TEXAS Health and Human Services Commission

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EXECUTIVE COMMISSIONER

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To: Eligibility Services – Regional Directors
Program Managers
Eligibility Services Supervisors
Regional Attorneys
Hearings Officers

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Subject: **Federally Required Eligibility Changes for Medicaid and CHIP**

This bulletin is being sent to supervisors and other regional managers. Supervisors must share this information with all Texas Works staff. Please ensure copies are provided to staff that do not have access to email. If you have any questions regarding the policy information in this bulletin, follow regional procedures. Active bulletins are posted on the Texas Works Handbook website at http://www.dads.state.tx.us/handbooks/TexasWorks/.

Federally Required Eligibility Changes for Medicaid and CHIP

Background

This policy bulletin describes federally required eligibility changes to Medicaid and the Children's Health Insurance Program included in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), commonly referred to together as the Affordable Care Act (ACA). In general, ACA requires states to base household income and composition on federal income tax rules; make eligibility determinations for most medical programs based on modified adjusted gross income rules; eliminate resources and current deductions for expenses when making eligibility determinations; and to use a single streamlined application for all insurance affordability programs including new federal programs such as advance payments of the premium tax credit and cost-sharing reductions, and state Medicaid and CHIP programs.

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REFERENCES

Acronym List

Revised October 1, 2014

ACA – Affordable Care Act
AI/AN – American Indian/Alaska Native
APTC – advanced premium tax credit
AR – authorized representative
BVS – Birth Verification System
CBS – Centralized Benefits Services
CCC – Customer Care Center
CHIP – Children's Health Insurance Program
CHIP-P – CHIP Perinatal
CMS – Centers for Medicare & Medicaid Services
CSR – Cost-Sharing Reductions
DFPS – Department of Family and Protective Services
DHS – Department of Homeland Security
EDG – Eligibility Determination Group
EDBC – Eligibility Determination Benefit Calculation
ELDS – electronic data sources
FFCC – Former Foster Care Children's program
FFCHE – Former Foster Care in Higher Education program
FPIL – federal poverty income limits
HHSC – Texas Health and Human Services Commission
IRA – individual retirement arrangement
IRS – Internal Revenue Service
LUW – Logical Unit of Work
MA – medical assistance
MAGI – modified adjusted gross income
MED – medical effective date
MEPD – Medicaid for the Elderly and People with Disabilities
MTFCY – Medicaid for Transitioning Foster Care Youth
PDF – portable document format
QC – Quality Control
QHP – qualified health plan
PIC – periodic income check
RMA – Refugee Medical Assistance
RSDI – Retirement, Survivors and Disability Insurance
SDX – State Data Exchange
SNAP – Supplemental Nutrition Assistance Program
SOLQ – State Online Query system
SSA – Social Security Administration
SSI – Supplemental Security Income
SSN – Social Security number
SSP – Self-Service Portal
STP – State Portal
TANF – Temporary Assistance for Needy Families
TIERS – Texas Integrated Eligibility Redesign System
TLM – Task List Manager
TMHP – Texas Medicaid & Healthcare Partnership
TOA – type of assistance
TPR – third-party resources
TWC – Texas Workforce Commission
TWH – Texas Works Handbook
WTPY – Wire Third-Party Query

Glossary

Revised September 1, 2015

New federally-required MAGI rules will be used to make eligibility determinations for certain Medicaid programs and CHIP. It is necessary to update terms currently used for all programs in the Texas Works Handbook because their meaning will change under the new federal rules. These terms are identified with an asterisk*. The glossary will include new terms that will apply only to medical programs subject to MAGI rules.

Account Transfer
The way in which an applicant's information moves between the Marketplace and HHSC when applying for medical assistance. The account transfer from the Marketplace to HHSC and from HHSC to the Marketplace will include most of the information the applicant submitted through the Marketplace application and HHSC applications along with information on any verifications performed by either the Marketplace or HHSC.

Administrative Renewal
The method used to redetermine eligibility for most TW and MEPD Medicaid programs and CHIP. The automated process uses existing client information, electronic data source information, and reasonable compatibility when income verification is required. This results in:

- An automated eligibility determination, or
- Requiring additional information from the client to manually process the redetermination.

Advanced Premium Tax Credit (APTC)
The payment of a tax credit by the federal government, provided on an advance basis or at tax filing time, to an eligible individual enrolled in a QHP through the Marketplace.

Alimony Paid
A federal income tax deduction for individuals making payments to a spouse or former spouse under a divorce or separation decree.

Annuity
An annuity is a series of payments paid under a contract and made at regular intervals over a period of more than one full year. Payments can be either fixed (under which one receives a definite amount) or variable (not fixed). An individual can buy the contract alone or with the help of an employer.

***Authorized Representative (AR)**
For medical programs, the individual or organization designated by an applicant or recipient to:

• Sign an application on the applicant's behalf
• Complete and submit a renewal form
• Receive copies of the applicant's/client's notices and other communications from the agency
• Act on behalf of the applicant/client in all other matters with the agency

Automated Income Check Process
The first step in a periodic income check (PIC). During this step, information from electronic data sources is automatically requested and a reasonable compatibility test is run. This process occurs without advisor action.

Automated Renewal Process
The first step in an administrative renewal. During this step, information from electronic data sources is automatically requested, reasonable compatibility is run when income verification is required, and correspondence is sent to the client. This process occurs without advisor or specialist action.

Canceled Debts
Debts that have been canceled, forgiven, or discharged and the canceled amount is included as countable income on federal income tax returns (for example, loan foreclosures, or canceled credit card debt).

Capital Gains
A profit from the sale of property or of an investment when the sale price is higher than the initial purchase price (for example, profits from the sale of stocks, bonds, or from the sale of real estate).

***Caretaker**
For Parents and Caretaker Relatives Medicaid (TP 08), a person who supervises and cares for a dependent child within the required degree of relationship and who meets the income limits for that program.

***Certified Group**
The members in an EDG who are eligible for a given program.

- For all MAGI groups, except CHIP-P, the certified group contains one individual.
- For CHIP-P, the mother and child will be in the same certified group during the month the child is born. After the child is born, only the child will be in the certified group.

Child
For medical programs, a child is an adoptive, step, or natural child who is under 19 years of age.

Child Support
A payment made from a biological or adoptive parent to a biological or adoptive child. Child support may be:

- Formal – court-ordered or legally mandated; or
- Voluntary – not court-ordered and given voluntarily when the child's caretaker or the person making the payment states the purpose of the payment is to support the child.

***Child Support Disregard**
For medical programs not subject to MAGI rules, an amount up to $75 subtracted from monthly child support received before determining eligibility for medical assistance.

Continuous Eligibility
A period of time that begins on the effective date of the individual's most recent determination or redetermination of eligibility and ends on the last calendar day of the month for the specified length of that eligibility period for that specific program. An individual remains eligible during a continuous eligibility period regardless of any change in circumstances, except:

- Attaining the maximum age for that specific program;
- Death;

- Voluntary disenrollment;
- Change in state residence;
- State error in the eligibility determination; or
- Fraud, abuse, or perjury attributed to the child or child's representative.

Cost-Sharing Reductions
Federal payments toward out-of-pocket costs made for an eligible individual enrolled in a QHP through the Marketplace.

Court Awards
Taxable money that an individual receives as the result of a lawsuit (for example, compensation for lost wages or punitive damages awards).

Deductible Part of Self-Employment Tax
A federal income tax deduction for self-employed individuals paying self-employment taxes.

Dependent Child
For Parents and Caretaker Relatives Medicaid (TP 08), a child who is under the age of 18 or is 18 and a full-time student meeting school requirements.

***Deprivation**
Loss of parental support caused by death, absence from the home, physical or mental incapacity, or unemployment of at least one parent.

Domestic Production Activities Deduction
A federal income tax deduction individuals may receive for certain qualified production activities (such as construction of real property, lease, rental, license, sale, exchange or other disposition of personal property, computer software, sound recordings, produced films, produced electricity, natural gas, or potable water).

Educational Expenses/Student Loan Interest
A federal income tax deduction for individuals paying interest on student loans or for individuals with education expenses such as tuition, fees, room and board, books, and other supplies.

Educator Expenses
Kindergarten through grade 12 teachers, counselors, principals, or aids can receive a federal income tax deduction for qualified expenses. Qualified expenses include purchased books, supplies, equipment, and other classroom materials.

Electronic Data Sources (ELDS)
Verification sources that are available electronically and presented to advisors in TIERS during Data Collection.

Expenses of Fee-Basis Government Officials
Federal income tax deductible employment related expenses paid for or accrued by employees of a state or political subdivision who are compensated on a fee basis.

Expenses of Performing Artists
Federal income tax deductible expenses for qualified performing artists paid or accrued through performances while serving as an employee in the performing arts.

Expenses of Reservists
Federal income tax deductible expenses for National Guard and military reserve members who traveled more than 100 miles from home for service.

***Four Months Post-Medical**
Medicaid coverage extended for a maximum of four months after denial of a case because of spousal support income.

Health Savings Account
A federal income tax deduction for contributions to a health savings account.

IRA Deduction
A federal income tax deduction for individuals who contributed to a traditional IRA.

Jury Duty Pay
Taxable income received from jury duty as compensation.

Life Estate
Income an individual receives from ownership of property that an individual only possesses ownership of for the duration of one's life (for example, rental income).

MAGI
Modified Adjusted Gross Income. The rules used to determine financial eligibility for certain medical programs that are based on IRS tax rules.

MAGI Household Composition
The individuals whose income and needs are considered in determining eligibility for an applicant or recipient for certain medical programs based on tax status, tax relationships, living arrangement, and family relationships.

MAGI Household Income
The sum of every individual's MAGI individual income within an applicant's or recipient's MAGI household composition, from which is subtracted the standard MAGI disregard.

MAGI Household Size
The number of individuals in an applicant's or recipient's MAGI household composition, plus the number of unborn children if applicable.

MAGI Individual Income
The sum of certain income received by an individual in a MAGI household composition, from which is subtracted certain expenses.

MAGI Financial Eligibility
The result of a comparison between an applicant's or recipient's MAGI household income to the income limit of the applicable Medicaid or CHIP program based on the FPIL and the MAGI household size.

Marketplace
The governmental entity that makes qualified health plans available to qualified individuals and/or qualified employers. The Marketplace in Texas is operated by the United States Department of Health and Human Services. Also known as the Exchange, Health Insurance Marketplace, and Federally Facilitated Marketplace (FFM).

***Medicaid**
A state and federal cooperative program, authorized under Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) and Chapter 32 of the Texas Human Resources Code, that pays for certain medical and health care costs for people who qualify. Also known as the medical assistance program.

Moving Expenses
Federal income tax deductible expenses an individual may claim from moving due to a job or business.

***Newborn Child**
A child receiving TP 45, Medical Assistance for Newborn Children, because the child's mother was eligible for and received Medicaid coverage at time of the child's birth, or whose mother was eligible for and received Medicaid coverage retroactively for the time of the child's birth.

Non-Continuous Eligibility
A period of time that begins on the specified effective date of the individual's most recent determination of eligibility, redetermination of eligibility, or during the certification period and ends on the last calendar day of the month for the specified length of that non-continuous eligibility period for that specific program. Reported changes in circumstances during the non-continuous eligibility period may affect an individual's eligibility.

Parent
A natural or biological, adopted, or step parent.

Penalty on Early Withdrawal
A federal income tax deduction for individuals who withdrew money from a time-deposit savings account prior to the certificate maturing, and were charged a penalty for early withdrawal.

Periodic Income Check (PIC)
The process to determine whether electronic data indicates there has been a change in a MAGI household income that could make the client ineligible for certain MAGI programs. Changes in income identified through this process may impact eligibility for other programs.

Qualified Health Plan
A private insurance plan that is certified by the Marketplace, provides essential health benefits, follows established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.

Reasonable Compatibility
The method of verification used for Medicaid and CHIP that compares a client's statement of income against income as provided by electronic data sources.

***Reasonable Opportunity**
The 95-day period following the date on which a notice is sent to an individual to provide another source of citizenship or alien status verification.

Self-Employed Health Insurance
A federal income tax deduction for self-employed individuals paying for health insurance for themselves, their spouse, their tax dependents, or their child under age 27.

Self-Employed IRA, Simple IRA, and Qualified Plan Deductions
A federal income tax deduction for self-employed individuals or for partners in a business.

Standard MAGI Income Disregard
An income disregard equal to five percentage points of FPIL for the applicable MAGI household size.

TALX
A verification of employment and income database created by the TALX Corporation, also known as The Work Number system.

Taxable Year
The 12-month period an individual uses to report income for federal income tax purposes. For most individuals, their tax year is the calendar year. A calendar tax year is 12 consecutive months beginning January 1 and ending December 31.

Tax Dependent
An individual who expects to be claimed by someone else as a dependent on a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested.

Taxpayer
An individual, or a married couple, who expects:

- To file a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested.
- If married, to file a joint federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested.
- That no other taxpayer will be able to claim him, her, or them as a tax dependent on a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested.
- To claim a personal exemption deduction on his or her federal income tax return for one or more applicants, this may or may not include himself or herself and his or her spouse.

Tuition or GI Bill Deduction
A federal income tax deduction for individuals that paid qualified tuition fees to eligible post-secondary educational institutions for themselves, their spouse, or their dependents.

Federal Poverty Income Limits

Revised March 1, 2015

Effective January 1, 2014, the ACA required a one-time conversion of existing income limits for medical programs subject to MAGI rules. States were required to convert income limits as a way to offset the loss of current income deductions for individuals applying to such programs. As a result of the MAGI income conversion, there were changes in the income limits used for the programs that are subject to MAGI rules.

The tables on the following pages provide the monthly income limits based on the 2015 Federal Poverty Level and are effective March 1, 2015.

2015 Monthly Income Limits Effective March 1, 2015
TP 40, Pregnant Women Medicaid,
TP 42, Pregnant Women Presumptive, and
TP 36, Pregnant Women – Emergency Medicaid

MAGI Household Size	***MAGI-Converted Limits*** *198% FPL*
1	$1,943
2	$2,629
3	$3,315
4	$4,002
5	$4,688
6	$5,375
7	$6,061
8	$6,747
9	$7,434
10	$8,120
11	$8,807
12	$9,493
13	$10,179
14	$10,866
15	$11,552
Each added person	$687

2015 Monthly Income Limits Effective March 1, 2015
TP 43, Children Under Age One and
TP 35, Children Under Age One – Emergency

MAGI Household Size	***MAGI-Converted Limits*** *198% FPL*
1	$1,943
2	$2,629
3	$3,315
4	$4,002
5	$4,688
6	$5,375
7	$6,061
8	$6,747
9	$7,434
10	$8,120
11	$8,807
12	$9,493
13	$10,179
14	$10,866
15	$11,552
Each added person	$687

2015 Monthly Income Limits Effective March 1, 2015
TP 48, Children Ages 1-5 and
TP 33, Children Ages 1-5 – Emergency

MAGI Household Size	***MAGI-Converted Limits*** *144% FPL*
1	$1,413
2	$1,912
3	$2,411
4	$2,910
5	$3,410
6	$3,909
7	$4,408
8	$4,907
9	$5,406
10	$5,906
11	$6,405
12	$6,904
13	$7,403
14	$7,902
15	$8,402
Each added person	$500

2015 Monthly Income Limits Effective March 1, 2015
TP 44, Children Ages 6-18 and
TP 34, Children Ages 6-18 – Emergency

MAGI Household Size	***MAGI-Converted Limits*** *133% FPL*
1	$1,305
2	$1,766
3	$2,227
4	$2,688
5	$3,149
6	$3,610
7	$4,071
8	$4,532
9	$4,994
10	$5,455
11	$5,916
12	$6,377
13	$6,838
14	$7,299
15	$7,760
Each added person	$462

2015 Monthly Income Limits Effective March 1, 2015
TA 84, CHIP

MAGI Household Size	***MAGI-Converted Limits*** *201% FPL*
1	$1,972
2	$2,669
3	$3,366
4	$4,062
5	$4,759
6	$5,456
7	$6,153
8	$6,850
9	$7,546
10	$8,243
11	$8,940
12	$9,637
13	$10,334
14	$11,030
15	$11,727
Each added person	$697

2015 Monthly Income Limits Effective March 1, 2015
TA 85, CHIP Perinatal

MAGI Household Size	***MAGI-Converted Limits*** *202% FPL*
1	$1,982
2	$2,682
3	$3,382
4	$4,083
5	$4,783
6	$5,483
7	$6,183
8	$6,884
9	$7,584
10	$8,284
11	$8,984
12	$9,685
13	$10,385
14	$11,085
15	$11,786
Each added person	$701

2015 Monthly Income Limits Effective March 1, 2015
TP 70, Medicaid for Transitioning Foster Care Youth

MAGI Household Size	***MAGI-Converted Limits*** *413% FPL*
1	$4,051
2	$5,483
3	$6,915
4	$8,347
5	$9,778
6	$11,210
7	$12,642
8	$14,073
9	$15,505
10	$16,937
11	$18,369
12	$19,800
13	$21,232
14	$22,664
15	$24,096
Each added person	$1,432

2015 Monthly Income Limits Effective March 1, 2015
TP 02, Refugee Medical Assistance

Family Size	***Income Limits*** *200% FPL*
1	$1,962
2	$2,655
3	$3,349
4	$4,042
5	$4,735
6	$5,429
7	$6,122
8	$6,815
9	$7,509
10	$8,202
11	$8,895
12	$9,589
13	$10,282
14	$10,975
15	$11,669
Each added person	$694

2015 Monthly Income Limits Effective March 1, 2015
TP 56, Medically Needy with Spend Down and
TP 32, Medically Needy with Spend Down – Emergency

Family Size	***Income Limits***
1	$104
2	$216
3	$275
4	$308
5	$357
6	$392
7	$440
8	$475
9	$532
10	$567
11	$624
12	$659
13	$716
14	$751
15	$808
Each added person	$57

2015 Monthly Income Limits Effective March 1, 2015
TP 07, Earnings Transitional Medicaid and
TP 37, Earned Income Deduction Transitional Medicaid

Family Size	***Income Limits*** *185% FPL*
1	$1,815
2	$2,456
3	$3,098
4	$3,739
5	$4,380
6	$5,022
7	$5,663
8	$6,304
9	$6,946
10	$7,587
11	$8,228
12	$8,870
13	$9,511
14	$10,152
15	$10,794
Each added person	$642

When processing a Form H1146 for Transitional Medicaid (TPs 07/37) EDGs use the following chart to determine when the updated 185 percent FPIL and income limits will be used:

If Form H1146 is due…	**Use the…**
February 2015 or earlier	2014 income limits
March 2015 or later	2015 income limits

