position to partner with HHSC to communicate with clients, conduct outreach and assistance, and ultimately help clients maintain health insurance coverage (including facilitating transitions to the Marketplace).

The voluntary Case Assistance Affiliate (CAA) program, implemented in fall 2022, is specifically designed to provide MCOs and dental contractors with additional tools to educate their members about YourTexasBenefits.com and its mobile app, and assist their members in navigating the Medicaid redetermination process during the unwinding period. The CAAs may assist members with:

- Mailing or faxing a signed completed paper application to HHSC.
- Mailing, faxing, or uploading supportive documents to HHSC.
- Locating their YourTexasBenefits.com account username.
- Upgrading their YourTexasBenefits.com account from limited to full access.
- Linking their HHSC case number to their YourTexasBenefits.com account.
- YourTexasBenefits.com unlock and password resets.

Maintain Coverage Until Eligibility is Redetermined

HHSC implemented systems changes to maintain Medicaid coverage for clients on a month-to-month basis in the event HHSC has not completed their redetermination by the time their current coverage ends. Clients will not lose coverage until their redetermination is complete, provided they respond by the due date to redetermination packets or requests for information.

Improved Self-Service

HHSC is developing a visual application tracker clients may access through YourTexasBenefits.com and mobile app. Building upon HHSC's current application tracker, the enhancements will provide clients with clear information on their

application or renewal status and will reduce the need to call 2-1-1 Option 2. The enhanced tracker is expected to be launched in the second half of 2023.

Eligibility Call Center

HHSC and the eligibility support services (2-1-1 Option 2) vendor have worked together to implement the following changes to address 2-1-1 Option 2 call times in preparation for the end of continuous Medicaid coverage:

- HHSC authorized existing call center staff to work overtime to increase call taking capacity until staffing levels stabilize. This initiative is ongoing and evaluated based on staffing and call volumes.
- HHSC authorized the diversion of staff from other normal duties, such as quality control, escalation units, and mentoring, to service calls when needed.
- In February 2022, the vendor hired more trainers to accommodate new hire training classes. This initiative is ongoing and evaluated based on staffing levels.
- In April 2022, HHSC implemented a virtual lobby to offset Medicaid calls related to the end of continuous Medicaid coverage. The virtual lobby uses trained state clerical staff to help clients with:
 - ▶ Answering questions about YourTexasBenefits.com and the mobile application.
 - ▶ Printing and reprinting forms or notices.
 - ▶ Providing general program and office location information.
 - ▶ Transferring clients needing an interview to the flexible appointment line (once the current interview waiver ends).
 - ▶ Escalating applications or redeterminations to eligibility staff.
- In May 2022, HHSC implemented a specialized call queue for the unwinding period. Clients calling with specific questions will be routed to either the virtual lobby or to specially trained call center agents.

6. Appeals and Fair Hearings

HHSC examined how best to prepare the state's appeals processes for the potential volume expected during the unwinding period. HHSC has developed strategies to increase uniformity and efficiency in the hearing process to reduce time for conducting hearings, reduce time spent on administrative tasks, and increase efficiency in how hearings are scheduled and how decisions are written.

The Eligibility Services Support Department, which includes three specialized divisions (the Centralized Representation Unit (CRU)⁶, Data Integrity (DI) and CHIP Request for Review (CHIP-RFR)) assists with participating in Fair Hearings and CHIP administrative reviews.

HHSC implemented the following strategies to increase efficiency of appeals, including:

- Deployed quality assurance field services staff to develop and conduct training for appeals and management staff.
- Implemented an appeal pre-screening process to review tasks before assigning to staff.
- Hired staff to fill all vacancies within CRU.
- Effective May 1, 2023, HHSC's eligibility support services contractor will support the hearing request process by assembling appeals packets to support the CRU staff and mitigation processes during the unwinding period. Trained DI and CHIP-RFR staff in form processing procedures that will ensure all appeals are filed within the required timeframe.
- Allowed DI staff to assist with obtaining verbal withdrawals for appeals where the case issue is resolved.
- Allowed all CRU staff to process verbal withdrawals.

HHSC implemented the following strategies to increase efficiency of appeals, including:

- Increased recruitment and retention efforts for appeals staff.

⁶ CRU is the unit that represents HHSC in the fair hearings process by coordinating and preparing case information for hearings. and implements fair hearings officer decision

- Allowed for the temporary voluntary reassignment of administrative law judges to conduct fair hearings during the unwinding period.
- Created standardized templates for hearing decisions.
- Extended the period the CRU has to submit the appeal to FFH from 5 days to 10 days.
- Created a streamlined basic skills training document for return-to-work retirees or other agency staff who will be assisting with appeals and Fair Hearings to bring them up to speed quickly.
- Eligibility support services vendor will also answer all incoming calls for Fair and Fraud Hearings and will record client verbal withdrawals for Hearing Officers to process.

7. Conclusion

Throughout the PHE, HHSC has adhered to CMS guidance in maintaining Medicaid coverage as required by the FFCRA and CAA 2023. In preparation for the unwinding of continuous Medicaid coverage, HHSC has reviewed the CMS recommended strategies and formulated an approach that will reduce the strain on the workforce, improve the efficiency of redeterminations, and minimizing client impact.

Texas has prepared to efficiently unwind continuous Medicaid coverage by implementing operational and system changes to reduce and streamline the expected workload while ensuring program integrity and reducing client abrasion. During the unwinding period, Medicaid coverage will continue for clients until their redetermination is initiated and they are determined ineligible.

To manage the expected increase in workload volume, HHSC has improved efficiency while promoting staff retention and further building the workforce. Beyond increasing internal workload efficiency, HHSC has increased client communications, emphasizing a positive client experience as normal Medicaid operations resume. HHSC has set up a monitoring center of agency experts to monitor key metrics and systems to manage deviations and address issues that may arise before and during the unwind period. Team members established key metrics and thresholds across all relevant HHSC departments to oversee their responsibilities and required actions during the unwinding.

In the months to come, HHSC will continue implementing innovative and responsible solutions to improve eligibility operations. HHSC will periodically update this operational plan as additional improvements are implemented. During the unwinding, HHSC will carefully monitor operations and may make further adjustments as appropriate.

List of Acronyms

Acronym	Full Name
CAA	Case Assistance Affiliate
CAA 2023	Consolidated Appropriations Act, 2023
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIP-RFR	CHIP Request for Review
CMS	Centers for Medicare & Medicaid Services
CRU	Centralized Representation Unit
DI	Data Integrity
EWMS	Electronic Workload Management System
FFCRA	Families First Coronavirus Response Act
FMAP	Federal Medical Assistance Percentage
HHSC	Health and Human Services Commission
IFC	Interim Final Rule with Comment
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization

NCOA	National Change of Address Database
PHE	COVID-19 Public Health Emergency
PIC	Periodic Income Check
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families
TIERS	Texas Integrated Eligibility Redesign System
USPS	United States Postal Service