2015 Monthly Income Limits Effective March 1, 2015
TA 77, Former Foster Care in Higher Education

Family Size	***Income Limits*** *400% FPL*
1	$3,924
2	$5,310
3	$6,697
4	$8,084
5	$9,470
6	$10,857
7	$12,244
8	$13,630
9	$15,017
10	$16,404
11	$17,790
12	$19,177
13	$20,564
14	$21,950
15	$23,337
Each added person	$1,387

2015 Monthly Income Limits Effective March 1, 2015
TP 08, Parents and Caretaker Relatives Medicaid and
TA 31, Parents and Caretaker Relatives Medicaid – Emergency

MAGI Household Size	***One Parent MAGI-Converted Limits***	***Two Parent MAGI-Converted Limits***
1	$103	N/A
2	$196	$161
3	$230	$251
4	$277	$285
5	$310	$332
6	$356	$367
7	$389	$412
8	$441	$447
9	$476	$500
10	$527	$535
11	$562	$587
12	$613	$622
13	$648	$675
14	$700	$710
15	$734	$762
Each added person	$52	$52

Type Program Charts

Revised March 1, 2014

MAGI Programs

Program Group	Program Code	Code	Description
Children's Medicaid	MA	TP 43	Children Under Age One
	MA	TP 35	Children Under Age One – Emergency
	MA	TP 48	Children Ages 1-5
	MA	TP 33	Children Ages 1-5 – Emergency
	MA	TP 44	Children Ages 6-18
	MA	TP 34	Children Ages 6-18 – Emergency
	MA	TP 47	Children Denied TANF With Applied Income (no one will be placed on this TP after December 31, 2013)
Pregnant Women Medicaid	MA	TP 40	Pregnant Women
	MA	TP 36	Pregnant Women – Emergency
	MA	TP 42*	Pregnant Women – Presumptive
Parents And Caretaker Relatives Medicaid	MA	TP 08	Parents And Caretaker Relatives
	MA	TA 31	Parents And Caretaker Relatives – Emergency
Former Foster Care	MA	TP 70	Medicaid For Transitioning Foster Care Youth Ages 18-20
	MA	TA 77**	Former Foster Care in Higher Education Ages 21-22
Medically Needy With Spend Down	MA	TP 56**	Medically Needy With Spend Down
	MA	TP 32**	Medically Needy With Spend Down – Emergency
Transitional Medicaid	MA	TP 07**	Earning Transitional
	MA	TP 20**	Child Support Transitional
	MA	TP 37**	Earned Income Deduction Transitional
Refugee Medical Assistance	MA	TP 02**	Refugee Medical Assistance
Children's Health Insurance Program	CI	TA 84	Children Under Age 19
	CI	TA 85	CHIP Perinatal

*Does not currently use MAGI rules, but has MAGI-converted income limits.
**Uses MAGI rules or a hybrid of MAGI rules, but does not have MAGI-converted income limits.

Non-MAGI Programs

Program Group	Program Code	Code	Description
Aged, Blind, Or Disabled As A Condition Of Eligibility	ME	TA 01	Interim SSI Denied Child (no one will be placed on this TP after December 31, 2013 and it will be retired in April 2014)
	ME	TA 10	Waivers
	ME	TA 12	State Group Home
	ME	TA 27	Prior Medicaid Institutional – Waiver
	ME	TA 88	Medicaid Buy-In For Children
	ME	TP 03	Pickle
	ME	TP 10	State Supported Living Center
	ME	TP 14	Community Attendant
	ME	TP 16	State Hospital
	ME	TP 17	Nursing Facility
	ME	TP 18	Disabled Adult Child
	ME	TP 19	SSI Denied Children (no one will be placed on this TP after December 31, 2013 and it will be retired in April 2014)
	ME	TP 15	Non-State Group Home
	ME	TP 21	Disabled Widow(er)
	ME	TP 22	Early Aged Widow(er)
	ME	TP 30	A and D – Emergency
	ME	TP 87	Medicaid Buy-In
Cost Sharing Programs	MC	TP 23	Specified Low-Income Medicare Beneficiaries (SLMB)
	MC	TP 24	Qualified Medicare Beneficiaries (QMB)
	MC	TP 25	Qualified Disabled And Working Individuals (QDWI)
	MC	TP 26	Qualified Individual (QI1)
	MC	TP 27	QI2
Former Foster Care	MA	TA 82	Former Foster Care Children Ages 18-25
State-Funded		TA 62	State Paid Coverage
	MA	TA 41	Texas Women's Health Program
Children's Medicaid	MA	TP 45	Newborn Children

HHSC Does Not Determine Income Eligibility

Program Group	Program Code	Code	Description
SSI Determines Eligibility	ME	TA 02	SSI Waivers
	ME	TA 03	Manual SSI Waivers
	ME	TA 04	Manual SSI State Group Home
	ME	TA 05	Manual SSI Non-State Group Home
	ME	TA 06	Manual SSI Nursing Facility
	ME	TA 07	Manual SSI State Hospital
	ME	TA 08	SSI State Group Home
	ME	TA 09	Manual SSI State Supported Living Center
	ME	TA 22	Manual SSI
	ME	TA 26	SSI Non-State Group Home
	ME	TP 11	SSI Group Prior
	ME	TP 13	SSI
	ME	TP 38	SSI Nursing Facility
	ME	TP 39	SSI State Hospital
	ME	TP 46	SSI State Supported Living Center
DFPS Determines Eligibility	MA	TA 78	PCA Medicaid – Federal Match – No Cash
	MA	TA 79	PCA Medicaid – No Federal Match – No Cash
	MA	TA 80	PCA Medicaid – Federal Match – With Cash
	MA	TA 81	PCA Medicaid – No Federal Match – With Cash
	MA	TP 91	Adoption Assistance – Federal Match – No Cash
	MA	TP 92	Adoption Assistance – Federal Match – With Cash
	MA	TP 93	Foster Care – Federal Match – No Cash
	MA	TP 94	Foster Care – Federal Match – With Cash
	MA	TP 95	Adoption Assistance – No Federal Match – No Cash
	MA	TP 96	Adoption Assistance – No Federal Match – With Cash
	MA	TP 97	Foster Care – No Federal Match – No Cash
	MA	TP 98	Foster Care – No Federal Match – With Cash

MBCC	MA	TA 66	Medicaid For Breast And Cervical Cancer – Presumptive
	MA	TA 67	Medicaid For Breast And Cervical Cancer
Community Care Programs	CC	TA 11	Community Attendant
	CC	TA 23	LTC-Specialized Services
	CC	TP 05	Consolidated Waiver Program
	CC	TP 59	Texas Home Living Waiver Program (THLW)
	CC	TP 62	Community Living Assistance And Support Services (CLASS)
	CC	TP 63	Community-Based Alternatives Program (CBA)
	CC	TP 64	Deaf Blind Multiple Disability Program (DBMD)
	CC	TP 65	Home And Community-Based Services Program (HCS)
	CC	TP 67	Medically Dependent Children's Program (MDCP)
	CC	TP 68	Program Of All Inclusive Care For The Elderly (PACE)
	CC	TP 73	Adult Foster Care Services (AFC)
	CC	TP 75	Consumer Managed Personal Assistance Services (CMPAS)
	CC	TP 76	Day Activity And Health Services (DAHS) (Title XIX)
	CC	TP 77	Day Activity And Health Services (DAHS) (Title XX)
	CC	TP 78	Emergency Response Services (ERS)
	CC	TP 79	Family Care Services (FCS)
	CC	TP 80	Home Delivered Meal Services (HDM)
	CC	TP 81	Primary Home Care Services (PHC)
	CC	TP 82	Residential Care Services (RC)
	CC	TP 84	Special Services To Persons With Disabilities (SSPD)
	CC	TP 89	STAR+PLUS Programs

Inactive or Historical Type Programs

Program Group	Program Code	Code	Description
Medicaid Programs	MA	TA 19	Children Born Before 1983
	MA	TA 20	18-21 Years Not In School
	MA	TP 29	State Time Limit Transitional
	MA	TP 31	Medically Needy – Emergency
	MA	TP 52	State Foster Care – A
	MA	TP 53	State Foster Care – B
	MA	TP 54	State Foster Care – 32
	MA	TP 55	Medically Needy
	MA	TP 57	State Foster Care – D
	MA	TP 58	State Foster Care – JPC
	MA	TP 88	Non-AFDC Foster Care – JPC
	MA	TP 90	State Foster Care
	MA	TP 99	Non-AFDC Foster Care
	MA	TP AL	Historical FMA – Emergency
	MA	TP AS	Historical Adoption Subsidy
	MA	TP DE	Deceased Prior Medical
	MA	TP PM	Historical Prior Medical
	MA	TP SP	Historical State Adoption Subsidy
Community Care Programs	CC	TA 13	MRLA
	CC	TA 14	Alzheimer's Level II
	CC	TP 04	Alzheimer's Level III
	CC	TP 28	LTC – Emergency Dental
	CC	TP 49	LTC – Rehabilitative Services
	CC	TP 66	Home And Community-Based Services-OBRA Program
	CC	TP 69	LTC-Transition To Life In The Community (TLC)
	CC	TP 74	CCAD Case Management Services
	CC	TP 83	CCAD Respite Care Services

	CC	TP 85	CCAD 24 Hour Shared Attendant Care Services
	CC	TP 86	CCAD In-Home And Family Support Services (IHFS)
Aged, Blind, Or Disabled As A Condition Of Eligibility	ME	TA 15	Rider 51 – Non-State Group Home
	ME	TA 16	Rider 51 – State Supported Living Center
	ME	TA 17	Rider 51 – Nursing Facility
	ME	TA 18	Grandfathered LTC
	ME	TA 21	SSI Chest Hospital
	ME	TA 24	Rider 51 – State Group Home
	ME	TA 25	Rider 41 – State Hospital
	ME	TP 12	Temp Manual SSI
	ME	TP 41	Skilled Nursing Care
	ME	TP 50	Rider 51J
	ME	TP 51	Rider 51J – Waivers
	ME	TP IN	Temp Institutional
	ME	TP IW	Historical Institutional – Waivers
	ME	TP RI	Temp Rider 51
	ME	TP SL	Temp SLMB QI1
	ME	TP SS	Temp SSI
	ME	TP WA	Temp Waivers
	ME	TP WI	Temp Widow(er)

Standard MAGI Income Disregard

Revised March 1, 2015

Standard MAGI Income Disregard
Five Percentage Points of FPL

MAGI Household Size	2015 Monthly Disregard Amount
1	$49.05
2	$66.40
3	$83.75
4	$101.05
5	$118.40
6	$135.75
7	$153.05
8	$170.40
9	$187.75
10	$205.05
11	$222.40
12	$239.75
13	$257.05
14	$274.40
15	$291.75
Per Each Additional Member	$17.35

IRS Monthly Income Thresholds

Revised March 1, 2015

Each year the IRS establishes income thresholds for earned and unearned income. Individuals whose income (earned, unearned, or a combination) exceeds the federal income tax filing threshold are “expected” by the IRS to file a federal income tax return under federal law.

Determining whether an individual is expected to be required to file a federal income tax return is determined by comparing the specified income types to the IRS thresholds in the following table.

Monthly Tax Filing Threshold Table

Based on IRS Thresholds

Type of Income	2015 Threshold	Apply Threshold Value in MAGI Budget Worksheet
Unearned Income	$83.33	• Pages 5-7, Step 3, Line 6 • Pages 5-7, Step 3, Line 8
Earned Income	$516.67	• Pages 5-7, Step 3, Line 7

MAGI Cascade

A limited cascade has been created for applications requesting MAGI-only benefits. When an application is received and there is a request that indicates only MAGI benefits, TIERS will support the use of a new sub-program code called “MAGI.”

MAGI Cascade

TP Code	Description
TA 82	MA – Former Foster Care Children’s program
TP 70	MA – Medicaid for Transitioning Foster Care Youth
TP 40	MA – Pregnant Women
TP 36	MA – Pregnant Women – Emergency
TP 45	MA – Newborn Children
TP 43	MA – Children Under Age One
TP 48	MA – Children Ages 1-5
TP 44	MA – Children Ages 6-18
TP 33	MA – Children Ages 1-5 - Emergency
TP 34	MA – Children Ages 6-18 - Emergency
TP 35	MA – Children Under Age One - Emergency
TP 47	MA – Children Denied TANF with Applied Income
TP 08	MA – Parents and Caretaker Relatives
TA 31	MA – Parents and Caretaker Relatives - Emergency
TP 07	MA – Earnings Transitional
TP 20	MA – Child Support Transitional
TP 37	MA – EID Transitional
TP 02	MA – Refugee Medical Assistance
TP 56	MA – Medically Needy with Spend Down
TP 32	MA – Medically Needy with Spend Down - Emergency
TA 84	CI – CHIP
TA 85	CI – CHIP-P
TA 77	Health Care – FFCHE
TP 42	MA – Pregnant Women - Presumptive

MARKETPLACE

Coordinating With the Marketplace

Current Policy

HHSC does not currently transfer applicant information to/from the Marketplace.

New Policy
Revised June 1, 2014

Beginning October 1, 2013, an individual can apply and enroll in health coverage through the Marketplace at HealthCare.gov, or through one of the three paper Marketplace applications. Through the Marketplace, an individual can apply for insurance affordability programs, including APTCs, CSRs, Medicaid, and CHIP. An individual can also purchase health care coverage through a QHP from the Marketplace.

The ACA requires coordination between state Medicaid and CHIP agencies and the Marketplace. Individuals cannot be required to provide the same information more than once, regardless of whether they apply through an application to the Marketplace or through an application to HHSC. This applies to any information provided on an application, as well as any verification materials provided by the applicant.

To achieve this, information provided by the applicant or verified for the applicant will be sent through an interface between the Marketplace and HHSC. Referred to as an account transfer, the two systems--the Marketplace and HHSC--will transfer an applicant's information from one system to the other. An account transfer is the way in which a client's information will move between the Marketplace and HHSC. The account transfer from the Marketplace to HHSC will include most of the information the applicant submitted through the Marketplace application, along with information on any verifications performed by the Marketplace.

Beginning January 1, 2014, if a client is determined ineligible under the MAGI rules for Medicaid or CHIP (due to Texas eligibility requirements), HHSC will transfer that individual's account information to the Marketplace to be assessed for eligibility for other health care coverage programs. The TF0001 will inform the client that they have been transferred to the Marketplace.

If a client is denied Medicaid or CHIP for failure to comply (such as for failure to return missing information), that individual's account information will not be transferred to the Marketplace.

If a client is determined eligible for CHIP but is subject to the 90-day waiting period, HHSC will transfer that individual's account information to the Marketplace to be assessed for eligibility for other health care coverage programs. This is done to allow the individual access to coverage during the 90-day waiting period and to avoid federal sanctions for failing to acquire health coverage.

Individuals must be ineligible for Medicaid programs and CHIP using MAGI rules to qualify for new federal programs.

Processing Account Transfers on or after January 1, 2014

Beginning January 1, 2014, all eligibility staff at HHSC will begin processing account transfers from the Marketplace. These applications will be received by staff in the same manner as an application from YourTexasBenefits.com.

However, as previously mentioned, account transfers from the Marketplace might also include verification information provided by the Marketplace. If an account transfer indicates that an applicant's SSN and/or citizenship status have been verified by SSA or an applicant's alien status has been verified by DHS, these eligibility criteria should be considered verified.

Other eligibility criteria must be verified for Medicaid and CHIP eligibility determinations using HHSC verification procedures. If the Marketplace has verified according to HHSC procedures, then that data must be treated as verified. If not, advisors must verify according to HHSC procedures. For more information on verifications, see the sections on Household Composition Verifications, Financial Eligibility Verifications, and Nonfinancial Eligibility Verifications.

Non-MAGI Account Transfers
Revised June 1, 2014

A non-MAGI account transfer is an account transfer that is sent from the Marketplace to HHSC when the Marketplace has identified that an applicant may be eligible for MEPD because the applicant reported being age 65 or older, disabled or blind. In order for an individual to apply for MEPD programs, they must submit an MEPD application Form H1200.

If the PDF included in the account transfer indicates "Medicaid Non-MAGI Eligibility" in the Referral Activity Eligibility Reason for an individual on the application, a "Full Determination" is not requested, and no MAGI eligibility determination is listed for any other applicant on the application, advisors must deny that application as "Filed in Error" and send the applicant a Form H1200, Application for Assistance – Your Texas Benefits.

Automation
Revised June 1, 2014

Account transfers from the Marketplace will include a PDF with additional information provided by the Marketplace. Similar to an application from YourTexasBenefits.com, enter applicant information into the appropriate LUW pages following the new verification policies. Application information should not be input for applicants who are denied as "Filed in Error" and sent the Form H1200, Application for Assistance – Your Texas Benefits.

Examples of account transfer PDFs are provided on the following pages.

Your Texas Benefits: Form

Please use dark ink. Please print. If you need more room, add pages.
Fill in the circles (○) like this → ●

Section A
Your Facts

If you're applying to get SNAP food benefits, the first month's amount will be based on the date we get pages 1 and 2.

Other benefits also are based on when we get pages 1 and 2.

If you send only pages 1 and 2 now, you will still need to fill out the rest of the application to get benefits.

You have the right to file this form immediately if it has your name, address, and signature.

Mark the benefits anyone on your case is applying for:

- ◉ Food Benefits (SNAP)
- ◉ Cash Help for Families (TANF)
- **Health Care (Medicaid or CHIP):**
  - ○ Children
  - ◉ Adult Caring for a Child
  - ◉ Pregnant Woman

Person 1: contact person or head of household

First name	Middle name	Last name
Bob	George	Parr

Social Security number: 345-34-3456
Birth date (month/day/year): 12/25/1960

Mailing address: 12345 N LaMar Blvd

City	State	ZIP
Austin	Texas	78753

Home phone	Cell or daytime phone
(555) 123-1234	(555) 987-9876

Home address: 12345 N LaMar Blvd
County: Nueces

City	State	ZIP
Austin	Texas	78753

Section B
Food Benefits

This section is only for people applying for food benefits.

Find out how to return your form: See page 3.

You might be able to get SNAP food benefits the next work day based on your answers to these questions. Answer them for everyone living in your home.

1. Is anyone a migrant worker or seasonal farm worker? ..... ○ Yes ◉ No
2. Is the total amount of money that everyone has today $100 or less? (include cash and money in the bank) ..... ◉ Yes ○ No
3. Do you expect the total amount of money everyone will have this month to be less than $150? ..... ◉ Yes ○ No
4. Is the amount of your housing bills more than the amount of money (cash and money in the bank) everyone expects to have this month? (Count bills that are paid only by people living in the home. Bills can include rent, mortgage, water, gas, electric, sewage, and phone.) ..... ◉ Yes ○ No

Sign here (or have someone with the right to act for you sign) _____ **Date** _____

More on page 2

Addendum

Address

Helen G Parr

Home address

Home address (line 1):	**12345 Lamar Blvd.**
Home address (line 2):	**#322**
City:	**Austin**
State:	**Texas**
ZIP:	**78758**
County:	**Comal**

Mailing address

Mail address (line 1):	**234 Pecan Blvd.**
Mail address (line 2):	**Suite 500**
City:	**Pflugerville**
State:	**Texas**
ZIP:	**78760**
County:	**Colorado**

Relationships

Helen G Parr

Bob G Parr	Wife
Do they live in the same home?	**No**

Addendum

Violet A Parr	.....	Mother
Do they live in the same home?	.....	**Yes**
Dash T Parr	.....	Mother
Do they live in the same home?	.....	**Yes**

Tax return status

Helen G Parr

How this person will file taxes next year:	.....	**Filing jointly and as a tax dependent**
Will this person file jointly with someone who isn't a part of this benefits case?	.....	**Yes**
This person will file jointly next year with:	.....	**Bob G Parr**
Will this person claim any dependents on their tax return next year?	.....	**Yes**
This person's tax dependent:	.....	**Violet A Parr**
This person's tax dependent:	.....	**Dash T Parr**
Will this person claim a dependent who isn't a part of this benefits case?	.....	**Yes**

Violet A Parr

How this person will file taxes next year:	.....	**Tax dependent**
Will this person file jointly with someone who isn't a part of this benefits case?	.....	**No**
Will this person claim any dependents on their tax return next year?	.....	**No**
This person will be claimed as a tax dependent by:	.....	**Helen Parr**

Other health insurance

Addendum

	Helen G Parr
Policy number:	**950488**
Insurance company:	**Humana Dental PPO**
Type of coverage:	**Dental Insurance**
Reason coverage ended:	**missed premium payment.**

Money you expect to get

	Helen G Parr
Total amount of money this person expects to get this year:	**$16,738.74**
Total amount of money this person expects to get next year:	**$13,489.48**
Has this person ever gotten health-care services or a referral from either: (1) the Indian Health Service, (2) a tribal health program, or (3) an urban Indian health program?	**No**
If NO, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs or through a referral from one of these programs?	**No**

Other questions (Agency use only)

Authorization representative organization:	**Salvation Army**
Authorization representative ID:	**89487747**
Have you been helped by an assister organization?	**Yes**
Assister organization name:	**Ann Johnson**
Assister organization identification number:	**333993**
Assistance start date:	**02/09/2013**

Addendum

Did this person ask to apply for health-care benefits for an adult who isn't taking care of a child?	**No**
Did this person ask to apply for health-care benefits for people who were in foster care or the Unaccompanied Refugee Minor Resettlement Program?	**Yes**
Do you agree to allow the agency to renew your health coverage in future years?	**Yes - for 2 years**

Individual Information (Agency use only)

Helen G Parr

Social Security Number:	**345-34-3456**
Referral Activity Reason Code:	**Full Determination**
Referral Activity Eligibility Reason:	**APTC Eligibility**
Medical Bills Within 90 Days:	**Yes**
Person Living Indicator:	**Yes**
Qualified Non Citizen Indicator:	**Yes**
Five Year Bar Met Indicator:	**Yes**
Quarters Earned:	**5**
Has a parent or spouse who is absent?	**No**
Enrolled in non employer sponsored health insurance:	**Yes**
Other coverage (Lost) within 6 months indicator:	**No**
Has access to state employee benefit plan?	**Yes**
Does this person have any costs for things such as: educator expenses, health savings accounts, or moving?	**No**
Does this person have any costs for education or school?	**Yes**

Addendum

Did this person ask to apply for health-care benefits for an adult who isn't taking care of a child?	**No**
Did this person ask to apply for health-care benefits for people who were in foster care or the Unaccompanied Refugee Minor Resettlement Program?	**Yes**
Were you in an approved Unaccompanied Refugee Minor's Resettlement program at age 18 or older?	**Yes**
If yes, in which state?	**Alaska**
Pregnancy	
Unborn child's father name:	**Bob Parr**
Unborn child's father address (line 1):	**332 University Dr.**
Unborn child's father address (line 2):	**Apt #1203**
Unborn child's father city:	**Georgetown**
Unborn child's father ZIP:	**78578**
Foster care	
Was client in Foster care?	**Yes**
Was client in Foster care at age 18 or older?	**Yes**
If yes, in which state?	**Alaska**
Age left Foster care:	**18**
Verification	
Verification Type:	**Lawful presence**
Verification Source :	**Green card**
Verified Status Indicator (Y/N):	**No**
Verification received date:	**02/09/2013**
Income and Deductions	

Addendum

Undefined income and expense:	**Have college tuition costs of $654.32 in August 28, 2013**

Employment (Agency use only)

Helen G Parr

Employer

Self employment type:	**Farming**
Employer name:	**Springhill Catfish Parlor**
Employer identification number:	**84398397**
Employer phone number:	**(999) 444-3000**
Employer address (line 1):	**443 Three Points Rd**
Employer address (line 2):	**#908**
Employer City:	**Pflugerville**
Employer State:	**Texas**
Employer ZIP:	**78766**
Date employee left this employer:	**11/09/2013**

Employer insurance

Is this a state health benefit plan?	**Yes**
Employer ESI Enrollment Status:	**Yes**
Employer TPR Enrollment Status:	**Enrolled**
Does the employer offer a health plan that meets the minimum value standard?	**No**
Employer Lowest Cost Plan Cost:	**$54.33**
Employer Lowest Cost Plan Name:	**Blue Cross Blue Shield**

Addendum

Employer Lowest Cost Plan Payment Frequency:	**Hourly**
Employer MEC Indicator:	**Yes**
Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?	**No**
Person Eligible to Enroll Date:	**02/09/2013**
List names of anyone else who is eligible for coverage from this job:	**Violet Parr, Dash Parr**
Is this employer planning to change their insurance plan or start offering a plan next year?	**Yes**
Will this employer stop offering insurance coverage next year?	**No**
Amount this person would need to pay each month for the new insurance premium:	**$85.00**
How often this person would need to pay the new premium amount:	**Monthly**
Date the new insurance will begin:	**02/09/2013**

Employer insurance

Is this a state health benefit plan?	**No**
Employer ESI Enrollment Status:	**Yes**
Employer TPR Enrollment Status:	**Do not plan to enroll**
Does the employer offer a health plan that meets the minimum value standard?	**No**
Employer Lowest Cost Plan Cost:	**$94.54**
Employer Lowest Cost Plan Name:	**Humana**
Employer Lowest Cost Plan Payment Frequency:	**Hourly**
Employer MEC Indicator:	**Yes**
Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?	**Yes**
Person Eligible to Enroll Date:	**02/09/2013**

Addendum

List names of anyone else who is eligible for coverage from this job:	**Violet Parr, Dash Parr**
Is this employer planning to change their insurance plan or start offering a plan next year?	**No**
Will this employer stop offering insurance coverage next year?	**Yes**
Amount this person would need to pay each month for the new insurance premium:	**$125.00**
How often this person would need to pay the new premium amount:	**Monthly**
Date the new insurance will begin:	**02/09/2013**

Immigration (Agency use only)

Helen G Parr

Alien Status Verification Annotation Type:	**annotation type**
Document Type (with Other: XXX):	**I-94 - Arrival/Departure Record**
Document Number:	**(548) 856-3439**
SEVIS ID:	**32348793**
Document Expiration Date:	**02/09/2015**
Date the applicant's Asylum, Parolee, Refugee, or LPR status was granted:	**02/09/2012**

Alternate Payee – Details Page
Revised June 1, 2014

The advisor needs to go to the **Issuance – Details** page to indicate that there is an alternate payee in the household. Once the advisor has answered "yes" to the question, "Is there an alternate payee?," the **Alternate Payee – Details** page will be displayed. The advisor must enter the name of the individual or organization that has been designated as the Medicaid AR. The advisor **must** enter the address of the head of the household (applicant) under the Alternate Payee address section. This will ensure that the Medicaid Identification Card goes to the correct address.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to TIERS.

Unidentified Income/Expenses

Current Policy

HHSC does not currently transfer applicant information to/from the Marketplace.

New Policy

The account transfers received by HHSC from the Marketplace will include most of the information the applicant submitted through the Marketplace application, including information from any verifications performed by the Marketplace. During the account transfer process, if the client provides income or expenses information that cannot automatically be identified and populated into TIERS, the information will be received as “unidentified income/expenses,” and the advisor will have to review and verify the reported unidentified income or expenses. If necessary, the advisor must contact the applicant or send Form H1020, Request for Information or Action, to request verification. All income and expenses reported by the applicant must be verified. Once verification has been received and the advisor is able to determine what type of income or expense is being claimed, the advisor must enter the information into the appropriate income or expenses field.

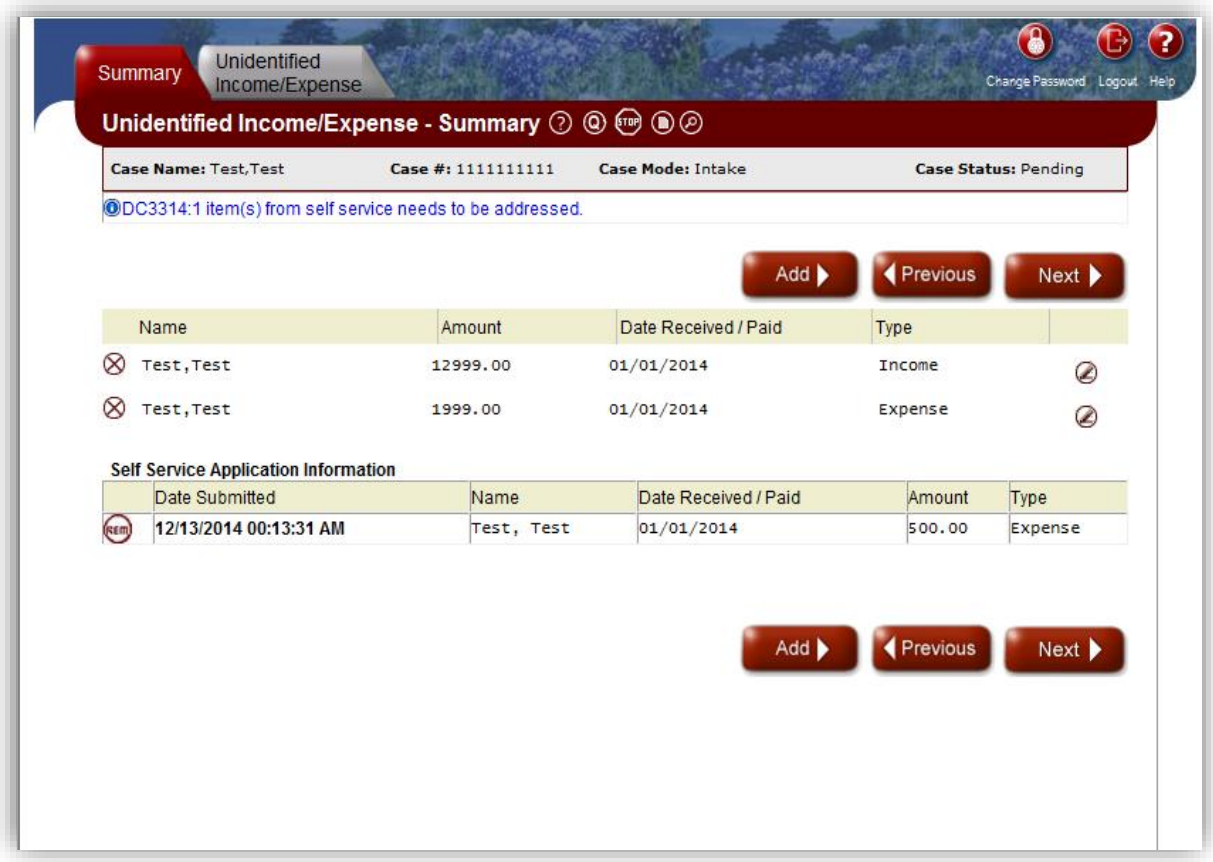
Automation
Revised March 1, 2014

A new LUW has been created in TIERS to collect any unidentified income or expenses received from the Marketplace. This LUW will be called "Unidentified Income/Expenses." This LUW is considered a “notepad” where the unidentified income or expenses that clients include on their applications will be stored. Advisors must review this LUW, determine which type of income or expense is reported by the applicant, and pend for the appropriate verifications. This LUW is not able to pend for verification. Advisors should hard pend when needing verification from this LUW.” Once verification has been received and the advisor is able to determine what type of income or expense is being claimed, the advisor must then enter the information into the appropriate income or expenses LUW in TIERS. In the Unidentified Income/Expenses LUW, the record must be deleted and the advisor must document in case comments this process in order to validate the case action.

This new LUW will also be triggered when an applicant applying through the SSP at YourTexasBenefits.com answers "Yes" to the question "Does anyone in the household have Unidentified Income/Expenses?" This LUW only has to be used for SSP applications and transfers because HHSC applications allow applicants to identify specific income types and expenses.

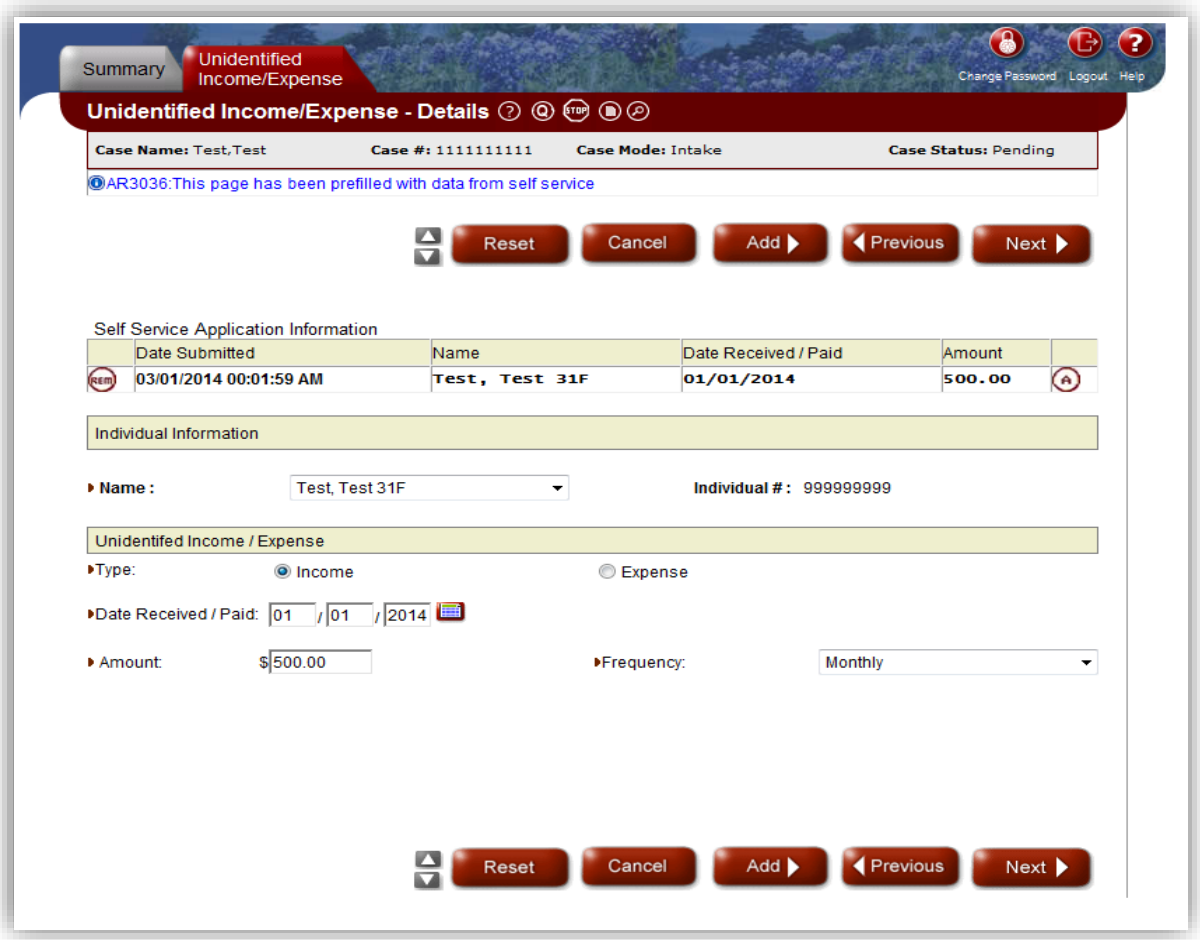
The summary page for Unidentified Income/Expenses will display the following fields:

- Name
- Amount
- Date received/paid
- Type
  - Income
  - Expense



The details page for Unidentified Income/Expenses will display the following fields:

- Name
- Type:
  - Income
  - Expense
- Date received/paid
- Amount
- Frequency



Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to TIERS.

Advance Payment Tax Credits and Cost-Sharing Reductions

Current Policy

HHSC does not currently transfer applicant information to/from the Marketplace.

New Policy

The ACA provides for two new federal programs (APTCs and CSRs) that subsidize the purchase of a QHP through the Marketplace by individuals who meet certain financial criteria and are ineligible for Medicaid, CHIP, or do not have access to affordable employer-provided coverage.

APTCs are payments that reduce premium costs for QHP enrollees who meet the following criteria:

- They do not have access to other affordable coverage, and
- Their MAGI household income is 100 percent FPIL through 400 percent FPIL.

The amount of the APTC is based on a sliding scale of MAGI household income and the type of QHP in which the individual enrolls. QHPs are provided in four categories through the Marketplace based on the share of health care costs that they are expected to cover: Bronze Plan, Silver Plan, Gold Plan, and Platinum Plan.

Individuals eligible for APTCs can receive the payments in advance when the QHP is purchased or at tax filing time. The IRS will reconcile over/underpayments of APTCs when individuals file their federal income tax return.

Individuals eligible for APTCs may also qualify for CSRs to help with out-of-pocket costs, such as deductibles, coinsurance and copayments, if:

- MAGI household income is 100 percent FPIL through 250 percent FPIL, and
- They enroll in a Silver Plan.

The amount of CSR payments is based on a sliding scale of MAGI household income.

AI/AN individuals who enroll in QHPs and whose MAGI household income is at or below 300 percent FPIL are exempt from out-of-pocket costs at any plan level. AI/AN individuals who enroll in QHPs and whose MAGI household income is above 300 percent FPIL are exempt from out-of-pocket costs for services provided by the Indian Health Service, tribal health services, or through referral under contract health services.

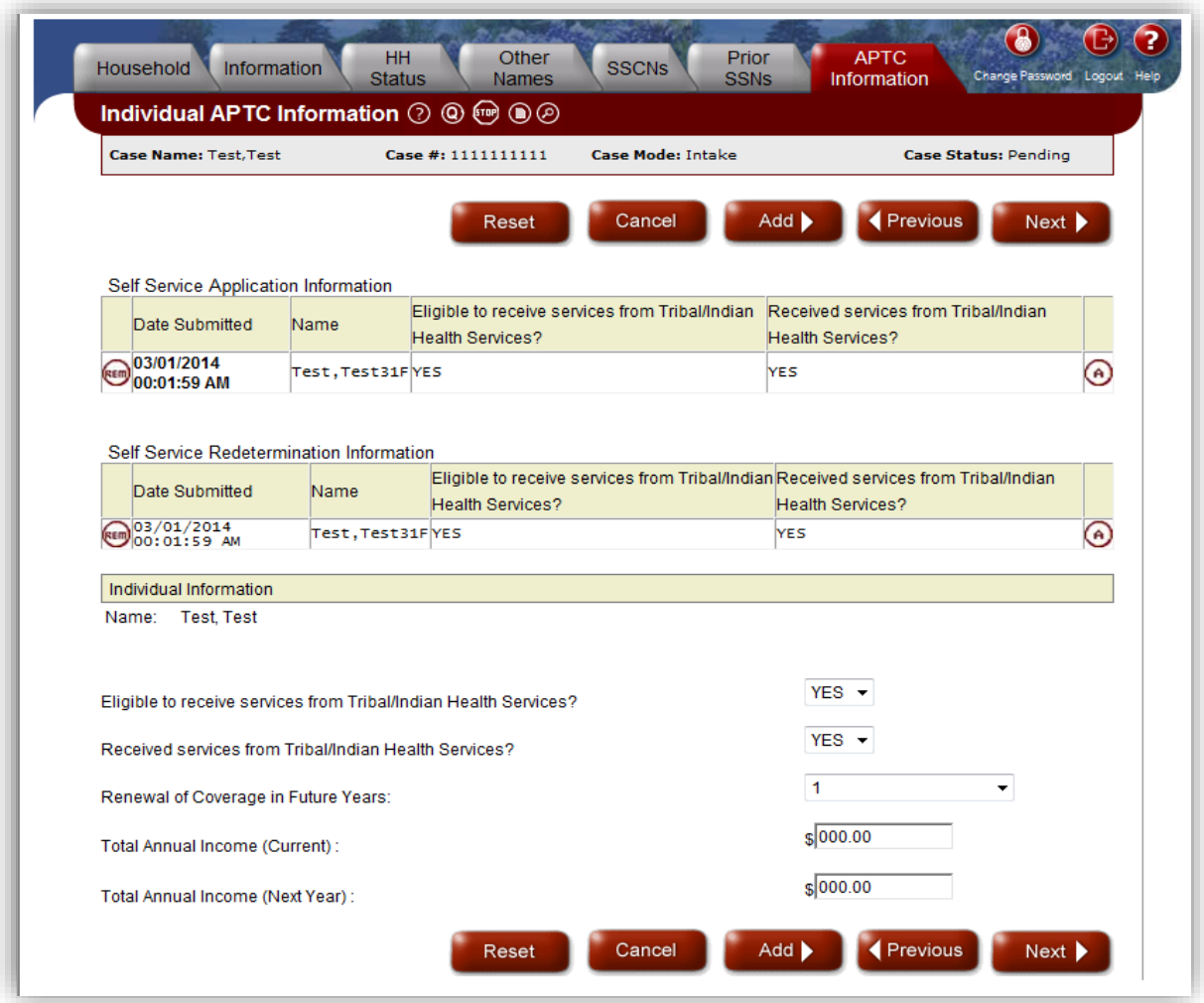
The account transfers received by HHSC from the Marketplace will include most of the information the applicant submitted through the Marketplace application, including information from any verifications performed by the Marketplace. The account transfer will include information provided by the applicant that is necessary to make an APTC determination. For more information on Marketplace applications, see the Applications Solely Used by the Marketplace section. Advisors must enter the APTC information from the account transfer or from an SSP application into TIERS.

Automation

A new LUW has been created in TIERS to collect information necessary to make an APTC determination. This LUW will be called "APTC Information." This information can be received through an account transfer from the Marketplace or through an application submitted via the SSP. Advisors must review this LUW to ensure that the information from the account transfer or from an SSP application is populated into TIERS.

The new APTC Information LUW will capture the following information:

- Whether an applicant is eligible to receive services from Tribal/Indian Health Services
- Whether an applicant has received services from Tribal/Indian Health Services
- Renewal of coverage in future years (whether an applicant allows the Marketplace to renew APTC coverage for up to five years)
- Total annual income (current)
- Total annual income (next year)



APTC question information will also be included in STP for advisors to document reported changes.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to TIERS.

APPLICATIONS

Application Processing

Current Policy

Applications

Households apply for SNAP, TANF, and Medicaid benefits using Form H1010, Texas Works Application for Assistance - Your Texas Benefits, or through the SSP at YourTexasBenefits.com.

When an applicant applies through the SSP, a copy of the application information is created in PDF and provided for advisors to use when processing the application.

Households applying for health care benefits, including Medicaid or CHIP, most commonly use the following application forms:

- Form H1010, Texas Works Application for Assistance - Your Texas Benefits
- Form H1014, Application Information for Children's Health Insurance Program (CHIP), Children's Medicaid, and CHIP Perinatal Coverage
- Form H1011, Application for Medicaid for Youth Transitioning from Foster Care
- Form H1868, Application for Health Care Benefits

Interviews

TP 08, TANF-Level Families Medicaid, applicants and recipients are required to complete an interview. A telephone interview is conducted if the household meets the following criteria:

- All adult members of the household are elderly or disabled and have no earned income.
- The applicant resides in a family violence shelter and would be in danger if the individual left the shelter.
- The household meets the telephone interview hardship criteria below. Accept the individual's statement regarding the hardship.

A household meets the hardship criteria if no responsible household member is able to come to the office for any of the following reasons:

- Residence is more than 30 miles away from the certification office (even if an itinerant office is less than 30 miles from the individual's home)
- Work or training schedule
- Transportation difficulties
- Prolonged severe weather
- Illness
- Care of a household member (the household member does not have to be part of the certified household)
- Victims of family violence

Advisors conduct a face-to-face interview if the household requests one or the household does not provide a telephone contact number.

Signature

Advisors must accept an application as long as it contains the applicant's name, address, and signature of:

- The applicant; or
- An AR, if the applicant is incapacitated or incompetent

If an application is received without a signature, it is considered invalid and incomplete.

New Policy
Revised June 1, 2014

New federal rules require that the application process for medical benefits be streamlined to allow an individual to submit one application for health care coverage that can be used for Medicaid, CHIP, and new federal health coverage programs. Therefore, a new streamlined application was created, the existing Form H1010 was modified, and Form H1014 will be phased out.

On October 1, 2013, the Marketplace also began using a single, streamlined application to determine eligibility for enrollment in QHPs through the Marketplace, and for insurance affordability programs. This application is used for the two new federal programs (APTCs and CSRs) that subsidize the purchase of a QHP through the Marketplace, and for Medicaid or CHIP. For more information about these new federal programs, see the Advance Payment Tax Credits and Cost-Sharing Reductions section.

HHSC must accept an application from:

- The applicant
- An authorized representative of the applicant
- An individual age 19 or older:
  - Included in the applicant's MAGI household composition, as described in the MAGI Household Composition section
  - Who has a tax relationship with the applicant, as described in the Tax Relationships section
- An individual that satisfies the definition of caretaker when the applicant is under age 19, as described in the TP 08 Relationship section

An application is valid as long as it contains the applicant's name, address, and signature of:

- The applicant
- An authorized representative
- An individual that can apply on behalf of the applicant

Form H1205, Texas Streamlined Application

Texas customized the federal streamlined application to reflect state eligibility policies and requirements. The Texas version of the federal application is Form H1205, Texas Streamlined Application. Individuals must use Form H1205 or Form H1010 to apply for health care benefits including Medicaid or CHIP. This application replaces Form H1014, Form H1011, and Form H1868. The Spanish version of the Texas Streamlined Application is Form H1205-S.

Form H1205, Texas Streamlined Application, collects information necessary to make eligibility determinations using new MAGI rules. The application will collect the following information that is necessary for MAGI rules:

- Tax filing status
- Tax relationships
- New types of countable unearned income
- Certain deductions that can be claimed on a federal income tax return
- Appendix A – Health Coverage from Jobs – must be completed when the applicant indicates he or she is being offered health coverage from a job
- Appendix B – AI/AN Family Member – must be completed when the applicant indicates someone living at the physical address is an AI/AN member of a federally-recognized tribe
- Appendix C – Identification of Application Assistance – must be completed when the applicant receives assistance from an AR, certified application counselor, navigator, or agent or broker

Note: Form H1205 cannot be used to apply for SNAP or TANF.

Parent(s) Living Outside of the Home Questions on Form H1205
Added September 1, 2014

HHSC cannot ask detailed questions about parents living outside of the home on an application for MAGI programs.

Note: Applicants/recipients evaluated for TP 08, Parents and Caretaker Relatives Medicaid, must continue to provide information on parent(s) living outside of the home to meet medical support requirements, unless the applicant meets a family violence exception. Questions on parent(s) living outside of the home in **Step 6** "If anyone on this application is eligible for Medicaid" are not included on the Form H1205. The Form H1205 includes a question on whether there is a parent living outside of the home.

Resources on Form H1205
Revised December 13, 2014

Under ACA, a resource test no longer applies when making an eligibility determination based on MAGI rules. Resource questions from **Step 3** the "Things Everyone Pays for or Owns" section are not included on the Form H1205.

If the client is evaluated for TP 02, Refugee Medical Assistance, TP 56 Medically Needy with Spend Down (children only), or TP 32 Medically Needy with Spend Down – Emergency (children only), and does not provide verification of resources with the application, advisors must send Form H1020, Request for Information or Action, to request verification. If the client does not provide the verification, the TP 02, TP 56 (children), or TP 32 (children) EDG will be denied for failure to provide verification, but other Medicaid and/or CHIP EDGs will not be affected.

Form H1010, Texas Works Application for Assistance - Your Texas Benefits

The Form H1010, Texas Works Application for Assistance - Your Texas Benefits, has been updated to collect information to determine eligibility using new MAGI rules and verification policies. Individuals can use this form to apply for the following benefits:

- SNAP food benefits

- TANF cash help for families
- Medicaid or CHIP for:
  - Children
  - Pregnant women
  - An adult caring for a child
  - An adult not caring for a child (allows individuals to identify themselves as a refugee, person under age 26 who was in foster care, or an unaccompanied refugee minor at the age of 18 or older)

Addendum to Form H1010: Form H1010-M, Applying for or Renewing Medicaid or CHIP?

An addendum, Form H1010-M, Applying for or Renewing Medicaid or CHIP?, has been created to capture all additional information needed at application to make a MAGI determination. Form H1010-M also includes the appendices (A, B, and C) that are included on Form H1205, Texas Streamlined Application. Form H1010-M is included with all Form H1010 applications effective January 1, 2014. The form is also available in Spanish, Form H1010-MS.

Addendum to Redetermination Packet: Form H1010-MR, Applying for or Renewing Medicaid or CHIP?

Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, is identical to Form H1010-M, but is used for redeterminations. Form H1010-MR will be sent out with redetermination packets (Form H1010-R or Form H1014-R) after November 13, 2013. This form is also available in Spanish, Form H1010-MR-S.

Parent(s) Living Outside of the Home Questions on Form H1010
Added September 1, 2014

Detailed questions about parents living outside of the home are necessary for non-MAGI programs and are included on the Form H1010, but this information is not required for MAGI programs. A question on whether there is a parent living outside of the home is included in the *Addendum to Form H1010* for applicants to MAGI programs.

Note: Applicants/recipients evaluated for TP 08, Parents and Caretaker Relatives Medicaid, must continue to provide information on parent(s) living outside of the home to meet medical support requirements, unless the applicant meets a family violence exception. Medicaid and CHIP applicants are not required to respond to questions on parent(s) living outside of the home in **Section I**.

Resources on Form H1010
Revised December 13, 2014

Form H1010 will continue to collect resources information since resources are still an eligibility factor for:

- TP 02, Refugee Medical Assistance
- Children receiving TP 56, Medically Needy with Spend Down
- Children receiving TP 32, Medically Needy with Spend Down - Emergency
- SNAP
- TANF

If the client is evaluated for TP 02, TP 56 (children), TP 32 (children), SNAP, or TANF and does not provide verification of resources with the application, advisors must send Form H1020, Request for Information or Action, to request verification. If the client does not provide the verification, the TP 02, TP 56 (children), TP 32 (children), SNAP, or TANF EDG will be denied for failure to provide verification, but other Medicaid and/or CHIP EDGs will not be affected.

Self-Service Portal (SSP)

The online application in the SSP has also been updated to include all the MAGI-related questions for applicants applying for health care benefits. The SSP continues to integrate Texas Works programs into one single application flow, but applicants will only see the questions applicable to the programs they request. A copy of the application information will be created in PDF for clients and advisors to view. Clients and advisors will see two PDFs: one containing application information and one for the addendum that includes information for health care benefits programs. The PDFs will be available for viewing and printing.

Individuals can use the SSP to apply for the following benefits:

- SNAP food benefits
- TANF cash help for families
- Health care for:
  - Children
  - Adults caring for a child
  - Adults not caring for a child (if this is selected the SSP will allow applicants to identify themselves as a refugee; if they are not a refugee they will be redirected to HealthCare.gov)
  - Pregnant women
  - Persons age 65 or older or persons with a disability
  - Person under the age of 26 who were in foster care or who were an unaccompanied refugee minor at the age of 18 or older
- Medicare Savings Programs
- Long-Term Care Services for:
  - Persons with intellectual or developmental disabilities
  - Persons with no intellectual or developmental disabilities

Resources within the SSP
Revised December 13, 2014

Applicants will continue to see questions related to resources when a request is made for TP 02, Refugee Medical Assistance, children receiving TP 56, Medically Needy with Spend Down, children receiving TP 32, Medically Needy with Spend Down – Emergency, SNAP, or TANF.

If the client is being evaluated for TP 02, Refugee Medical Assistance; TP 56 (children), Medically Needy with Spend Down; TP 32 (children), Medically Needy with Spend Down – Emergency; SNAP; or TANF and does not provide verification of resources with the application, advisors must send Form H1020, Request for Information or Action, to request verification. If the client does not provide the verification, the TP 02, TP 56 (children), TP 32 (children), SNAP, or TANF EDG will be denied for failure to provide verification, but other Medicaid and/or CHIP EDGs will not be affected.

Applications Solely Used by the Marketplace

The online Marketplace application is a single application that is interactive based on an applicant's selections. In addition, there are three paper applications for the Marketplace:

- *Application for Health Coverage* – for anyone who needs health coverage, but does not need help paying for health insurance costs:
  - Used for an applicant who is looking to purchase a QHP through the Marketplace.

- *Application for Health Coverage & Help Paying Costs (Short Form)* – for single adults who need help paying for health care coverage (mostly for states offering Medicaid expansion coverage to single adults ages 19 through 64) and:
  - Are not married, do not claim any tax dependents, and cannot be claimed as a tax dependent on someone else's federal income tax return;
  - Were not formerly in the foster care system; and
  - Are not AI/AN.

- *Application for Health Coverage & Help Paying Costs* – for anyone who needs help paying for health care coverage, including:
  - Individuals who are married, have tax dependents, or can be claimed as a tax dependent on someone else's federal income tax return;
  - Individuals with or without current health care coverage;
  - Families that include immigrants; and
  - Individuals who were formerly in the foster care system.

The *Application for Health Coverage & Help Paying Costs* is the model application that was used to create Form H1205, Texas Streamlined Application, and is expected to be used most frequently. However, all three paper Marketplace applications must be accepted by HHSC and used to make an eligibility determination based on MAGI rules.

Since these applications do not contain additional questions that were included on Form H1205, Texas Streamlined Application, advisors must send out a Form H1020, Request for Information or Action, to request any additional information necessary to make an eligibility determination.

These applications can be received by HHSC in person, by fax, by mail, or via an account transfer.

Interviews
Revised September 1, 2014

At application, clients are not required to complete a face-to-face interview.

Exception: Applicants/recipients under TP 08, now called "Parents and Caretaker Relatives Medicaid," will continue to be required to complete an interview, which will be conducted by telephone unless the client requests a face-to-face interview.

Note: Because questions on parents living outside of the home are not included on the Form H1205 and questions on parents living outside of the home are not required for MAGI applicants on the Form H1010, advisors may not have enough information to determine eligibility for applicants/recipients under TP 08, Parents and Caretaker Relatives Medicaid. TP 08 applicants/recipients must comply with medical support requirements, unless the applicant/recipient qualifies for a family violence exception. The advisor should request information on parent(s) living outside of the home during an interview for TP 08.

Signature

Advisors must continue to accept an application as long as it contains the applicant's name, address, and signature of:

- The applicant; or
- An AR, if the applicant is incapacitated or incompetent

Form H1010-M, Applying for or Renewing Medicaid or CHIP?, and Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, must be included with all Form H1010 applications effective January 1, 2014, and redetermination packets after the cutoff date on November 13, 2013. If an applicant only signs and returns Form H1010-M or Form H1010-MR without a corresponding application, it will be considered an invalid application.

If the applicant returns a signed application without Form H1010-M or Form H1010-MR, it will be considered an incomplete application. The advisor must send Form H1020, Request for Information or Action, with the Form H1010-M or Form H1010-MR requesting the necessary information to make a determination based on MAGI rules. If the applicant fails to provide a completed Form H1010-M or H1010-MR by the final due date, the advisor must deny the request for failure to provide information.

Advisors must continue to follow policy in TWH A-121 Receipt of Application and TWH A-122.1 Application Signature to determine if an application is considered valid and complete.

Timeframe

The timeframe to process new applications continues to be the same. Advisors must make an eligibility determination by the 45th day after the file date.

Automation

A limited cascade has been created for applications requesting MAGI-only benefits. When an application is received and there is a request that indicates only MAGI benefits, TIERS will support the use of a new sub-program code called “MAGI.”

The following changes will be implemented for Application Registration (App Reg) to allow a clerk to indicate MAGI when Medicaid is selected as the program type on Application Registration **Register/Maintain Program – Program** page. A new drop down of “MAGI” will be added under the “Sub Program Code” field, and it will be enabled only when Medicaid is selected. Once the clerk has selected MAGI as the sub-program code, TIERS will use the MAGI Cascade to determine eligibility.

Note: The clerk must select MAGI as the sub-program type in order for TIERS to run through the MAGI cascade; otherwise, TIERS will run through the entire cascade.

A limited driver flow has been created for applications requesting MAGI only benefits. This limited driver flow for MAGI TOAs will be enabled when:

- MAGI is selected as a Special Driver Flow.
- The case has only pending or approved MAGI Medicaid EDGs.

This will minimize the need to go through LUWs not used in MAGI determinations.

Effective Date

Effective January 1, 2014, the following forms will be used to determine eligibility:

- Form H1010, Texas Works Application for Assistance – Your Texas Benefits
- Form H1010-M, Applying for or Renewing Medicaid or CHIP?
- Form H1205, Texas Streamlined Application
- All applications used by the Marketplace

Effective November 13, 2013, Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, will be included in redetermination packets sent after this date.

Eligibility staff must begin using and distributing the new Form H1010 and Form H1205 on January 1, 2014.

After receipt of any initial supply of the new Form H1010 and Form H1205, destroy or recycle existing supplies of the current Forms H1010, H1014, and H1011, and their Spanish counterparts. Continue to accept current versions of Forms H1010, H1014, and H1011 as valid applications.

Note: If a current version of Forms H1010, H1014, or H1011 is received, advisors must send Form H1020, Request for Information or Action, with Form H1010-M or Form H1010-MR requesting the necessary information to make a determination based on MAGI rules.

Future supplies can be ordered through the State Processes Support Tool for Ordering ESS Supplies available at http://ofs.hhsc.state.tx.us/TWP/tw-StateProc.aspx.

The new policy related to the collection of resources information, interviews, and signatures is effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be delivered in the web-based courses titled ACA – Online HHSC Application Assistance, ACA – Paper HHSC Application Assistance, and ACA – Data Entry in Application Registration.

Authorized Representatives

Revised April 4, 2015

Policy Prior to January 1, 2014

If an individual designates an AR for his or her Medicaid or CHIP benefits, the AR is designated at the case level and has access to the individual's other benefit information. Organizations are not currently designated as ARs, except in the case of a volunteer agency for an individual certified for TP 02, Refugee Medical Assistance. If the individual chooses to designate an AR, the individual must designate the AR on the signature page of Form H1010, Texas Works Application for Assistance - Your Texas Benefits, or Form H1014, Application for Children's Health Insurance Program, Children's Medicaid, and CHIP Perinatal Coverage, and the AR must sign the acknowledgement. The AR designation is effective from the date the AR signs the acknowledgement through the end of the certification period or periodic review.

Current Policy

Effective January 1, 2014, an individual is able to designate an individual or organization as an AR solely to have access to his or her Medicaid or CHIP benefit information. AR designation varies based on the method used:

- On the Form H1010, Texas Works Application for Assistance - Your Texas Benefits, an applicant can choose an AR per program: Medicaid/CHIP, SNAP, and/or TANF.
- On the Form H1205, Texas Streamlined Application, on any of the available Marketplace applications, or through an account transfer, the AR designated only has access to Medicaid/CHIP benefit information.
- On SSP, the AR is designated at the case level for all benefit programs applied for through SSP.

The Medicaid AR is designated on the individual (or EDG) level for Medicaid or CHIP. If a Medicaid AR is designated for an individual, a case level AR on the case is not able to select plans on behalf of clients.

Note: Designating the Medicaid AR on the individual (or EDG) level for Medicaid or CHIP is done using the Alternate Payee fields in the eligibility system.

New Policy

This new policy applies to all MAGI Programs and Non-MAGI programs.

An AR is designated at the case level to have access to all benefit information for that case. A verified AR may:

- Sign an application on an applicant's behalf.
- Complete and submit a renewal form.
- Receive copies of an applicant's/client's notices in the preferred language selected on the application, and other communications from HHSC.
- Designate a health plan.
- Act on behalf of an applicant's/client's behalf in all other matters with HHSC.

The client or AR may also request that the AR receive the client's Medicaid or CHIP ID card and enrollment-related agency correspondence.

A valid AR designation remains in place until:

- The client notifies HHSC that the AR is no longer authorized to act on his or her behalf.
- The AR notifies HHSC that they no longer wish to act as the client's AR. **Note:** The AR will not be able to do this during the redetermination process if the AR is completing the redetermination.
- There is a change in the legal authority (i.e., legal guardianship or power of attorney) on which the AR's designation is based.
- The client designates a new AR to act on their behalf. If there is an existing AR designated on a case, the individual or organization that the client most recently designated as the AR will replace the existing AR on the case.

Note: Notices ending the designation of the AR must include the client's or AR's signature as appropriate.

Verifying an AR

An AR must be verified using one of the following:

- Client's signature on one of the following HHSC applications for benefits containing the AR designation:
  - H1010, Texas Works Application for Assistance - Your Texas Benefits
  - H1010R, Your Texas Works Benefits: Renewal Form
  - H1014R, Renewing children's health-care benefits
  - H1034, Medicaid for Breast and Cervical Cancer
  - H1200, Application for Assistance - Your Texas Benefits
  - H1200-MBI, Application for Benefits - Medicaid Buy-In

  - H1200-MBIC, Application for Benefits - Medicaid Buy-In for Children
  - H1205, Texas Streamlined Application
  - H1206, Health-care Benefits Renewal Form
  - H1840, SNAP food benefits renewal form
  - H1841, SNAP-CAP Application
  - H1842, SNAP-CAP Renewal Application
  - H2340, Medicaid for Breast and Cervical Cancer — Renewal
  - H2340-OS, Medicaid for Breast and Cervical Cancer
- Client's signature on a Marketplace application for health care benefits that is transferred to HHSC.
- Legal documentation that the AR has authority to act on behalf of the client under state law (i.e., legal guardianship or power of attorney).
- Letter from a client designating AR authority and containing the client's signature, in addition to the name, address, and signature of the AR.
- Completed Form H1003, Appointment of an Authorized Representative. **Note:** This form previously was only used for Medicaid for the Elderly and People with Disabilities (MEPD) types of assistance. The form has been updated and can now be used to verify ARs for all benefit programs.
- Client's electronic signature designating the AR through their case account on an application, renewal, or reported change submitted through YourTexasBenefits.com.

If an individual or organization has submitted an application on behalf of a client and indicates that they wish to be the client's AR, and the client has not signed the application, then the AR must be verified before the client's eligibility for benefits can be determined. Correspondence will be sent to both the unverified AR and the head of household on the case to request the verification.

- The head of household for the case will be sent:
  - Form H1020, Request for Missing Information, listing what missing information is needed before eligibility can be determined.
  - Form H1003, Appointment of an Authorized Representative, to capture the client's and AR's signature designating the AR.
- The AR will be sent:
  - Form H1004, Authorized Representative Cover Letter, to describe what is needed to verify the AR.
  - Form H1003, Appointment of an Authorized Representative, to capture the client's and AR's signature designating the AR.

In order for the AR to be verified, either the AR or the head of household will need to return the completed Form H1003 within 10 days in order for the application to be considered valid. If other missing information was listed on the H1020, Request for Missing Information, that was sent to the client, that information must also be returned timely. If the AR verification is not received by the due date, then the application is denied.

Alternate Payees

Policy regarding the alternate payee role for SNAP and TANF is not changing.

Effective January 1, 2014, a Medicaid AR could be designated on the individual level for Medicaid or CHIP by identifying the AR as an Alternate Payee. Effective April 4, 2015, an AR can no longer be designated at the individual level by using the alternative payee designation for most Medicaid and CHIP programs. The following programs are exceptions and will continue to have an individual (or EDG) level AR for Medicaid benefits using the Alternate Payee designation in the eligibility system:

- TA 41, Texas Women's Health Program
- TP 91, MA – Adoption Assistance – Federal Match – No Cash
- TP 92, MA – Adoption Assistance – Federal Match – With Cash
- TP 93, MA – Foster Care – Federal Match – No Cash
- TP 94, MA – Foster Care – Federal Match – With Cash
- TP 97, MA –Foster Care – No Federal Match – No Cash
- TP 98, MA –Foster Care – No Federal Match – With Cash

Automation

Case Level AR

On the **Household Authorized Representative** page, several new fields have been added to capture whether the AR is a special type and verification of the AR.

The field "Type of Authorized Representative" will be pre-populated based on the selection made in **Application Registration** or the Household Representative page in **Data Collection.** This allows advisors to indicate whether or not the AR is a legal guardian, power of attorney, or other designation.

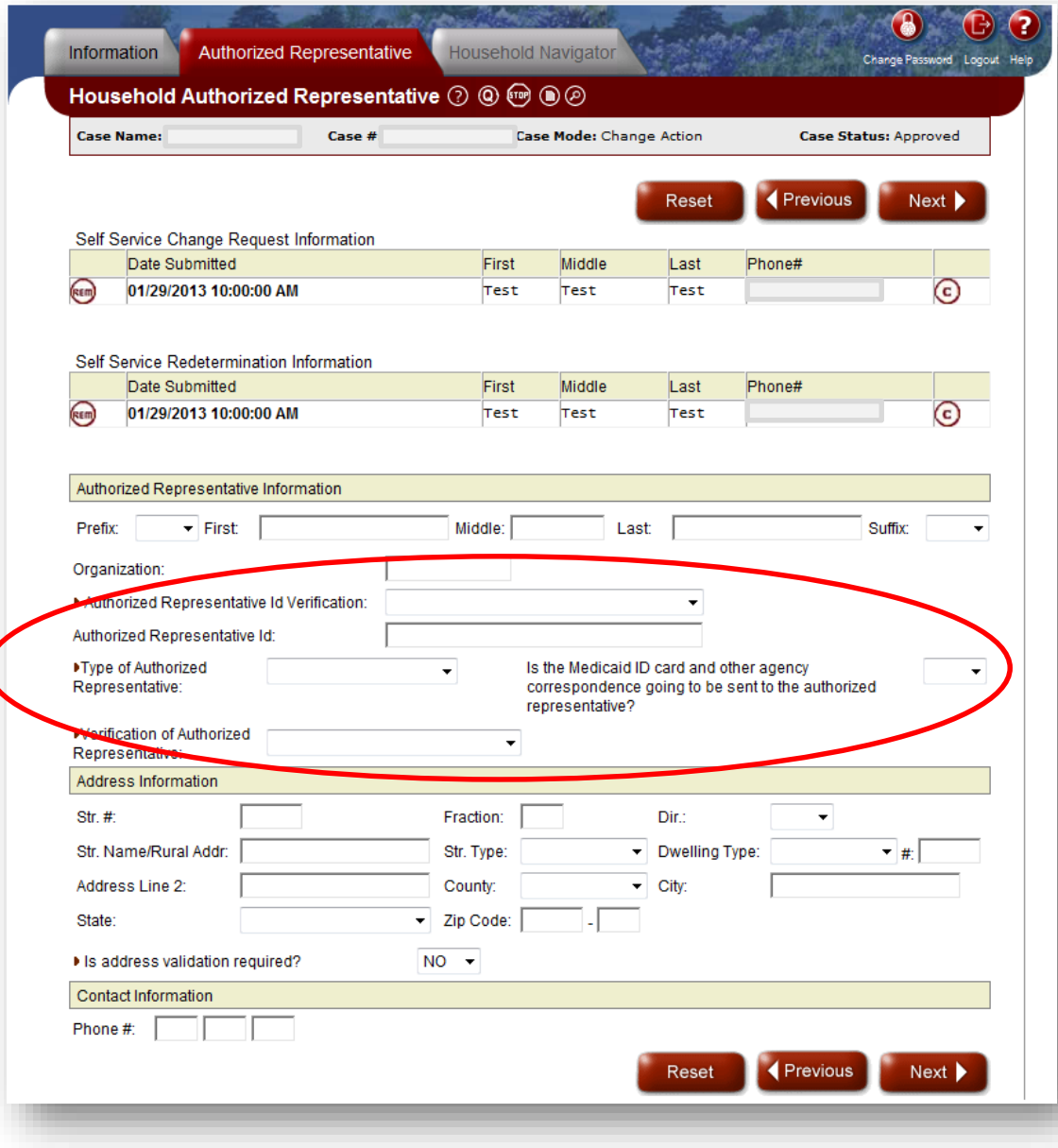
Being a "special type of AR" allows an AR to perform additional responsibilities, such as receiving the client's Medicaid or CHIP ID card and enrollment-related correspondence from HHSC. Choosing a special type of AR on this page will enable a new question: "Is the Medicaid ID card and other agency correspondence going to be sent to the authorized representative?" Advisors should select "Yes" only if the client or AR has requested to receive the Medicaid ID card and enrollment-related correspondence.

An AR who is a legal guardian or power of attorney must provide legal documentation indicating that they have this role for the client. If the AR is not a legal guardian or power of attorney, and the client wants the AR to receive the Medicaid or CHIP ID card and enrollment correspondence on behalf of the client, then advisors should indicate that the AR has the "other designation" as a special type of AR. Only a special type of AR can receive the Medicaid or CHIP ID card and enrollment correspondence.

This page will also indicate whether an AR has been verified. The possible selections include:

- Not Verified
- Form H1003
- Client signature on the application
- Legal Documentation
- Other acceptable

"Other acceptable" may include a letter of designation submitted by a client. However, such a letter must include all information required on Form H1003, Appointment of an Authorized Representative, including the client's signature and the AR's name, address, and signature.



Account Transfers

ARs designated in an account transfer received from the Marketplace will be mapped to the **Household Authorized Representative** page in the eligibility system. If an organization is designated as an AR in an account transfer, it will be mapped to the "Organization" field in the **Household Authorized Representative** page along with at least the last name of an individual that works for the organization.

Clients may only designate one AR for their case. A client's application transferred from the Marketplace may designate an AR that is the same or different than the AR currently designated in the eligibility system.

If the client **does not** have an existing AR, the advisor should update the case information in the eligibility system to include the newly designated AR for the case.

If the client **does** have an existing AR and the AR designated on the Marketplace application is:

- The **same** individual or organization, then no additional action by the advisor must be taken.
- A **different** individual or organization, then the advisor must take the following steps:
  - Call the head of household for the case and ask him or her to specify which person should be designated AR for the case. Make two attempts at least 10 minutes apart to contact the client. Document the time and reason for each attempt in Case Comments.
    - If contact is made with the client, make sure to remind them that the AR they choose will have access to all EDGs on the client's case.
    - If no contact is made, pend the client requesting confirmation of the AR. Update the Form H1020 with the following text in the Other Comments text box:

"We have received your application from the Marketplace and you indicated you are designating [Name 1] to be the authorized representative. Currently, we have [Name 2] as your authorized representative designated for your SNAP, Medicaid, CHIP, TANF programs in your case. Please contact HHSC to confirm who you want as your designated authorized representative for your case by the due date."

If no response is received by the due date indicated on Form H1020, the advisor should not deny the EDG. The advisor must update the case in the eligibility system with the name of the individual that the client most recently designated as the AR.

Alternate Payees

Effective January 1, 2014, a Medicaid AR could be designated on the individual level for Medicaid or CHIP using the Alternate Payee fields in the eligibility system.

Effective April 4, 2015, this functionality will be disabled for all Medicaid and CHIP TOAs not listed in the Alternate Payees section. Advisors will no longer be able to use the **Alternate Payee** page to enter alternate payee or AR information into the eligibility system for most Medicaid programs and CHIP. The name of the case level AR can be found in the Authorized Representative field on the **Case/Application-Search/Summary** page in TIERS Inquiry.

Effective Date

Changes to policy are effective April 4, 2015.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

AR training will be presented as part of web-based training in the following manner:

- For Lobby Computer Assistants, in Course R93-2A – Authorized Representative.
- For Texas Works Clerks, in Course R93-2B – Authorized Representative.
- For Texas Works Advisors, in Course R93-3A – Authorized Representative.

MAGI
Household Composition
Determining Household Composition

Current Policy

A budget group is composed of all the members of a household whose needs, income, resources, and medical expenses are considered in determining eligibility for medical programs. A budget group includes members who are eligible, not eligible, and not applying but required in the budget group. The budget group is determined based on living arrangements and family relationships. Most applicants are considered on the same EDG when living in the same home. Budget groups may vary by the type program.

A certified group is composed of all the individuals who are certified on a single EDG. The budget group and certified group may include different individuals depending on who is applying for benefits and who is certified. A parent/caretaker may choose to exclude other siblings when determining Medicaid or CHIP for a child. If a child is excluded, the child must remain excluded for all Medicaid programs.

New Policy

In order to determine financial eligibility for MAGI Programs, the MAGI household composition must first be determined. Under new rules, the MAGI household composition is determined on the individual level. The MAGI Household Composition is used to determine whose needs, income, and expenses are used to determine Medicaid or CHIP eligibility. Each individual living at the same physical address may have a different MAGI household composition.

The MAGI household composition will be based on an individual's:

- Tax status
- Tax relationships
- Living arrangements
- Family relationships

Exception: The following programs have certain exceptions to the MAGI household composition rules:

- Medicaid for Transitioning Foster Care Youth (MTFCY)
- Medically Needy with Spend Down (See: MAGI Programs with Exceptions)
- Refugee Medical Assistance (See: MAGI Programs with Exceptions)

An individual does not have to file a federal income tax return to apply for Medicaid or CHIP.

Tax Status

An individual's tax status must be designated before their MAGI household composition can be determined.

A tax status is based on the individual's self-declaration for what he or she plans to report on his or her federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested. The applicant will indicate his or her declared tax status on either Form H1010, Texas Works Application for Assistance - Your Texas Benefits, Form H1205, Texas Streamlined Application, SSP on YourTexasBenefits.com, or the Marketplace.

Individuals must be designated as one of the following:

- A taxpayer – an individual who plans to file a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested and who is not claimed by another taxpayer. Spouses who plan to file a joint or separate federal income tax return are both considered taxpayers.
- A tax dependent – an individual who plans to be claimed as a tax dependent by a taxpayer.
  - An individual who is both a taxpayer and tax dependent is considered a tax dependent.
  - **Example:** A college student who plans to file his or her own federal income tax return and expects to be claimed by his or her parents will be considered a tax dependent.
- A non-taxpayer/non-tax dependent – an individual who does not plan to file a federal income tax return in the taxable year in which Medicaid or CHIP eligibility is requested and does not plan to be claimed by a taxpayer.

Tax Relationships

Individuals have a tax relationship to one another if they:

- Plan to file a joint federal income tax return
- Are the taxpayer that plans to claim specific tax dependent(s)
- Are a tax dependent of a specific taxpayer

Individuals do not have a tax relationship to anyone if they:

- Do not plan to file a federal income tax return
- Are not the taxpayer planning to claim the specified tax dependent(s)
- Are not a tax dependent of a specified taxpayer

Determining Custodial Parent

A custodial parent is established based on physical custody and who has legal authority to claim a child as a tax dependent specified in a court order, binding separation agreement, divorce agreement, or custody agreement.

If there is no order or agreement, or in the event of a shared custody agreement without specifications for filing federal income tax returns, the custodial parent is the parent with whom the child spends most nights. In the event that the child spends an equal amount of nights with both parents, the advisor must make a prudent person decision regarding which parent should be considered the custodial parent.

If both a custodial parent and a non-custodial parent declare that they plan to claim the same child as a tax dependent on their federal income tax return, the child's MAGI household composition should be built as a tax dependent of the custodial parent.

Living Arrangements

Individuals are not required to live at the same physical address in order to apply for each other if they have a tax relationship. For example, a non-custodial parent may apply for Medicaid and CHIP on behalf of his or her child if he or she expects to claim the child as a tax dependent on his or her federal income tax return.

Domicile requirements for TP 08 still apply. A caretaker/second parent must reside with a dependent child to receive TP 08 benefits. For further information on domicile requirements, see the TP 08 – Parents and Caretaker Relatives Medicaid section.

Family Relationships
Revised August 25, 2015

Family relationships that impact MAGI household composition include:

- Marriage
- Parents of children under age 19
- Siblings under age 19 of a child under age 19

The tax status of the individual impacts how the family relationship is used in determining MAGI household composition.

Taxpayer's MAGI Household Composition

The following individuals are included in the taxpayer's MAGI household composition:

- The taxpayer
- The taxpayer's spouse, if the taxpayer and the spouse live together
- The taxpayer's spouse, if the taxpayer and spouse file a joint federal income tax return
- Any individual the taxpayer plans to claim as a tax dependent.

Tax Dependent Exceptions

If a tax dependent meets any one of the following exceptions, use the non-taxpayer/non-tax dependent rules (not the tax dependent rules) to build the tax dependent's MAGI household composition:

- The tax dependent is not the taxpayer's spouse or the taxpayer's child under the age of 19.
- The tax dependent is a child under age 19 who lives with both parents who do not plan to file a joint federal income tax return and the child was claimed by one parent.
- The tax dependent is a child under age 19 who is claimed as a tax dependent only by a non-custodial parent.

For a child claimed as a tax dependent by both parents who are filing jointly, with one parent living outside the home, the child does not meet the third tax dependent exception; build the child's MAGI household composition using the Tax Dependent Rules.

Tax Dependent's MAGI Household Composition

If an individual is a tax dependent and does not meet a tax dependent exception previously listed, the following individuals must be included in the tax dependent's MAGI household composition:

- The tax dependent.
- The individuals in the MAGI household composition of the taxpayer who is planning to claim the tax dependent.
- The tax dependent's spouse, if the tax dependent and the spouse live together.

Non-Taxpayer/Non-Tax Dependent's *or Tax Dependent with an Exception* MAGI Household Composition

If an individual does not plan to file a tax return nor plans to be claimed as a tax dependent, the individual is considered a non-taxpayer/non-tax dependent. All tax dependents who meet an exception – *Tax Dependent Exceptions* – will build his or her MAGI household composition using the non-taxpayer/non-tax dependent rules.

The following individuals must be included in the non-taxpayer/non-tax dependent or tax dependent with exception's MAGI household composition **if living together**:

- The individual
- The individual's spouse
- The individual's children under the age of 19
- If the individual is a child under the age of 19:
  - The individual's parents
  - The individual's siblings under the age of 19

Inclusion of the Needs of the Unborn in MAGI Household Composition

The table below identifies when the unborn child(ren) will be counted in the MAGI household composition.

Type of Assistance	Inclusion of the Unborn
TP 07, TP 20, and TP 37, Transitional Medicaid TP 08, Parents and Caretaker Relatives Medicaid TA 31, TP 32, TP 33, TP 34, TP 35, TP 36, Emergency Medicaid TP 40, Pregnant Women Medicaid TP 43, Children Under Age One TP 44, Children Ages 6-18 TP 48, Children Ages 1-5 TP 56 Medically Needy with Spend Down TP 70, Medicaid for Transitioning Foster Care Youth	Unborn child(ren) will continue to be included in the MAGI household composition of: • A pregnant woman • Any child under age 19 whose MAGI household composition includes a pregnant woman certified on Medicaid
TA 84, CHIP	Unborn child(ren) is/are not included in the MAGI household composition.
TA 85, CHIP-P	Unborn child(ren) is/are included in the MAGI household composition.

Certified Group
Revised September 1, 2015

For Medicaid and CHIP programs impacted by MAGI rules, each EDG has one individual in the certified group.

For CHIP- P:

- If the mother's income exceeds the income limit for TP 40, Pregnant Women Medicaid, the mother will be the only individual on the EDG for the majority of the certification period. However, the mother and child will be certified on the same EDG during the month the child is born. After the birth month of the child, only the child will be certified on the EDG.
- If the mother's income is at or below the income limit for TP 40, Pregnant Women Medicaid, and the mother receives TP 36, Pregnant Women – Emergency Medicaid, to cover the birth, the newborn will receive TP 45, Medicaid for Newborn Children.

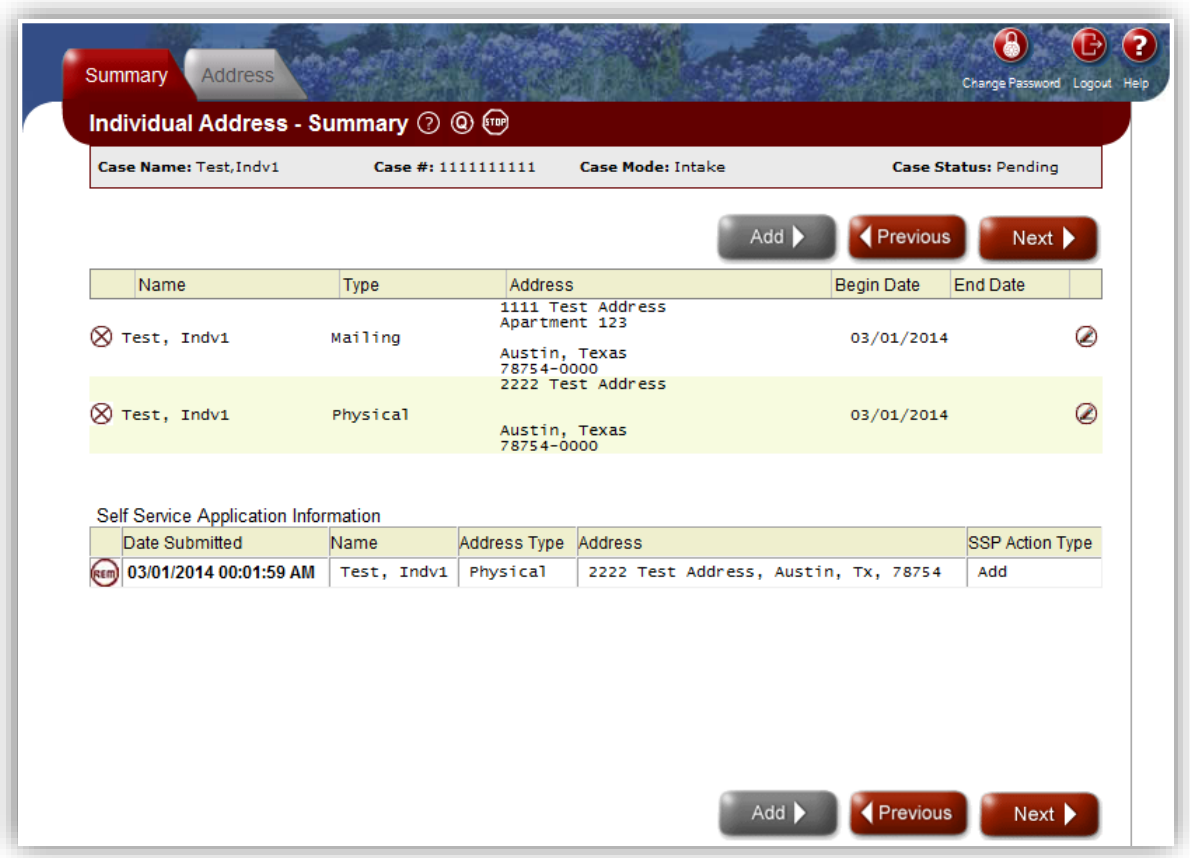
Opting Out a Child
Revised March 1, 2014

A household can no longer choose to exclude a child from the budget group when determining MAGI Medicaid or CHIP eligibility. MAGI household composition must include all individuals based on the new rules.

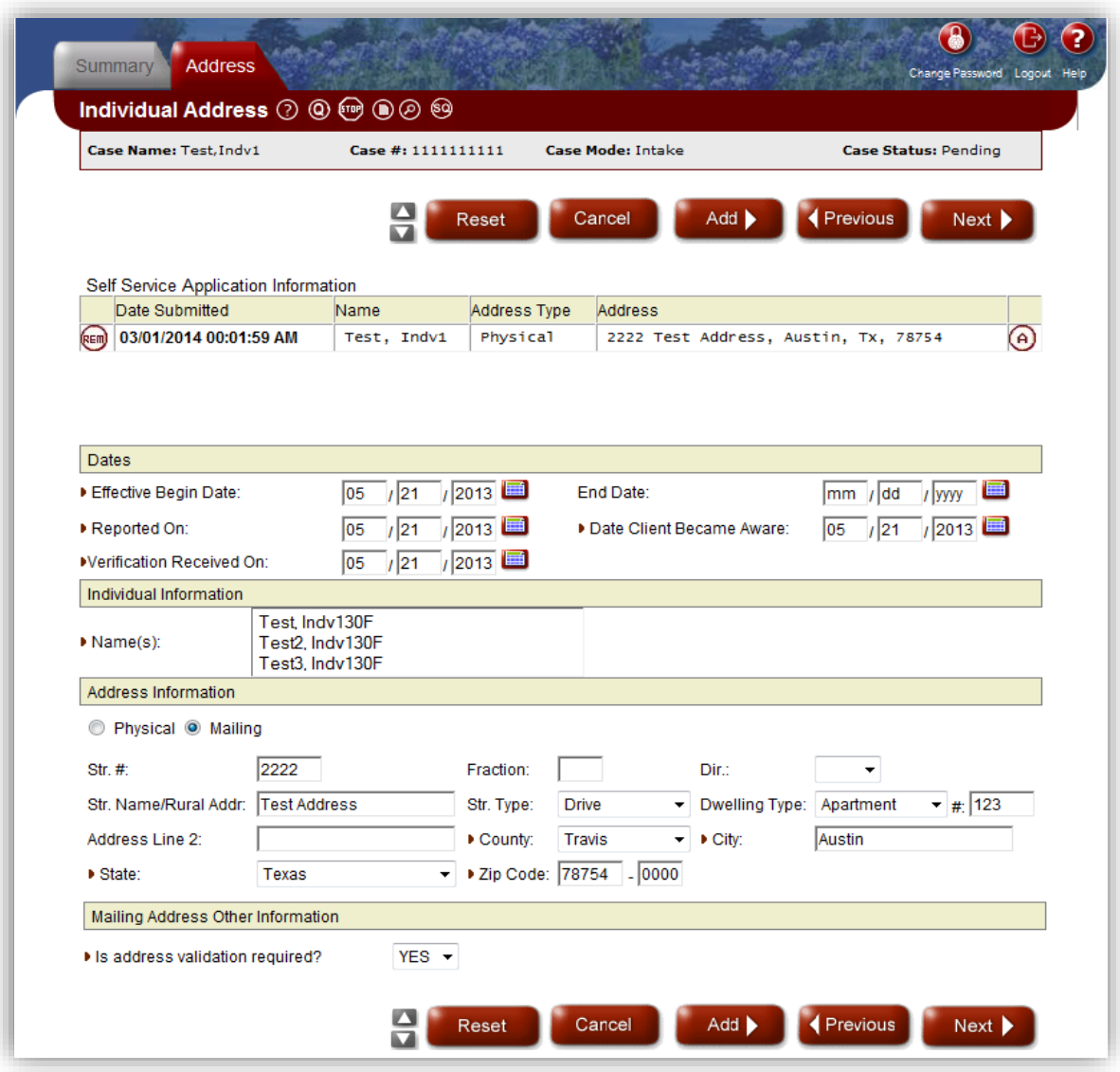
Automation

A new LUW has been created to capture the address information of an individual who does not live at the same physical address as the applicant but is included in his or her MAGI household composition. The new LUW, **Individual Address**, is scheduled when the question **"**All members live in the same household?" is answered "No" on the Household Information page. This LUW is used to collect Individual(s) Physical or Mailing Address Information similar to household address at individual level. This LUW allows the advisor to select more than one individual when entering the Physical or Mailing Address of the individual(s) who do not live at the same physical address of the applicant. **Individual Address** screen shots follow.

Individual Address – Summary LUW



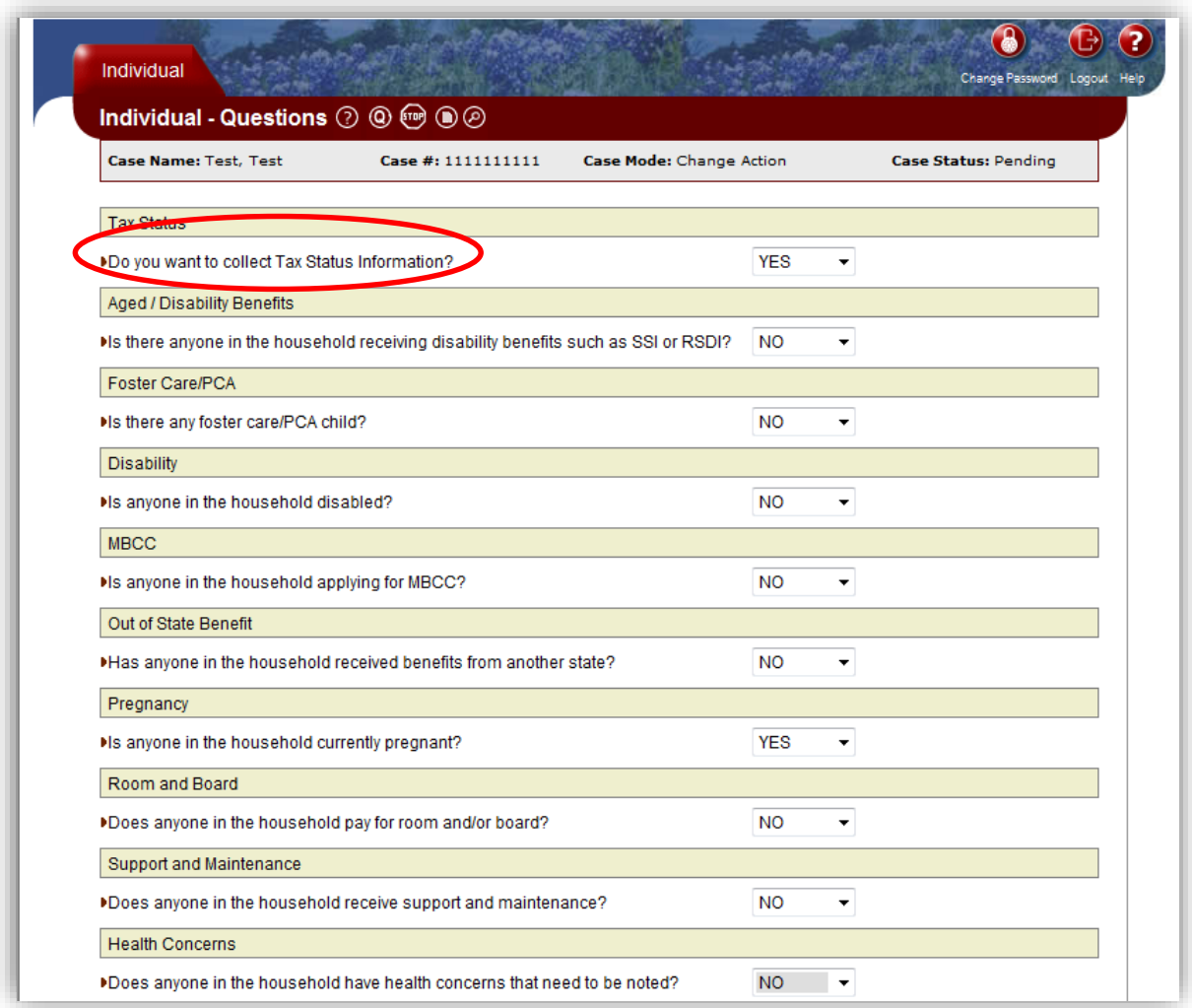
Individual Address LUW



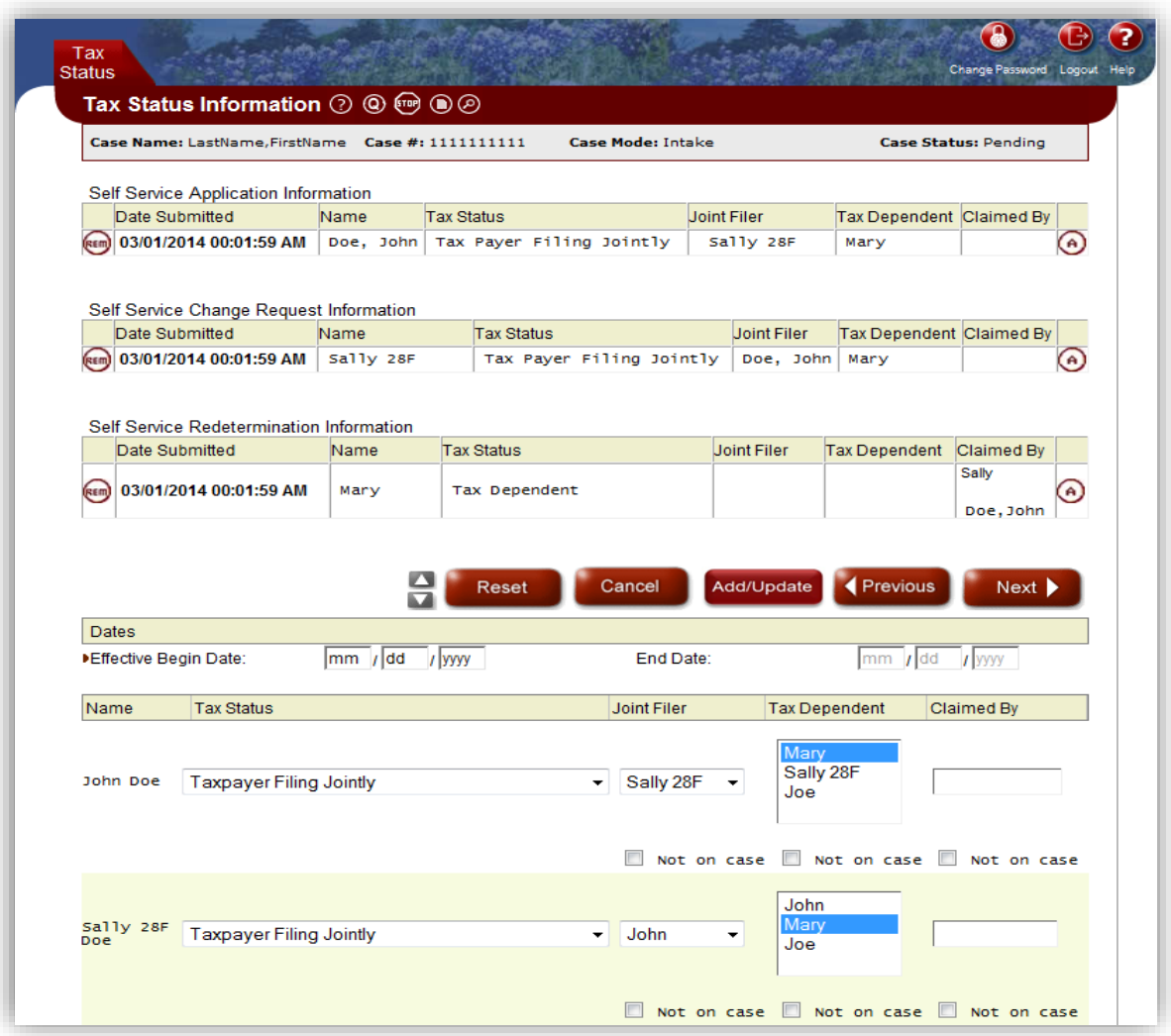
A new question “Do you want to collect Tax Status Information?” will be added to the Individual Questions LUW. A new LUW, **Tax Status Information,** is scheduled when the question “Do you want to collect Tax Status Information?” is answered “Yes” on the **Individual Questions** page. The question will be defaulted to “Yes” when the advisor selects the sub program MAGI, which then allows for the limited MAGI driver flow. The question will also be defaulted to “Yes” if the advisor navigates in a non-MAGI driver flow, but the case has an "MA Program" request with MAGI as a Sub Program Code. The LUWs that capture tax status are pictured next.

Individual Questions LUW

Updated to ask: Do you want to collect Tax Status Information?



Tax Status Information LUW



Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on MAGI household composition will be presented as part of an instructor led training series titled ACA – Overview of MAGI Changes and ACA- Changes to TIERS.

Family Violence Exemption to Household Composition

Added September 1, 2015

Current Policy

In order to determine eligibility for MAGI programs, certain information is needed from all individuals who are included in the applicant's/recipient's MAGI household composition. There are no exceptions provided for situations of family violence.

New Policy

This new policy applies to all MAGI Programs.

Individuals may not be able to or may not want to provide information about a member of their MAGI household composition because they fear physical or emotional harm by that person. Individuals who are pended for missing information about a MAGI household composition member who may be a family violence offender can contact HHSC to request the Family Violence Exemption by calling 2-1-1 or visiting a local office.

Advisors **must ask** the individual requesting the Family Violence Exemption, at the time the exemption is requested, if they want to be designated as the head of household for the case. Advisors must also confirm the address that should be used for agency correspondence and offer to set up an alternative address if needed. Individuals experiencing family violence must be allowed to provide an address for agency correspondence other than the address on the case with the offender.

If the individual wants to pursue the Family Violence Exemption, advisors must determine whether the individual has existing approved Office of the Attorney General (OAG) Good Cause for TANF or Parents and Caretaker Relatives Medicaid (TP 08) as described in TWH A-1130 Explanation of Good Cause.

- If the individual has existing OAG Good Cause, no further action is required for the individual. The advisor must select "OAG Good Cause" as the verification source in TIERS.
- If the individual does not have existing OAG Good Cause, the advisor must make a referral to a family violence specialist at a nearby family violence service provider, following the process described in Referral to a Family Violence Specialist below.

Referral to a Family Violence Specialist

Advisors must send the contact information for the nearest family violence shelter to the individual pursuing the Family Violence Exemption using Form H1071, Family Violence Exemption for Medicaid and CHIP. The Form H1071 informs the individual how they can claim the Family Violence Exemption and is sent along with the Form H1020, Request for Information or Action.

The individual must contact the family violence specialist and explain the need to claim the Family Violence Exemption. After the family violence specialist makes the recommendation, the family violence specialist completes Form H1706, Good Cause Recommendation and Family Violence Exemption, and may mail or fax the form to HHSC, or send the form back with the individual to HHSC. Only a family violence specialist can recommend the exemption using

Form H1706. The Form H1706 is due 10 days from the date the Form H1020 was sent (or 30 days from the file date, whichever is later).

- If the family violence specialist recommends the Family Violence Exemption, the exemption is granted and will affect all MAGI EDGs on the case by removing the offender from their MAGI household composition.
- If the family violence specialist does not recommend the Family Violence Exemption, the exemption is denied. The advisor must re-pend the MAGI EDGs to give the individual additional time to provide the information that was originally requested for the MAGI household member.
- If the Form H1706 is not returned by the due date, the exemption is denied. All pending MAGI EDGs are denied for failure to provide information that was originally requested for the MAGI household member.
- If the client withdraws the request for the Family Violence Exemption, the client must provide the information that was originally requested for the MAGI household member by the due date, or the pending MAGI EDGs are denied.

Duration of Family Violence Exemption

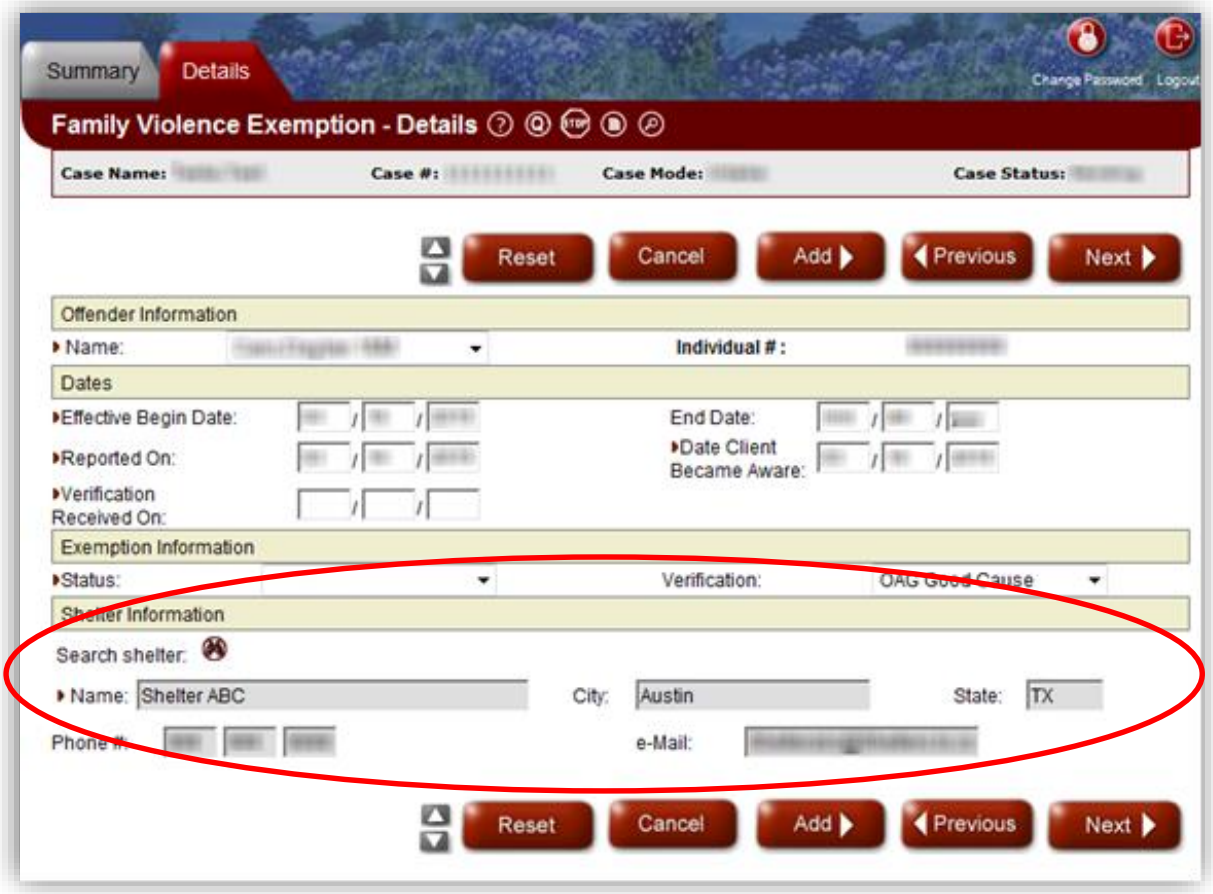
Once the Family Violence Exemption has been established by a family violence specialist, advisors do not need to re-evaluate the exemption.

The individual continues to receive the Family Violence Exemption until there is a break in eligibility for all MAGI EDGs on the case. If an individual wants to pursue the Family Violence Exemption again after a break in eligibility, advisors must follow the referral process explained in this section.

Automation

A new **Family Violence Exemption** page has been created to capture the information needed for a household to claim the Family Violence Exemption.

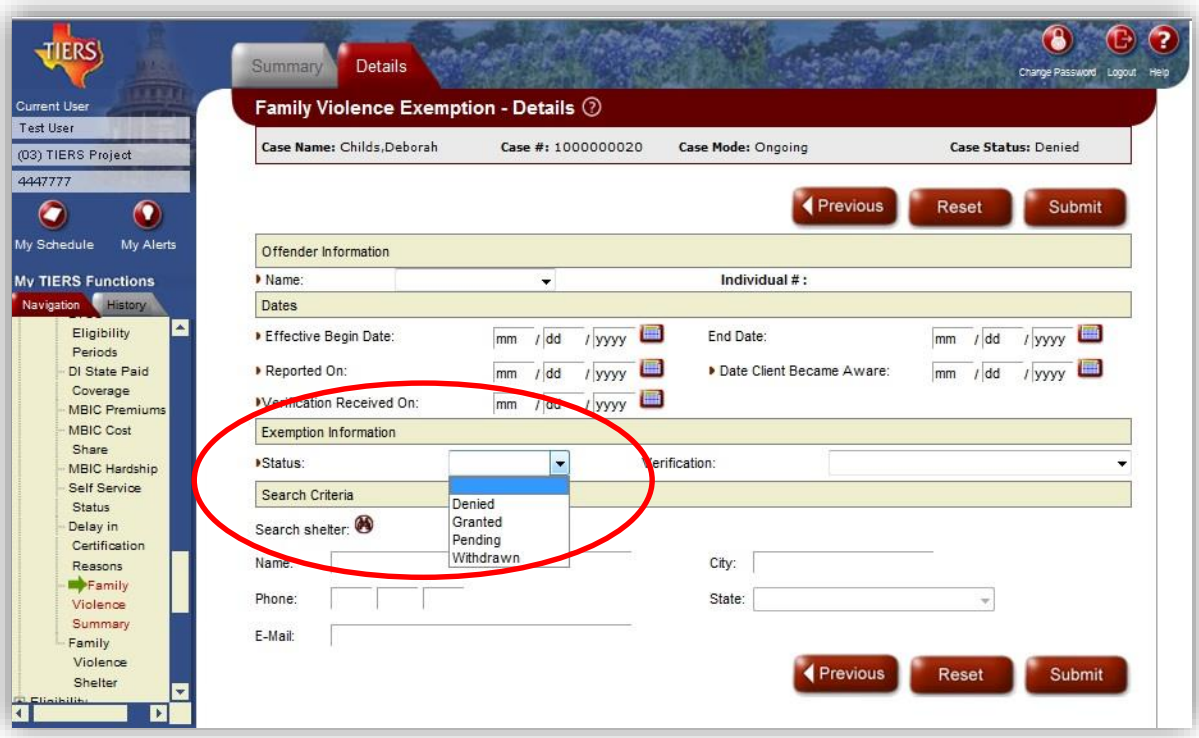
From this page, advisors can search the family violence shelter directory in TIERS to locate the nearest shelter. This information will then auto-populate the fields in the “Shelter Information” section in TIERS and on the Form H1071 sent to the client.



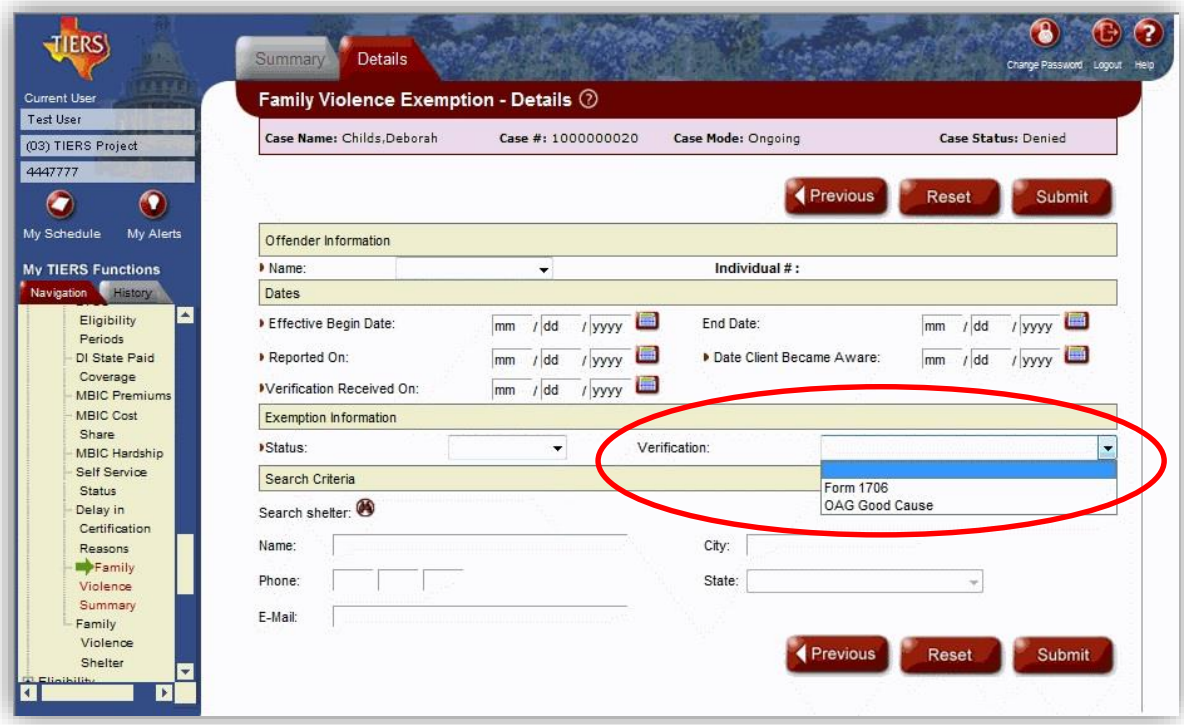
The “Status” field allows advisors to select the current status of the exemption. The possible selections in the “Status” field include:

- Denied
- Granted
- Pended
- Withdrawn

“Withdrawn” should be selected if the individual contacts HHSC to indicate that they no longer wish to receive the Family Violence Exemption.



This page also allows advisors to select whether a Family Violence Exemption was verified with the Form H1706 or because the individual has existing OAG Good Cause for TANF or Parents and Caretaker Relatives Medicaid (TP 08).



Effective Date

Changes to policy are effective September 19, 2015.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on the Family Violence Exemption will be presented in the web-based course titled "Course R94-2 – Family Violence and MAGI Household Composition."

Household Composition Verifications

Current Policy

Currently, there are no verification requirements for budget group determinations**.**

New Policy

Revised March 1, 2014

A client's statement is used for the determination of an individual's tax status and tax relationships for MAGI household composition.

In order for an advisor to determine an individual's MAGI household composition, each individual on the application must provide his or her tax status, which will identify the individual as a taxpayer, tax dependent, or a non-taxpayer/non-tax dependent. Additionally, applicants must provide the following information on their tax relationships to one another:

- A taxpayer who plans to claim one or more dependents must provide the name(s) of the dependent(s).
- A taxpayer who plans to file a joint federal income tax return with a spouse must provide the spouse's name.
- A taxpayer who plans to file a separate federal income tax return from his or her spouse must provide the name and filing status of the spouse.
- A tax dependent must provide the name of the taxpayer(s) who expects to claim him or her.

Note: If tax status information is not available and the client cannot be reached, the advisor can create a pregnant woman's Medicaid (TP 40 EDG) and certify the pregnant woman by postponing verification of tax status. TIERS will use the Non-tax payer/Non-tax dependent household rules to build and pend the pregnant woman's EDG for the Tax Status information; therefore, it will allow certification with postponed verification of the tax status for a pregnant woman (TP 40 EDG). Advisors must verify tax status for a pregnant woman (TP40 EDG) after certification if the tax status was not verified by the client during eligibility.

Automation

Automation changes will be implemented with Release 89 scheduled for December 2013.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on verifications will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Financial Eligibility

Calculation

Current Policy

Much of the financial eligibility policy for Medicaid and CHIP is similar to SNAP and TANF. Individuals are given income deductions, and resources are taken into consideration.

In general, income for Medicaid and CHIP is currently determined using the following steps:

- Determine the budget group for the type program.
- Add all countable earned income and unearned income for all individuals within the budget group.
- Subtract all applicable deductions (such as earned income or child support deductions) from the total to arrive at adjusted gross income.
- Apply the recognizable needs test for TP 08, TANF-Level Families Medicaid, and TP 47, Children Denied TANF with Applied Income.
- Compare the calculated budget group income amount to the income limit of the applicable Medicaid programs or CHIP.

New Policy
Revised September 1, 2014

New MAGI rules will now be used to determine financial eligibility for the MAGI Programs. These new rules are based on IRS rules for counting income and will be used to determine financial eligibility for certain Medicaid programs, CHIP, and, in addition, federal insurance affordability programs, such as Advance Payment Tax Credits and Cost-Sharing Reductions.

The ACA changes current policy as follows:

- Resource tests are not used in eligibility determinations for MAGI programs*.
- All current income deductions are not allowed.
  - Instead, certain expenses will be allowed and deducted when calculating income.

- The recognizable needs test is not allowed.
- There is a new income disregard equal to five percentage points of FPIL for the applicable MAGI household size.
- For most type programs subject to the MAGI rules, each individual will have his or her own EDG.
    - Individuals will have their own EDG because each individual's MAGI household composition and MAGI household income could be different from other individuals in the case.

*Resources **are** considered when determining eligibility for an individual in TP 02, Refugee Medical Assistance; a child in TP 56, Medically Needy with Spend Down; and a child in TP 32, Medically Needy with Spend Down – Emergency.

To determine MAGI financial eligibility under the MAGI rules, the following five steps must be completed in the specified order for **each individual applying for benefits**.

Step 1 – Determine MAGI Household Composition

Determine the MAGI household composition for the individual and use that MAGI household composition to continue onto to Steps 2, 3, 4, and 5. Use the following link to read how to perform this step: Household Composition.

Step 2 – Identify and List All Income, Expenses, and Overpayments for MAGI Individual Income

The following items must be identified for each individual within the MAGI household composition:

- Earned income
- Unearned income
- Self-employment income
- AI/AN disbursements
- Overpayments
- Expenses

Use the Form H1042, Modified Adjusted Gross Income (MAGI) Worksheet: Medicaid and CHIP, to fill in earned income, unearned income, self-employment income, AI/AN disbursement, Overpayments, and expenses for each person included in the individual's MAGI household composition.

The types of income included under MAGI rules for certain Medicaid programs and CHIP are the same types of income used by the IRS for tax purposes, but include adjustments for the following amounts:

- Lump sum payments will always be counted as income in the month received.
- Certain AI/AN income, known as AI/AN disbursements, may be exempt.
- Scholarships, awards, and fellowship grants for education are not counted as income.

The following table lists the types of income that are counted under MAGI rules. Those with an asterisk (*) are types of income that are counted under pre-MAGI eligibility rules (in effect on December 31, 2013). All countable income is added when determining MAGI individual income.

Types of Income Counted Under MAGI Rules

Those with an asterisk (*) are types of income that are counted under pre-MAGI eligibility rules (in effect on December 31, 2013).

Earned Income	*Wages and Tips
	Housing Allowance
	*On-the-job training income
	*Welfare-to-work income
Unearned Income	*Military allotment
	*Vacation pay
	Capital gains
	*Interest
	*Note Interest
	*Dividends
	*Royalties
	*Award prizes
	*Alimony received
	*RSDI
	*Unemployment compensation
	*Pension/retirement
	*Railroad retirement
	Annuity
	Canceled Debts
	Court Awards
	Jury duty pay
	Life estate
	*Trust payments
	Cash support (*Gifts or contributions)
Self-Employment Income	*Rental

	*Farming/fishing
	*Sales
	*Construction/repair work
	*Commission
	*Odd jobs
	*Contract/seasonal work
	*Other income
AI/AN Disbursements**	Distributions from Alaska Native corporations and settlement trusts
	Distributions from property held in trust, in the boundaries of a prior Federal Reservation
	Distributions and payments from rents, leases, rights of way, royalties, usage of rights, or using natural resources from land under the supervision of the Secretary of the Interior or rights to off-reservations hunting, fishing, gathering, or natural resource usage
	Payments from ownership/usage rights to items that are religious, spiritual, traditional, or cultural or rights that support subsistence/traditional lifestyle according to Tribal Law or custom
	Student financial assistance from the Bureau of Indian Affairs education program

**AI/AN disbursement income is exempt and not counted under MAGI rules *only* if the individual claiming that income type has verified his or her AI/AN status and provided verification of the income source. For more information on verifying AI/AN status, see the American Indian/Alaska Natives (AI/AN) section of nonfinancial verifications.

Cash Support
Revised September 1, 2015

Effective January 1, 2015, cash support (gifts or contributions) is a type of unearned income for MAGI programs.

Cash support may only be counted if:

- It is given from a taxpayer to his or her tax dependent,
- It is given by a taxpayer who is someone other than the receiver's spouse or parent, and
- The total amount exceeds $50 per month.

For example, Francis gives $100 per month to her nephew Sean and plans to claim Sean as her tax dependent. This cash support will count for Sean because Francis is a taxpayer giving an amount to her tax dependent, she is not Sean's parent or spouse, and the amount exceeds $50 per month.

Note: Effective September 1, 2015, since Child Support, as defined in the Glossary, does not meet the above criteria, voluntary child support is not considered cash support and is not a countable income source for MAGI programs.

Types of Income NOT Counted Under MAGI Rules

Those with an asterisk (*) are types of income that are counted under pre-MAGI eligibility rules (in effect on December 31, 2013).

*Private insurance
*Oil/mineral rights
*Child support
*TANF cash assistance
Supplemental Security Income
Educational scholarships, fellowships, or grant monies
Educational work study
Domestic Volunteer Service Act 1993 income
Temporary Census income
Wages-in-kind
*Workers' compensation
Workforce Investment Act wages
Housing and Utility Assistance

Overpayments

Under MAGI rules, recoupment of RSDI and unemployment overpayments is subtracted from the individual's income to determine the MAGI individual income.

Overpayments Captured Under MAGI Rules

Those with an asterisk (*) are overpayment types excluded under pre-MAGI eligibility rules (in effect on December 31, 2013).

*RSDI overpayments
*Unemployment overpayments

MAGI Expenses
Revised March 1, 2014

Income deductions such as child care, child support, or earned income deductions are not allowed under MAGI rules. The following are expenses that may be deducted from the individual's income in order to determine the MAGI individual income:

Expenses Captured Under MAGI Rules

Alimony Paid
Educational Expenses/Student Loan Interest
Moving Expenses
Tuition or GI Bill Deduction
Educator Expenses
Expenses of Fee-Basis Government Officials, Expenses of Performing Artists, and Expenses of Reservists
Health Savings Account
Deductible Part of Self-Employment Tax
Self-Employed IRA, Simple IRA, and Qualified Plan Deductions
Self-Employed Health Insurance
Penalty on Early Withdrawal
IRA Deduction
Domestic Production Activities Deduction

MAGI Expense Amounts
Revised March 1, 2014

For all MAGI expenses, verified using last year's federal income tax return, take the expense amount from the federal income tax return and divide that amount by 12 to determine the monthly expense amount for use for applicant/client. See Financial Eligibility Verifications for more information on acceptable verifications for MAGI expenses.

For the alimony paid expenses verified using other acceptable verification sources, use the actual amount verified for the MAGI alimony paid expense.

Step 3 – Determine Whether Any Exemptions Apply to MAGI Household Income

Within the applicant's or recipient's MAGI household composition, each individual's MAGI individual income is added together in order to calculate the MAGI household income, except in the case of individuals who meet one of the following exceptions for the taxable year in which Medicaid or CHIP eligibility is requested:

Exception #1:
Revised December 13, 2014

An individual is a child who is:

- Under age 19,
- Included in the MAGI household composition of a parent, and

- Not expected to be **required** to file a federal income tax return since the child's monthly income is below the monthly IRS income threshold.

Effective December 13, 2014, TIERS will only show that a child meets Exception #1 if the child is included in the MAGI household composition of a parent.

Exception # 2:
Revised June 1, 2014

An individual is a tax dependent who is:

- Included in the MAGI household composition of the taxpayer claiming them as a tax dependent, and
- Not expected to be **required** to file a federal income tax return since the tax dependent's monthly income is below the monthly IRS income threshold.

If an individual meets the criteria for Exception #1 or #2 and does not have any income, it is not necessary to determine whether the individual is expected to be required to file an income tax return, since there is no income to compare with the IRS income threshold. Move on to **Step 4**.

Each year the IRS establishes income thresholds for earned and unearned income. Individuals whose income (earned, unearned, or a combination) exceeds the federal income tax filing threshold are "expected" by the IRS to file a federal income tax return under federal law.

Determining whether an individual is expected to be required to file a federal income tax return is determined by comparing the specified income types to the IRS Monthly Income Thresholds.

Note: Even if an individual's tax status is –*Non-Taxpayer/Non-Tax Dependent* – the individual may be "**expected to be required to file**" a federal income tax return based on the IRS threshold amounts.

Based on the 2014 IRS thresholds, an individual is not expected to be required to file a federal income tax return for the taxable year if all of the following statements are true:

- The individual's unearned income is less than or equal to $83.33.
- The individual's earned income is less than or equal to $508.33.
- The individual's MAGI gross income (total amount for earned, unearned, self-employment income, and AI/AN disbursements, if applicable) is less than or equal to the larger of:
  - $83.33, or
  - The sum of earned income plus $25.

An individual **is** expected to be required to file a federal income tax return if none of the three statements above are true. For individuals who **are expected to be required** to file a federal income tax return, all MAGI individual income from **Step 2** counts in every MAGI household composition in which that individual is included.

If a child meets *Exception #1*:

- His or her income is excluded from the MAGI household income of every applicant or recipient whose MAGI household composition includes that child.
- The child's income is **exempt** from his or her own MAGI household income.

If a tax dependent meets *Exception #2*:

- The tax dependent's income is excluded from the MAGI household income of the taxpayer who plans to claim that individual on a federal income tax return for the taxable year in which Medicaid or CHIP eligibility is requested.
- This tax dependent's MAGI individual income **counts** in his or her own MAGI household income and counts in the MAGI household income of everyone else in whose MAGI household they are included.

If an individual meets the criteria for both exceptions—**a child under the age of 19 included in the MAGI household composition of a parent *and* a tax dependent included in the MAGI household composition of the taxpayer**, give the child the Exception #1. Exception #1 is more beneficial for the child because the child's income would then be exempt from the child's MAGI individual income.

Example: Katie, age 9, lives with her mother, has no income, and her mother expects to claim Katie on her federal income tax return. Both Katie and her mother are applying for Medicaid. Katie would meet Exception #1 and Exception #2. For the purposes of exempting Katie's income, Katie is considered a child under age 19 (Exception #1). Since Katie has no income, there is no need to compare her income to the tax thresholds because there is no income to exempt. If Katie did have income under the threshold, it would be more beneficial to allow her Exception #1, so that her income would not be counted on her own MAGI household income.

Note: The IRS Monthly Income Thresholds are updated annually and will be included in the handbook.

Step 4 – Calculate MAGI Household Income

First, calculate the MAGI individual income for each person included in the applicant's or recipient's MAGI household composition by:

- Adding earned income, unearned income, self-employment income, and AI/AN disbursements (if American Indian/Alaska Natives (AI/AN) is not verified or the income source is not verified)
- Subtracting overpayments
- Subtracting expenses

	Person 1	Person 2	Person 3	Person 4
Total earned/unearned income				
Add	+	+	+	+
Total self-employment Income				
Add	+	+	+	+
Total AI/AN disbursement				
Subtract	-	-	-	-
Total recoupment of overpayments				
Subtract	-	-	-	-
Total expenses				
Equals	=	=	=	=
MAGI Individual Income				

Second, add together the MAGI individual income for all persons included in the applicant's or recipient's MAGI household composition. Exempt anyone's income (as applicable) based on Exceptions #1 and #2 from **Step 3**.

Add MAGI Individual Income		+		+		+	=

Third, take the sum of the MAGI individual incomes and subtract the Standard MAGI Income Disregard to get the MAGI household income.

Sum of MAGI Individual Incomes	
Subtract	-
Standard MAGI Disregard	
Equals	=
MAGI Household Income	

The standard MAGI disregard is an income disregard equal to five percentage points of the FPIL. It is a standard amount across all MAGI programs based on the applicable MAGI household size. The Standard MAGI Income Disregard table illustrates the standard MAGI disregard amounts by MAGI household size.

Note: The Standard MAGI Income Disregard will be updated annually based on the annual updates to the FPIL.

Step 5 – Determine MAGI Financial Eligibility

Determine the individual's eligibility for a Medicaid program or CHIP, by comparing whether the applicant's or recipient's MAGI household income is less than or equal to the income limit of the applicable program based on FPIL and MAGI household size. Use the following link to see the income limits for each type program:

Federal Poverty Income Limits.

To determine MAGI financial eligibility for other individual's in MAGI household composition, repeat **Steps 1-5 for each individual applying for benefits.**

Automation

TIERS EDBC rules will calculate financial eligibility using the MAGI income rules. Automation changes will be implemented with Release 89 scheduled for December 2013.

Effective Date

MAGI rules will be used to determine financial eligibility when processing applications, changes, and redeterminations for the MAGI Medicaid programs and CHIP with a file date on or after January 1, 2014.

However, current eligibility rules will continue to be used when processing reported changes for individuals with a file date on or before December 31, 2013. For more information, see the Changes section.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on MAGI rules will be presented as part of an instructor led training series titled ACA – Overview of MAGI Changes.

MAGI Programs with Exceptions

Current Policy

Medically Needy with Spend Down

Children or pregnant women not eligible for Children's Medicaid, CHIP, or Pregnant Women Medicaid may qualify for Medicaid through TP 56, Medically Needy with Spend Down, if they have unpaid medical bills. Children or pregnant women are not eligible for Medicaid until spend

down is met (the household's excess income is depleted by medical expenses incurred by members of the budget group).

The applicant meets spend down by submitting or having a provider submit medical bills to the Clearinghouse. Income eligibility for TP 56, Medically Needy with Spend Down, and TP 32, Medically Needy with Spend Down – Emergency, mirrors the current income policy described in the MAGI Calculation section except the only income that is included for the applicant or recipient is income from the applicant, the applicant's parents, or the applicant's spouse, if those individuals are in the applicant's or recipient's household composition.

Refugee Medical Assistance (RMA)

Refugees ineligible for Medicaid or CHIP may qualify for RMA. Income eligibility for TP 02, RMA, mirrors the Financial Eligibility Current Policy section**,** except that certain income is not included in the calculation, such as:

- Cash assistance payments received from the refugee's Voluntary Agency:
  - Resettlement-reception and placement (R&P)
  - Match grant
  - Refugee Cash Assistance (RCA)
- Incomes of the Voluntary Agency or sponsor available to the refugee household are not included.

If an applicant is determined ineligible for RMA because his or her income (which excludes the income mentioned in the previous sentence) is over the limit, the CBS advisor must calculate the individual's income manually. The system uses projected incomes, rather than actual income as of the date of application. RMA eligibility must be determined using actual income.

New Policy

Financial eligibility for Medically Needy with Spend Down and RMA will be determined using the New Policy previously described in this bulletin to align with corresponding MAGI Programs. The income exceptions currently in place for these two programs are outlined within MAGI rules, but will continue to apply.

Medically Needy with Spend Down

Applicants with unpaid medical bills are first determined ineligible for Medicaid or CHIP before being considered for TP 56 or TP 32. In order to use the information the applicant has already provided, TP 56 or TP 32 will follow MAGI rules.

However, when determining whose MAGI individual income should be included in the applicant's MAGI household income, the only income that is included for the applicant or recipient is income from the following individual's, if those individuals are in the applicant's or recipient's MAGI household composition:

- The applicant
- If the applicant is under age 19, the applicant's parents
- The applicant's spouse (if applicable)

Refugee Medical Assistance (RMA)

Applicants must first be determined ineligible for Medicaid or CHIP before being assessed for RMA. Because eligibility determinations for those programs are made using MAGI rules, RMA will also follow MAGI rules to use the information that the individual has already provided. However, when calculating the MAGI individual income of each person in the applicant's MAGI household composition (**Step 2**) exempt the following:

- Cash assistance payments received from the refugee's Voluntary Agency:
  - Resettlement-reception and placement (R&P)
  - Match grant
  - Refugee Cash Assistance (RCA)
- Incomes of the Voluntary Agency or sponsor available to the refugee household are not included.

If an applicant is determined ineligible for RMA because his or her income (which excludes the income previously outlined) is over the limit, the CBS advisor must calculate the applicant's MAGI household income manually. The system uses projected income, rather than actual income as of the date of application. RMA eligibility must be determined using actual income.

Automation

TIERS EDBC rules will calculate financial eligibility using the MAGI income rules and account for the exceptions for Medically Needy with Spend Down and RMA. Automation changes for MAGI will be implemented with Release 89 scheduled for December 2013.

Effective Date

MAGI rules, with the applicable exceptions, will be used to determine financial eligibility for TP 02, TP 32, and TP 56 beginning January 1, 2014. Current eligibility rules will continue to be used when processing reported changes for individuals certified on or before December 31, 2013.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on the TP 56 and TP 32 MAGI exceptions will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs. Training on the TP 02 MAGI exceptions will be presented as part of an instructor led training series titled ACA – Changes to Specialized Medicaid, which will only be delivered to CBS advisors.

Resources

Added June 1, 2014

Current Policy
Revised September 1, 2014

Under the ACA, resources are no longer applicable when making an eligibility determination for MAGI programs. HHSC continues to collect resources information for MAGI programs and the Former Foster Care Children (FFCC) program for analysis purposes.

Effective January 1, 2014

Resources are collected in SSP for FFCC and all MAGI TOAs for analysis purposes, except for TP 40, Pregnant Women. A resource test is not performed when determining eligibility for these programs. The information from SSP is available for staff to accept in the Resources LUW. When processing an application from SSP, staff must accept all SSP information in the Resources LUW.

New Policy
Revised September 1, 2014

HHSC applies a resource test to:

- Individuals in TP 02, Refugee Medical Assistance
- Children in TP 56, Medically Needy with Spend Down
- Children in TP 32, Medically Needy with Spend Down – Emergency

Resources are not considered as a factor in determining eligibility for MAGI programs, except for TP 02, children in TP 56, and children in TP 32. These TOAs are not federally mandated to be subject to MAGI rules.

Note: For TP 02 and children in TP 56 and TP 32, the MAGI limited driver flow includes the Resources LUW, and applicable verification rules apply.

The resource limit for TP 02 and children in TP 56 and TP 32 is the same as it was on December 31, 2013:

- $2,000 or
- $3,000 for an applicant with a household member who is aged or has a disability and meets relationship requirements.

SSP Applications
Revised September 1, 2014

The online application through YourTexasBenefits.com does not ask applicants for their resource information if only applying for MAGI health care benefits.

Paper Applications
Revised September 1, 2014

H1205, Texas Streamlined Application, does not ask applicants to provide information about resources. Resource information is required for SNAP and TANF, so the H1010 asks applicants for this information.

Verification of Resources
Revised September 1, 2014

If individuals are determined potentially eligible for TP 02 or children are determined potentially eligible for TP 56 or TP 32, HHSC pends for resource information and verification of those resources.

Automation

EDBC rules will apply a resource test when calculating financial eligibility for individuals in TP 02, children in TP 56, and children in TP 32. The MAGI limited driver flow will trigger the Resource LUW for the following:

- Individuals who appear to be eligible for TP 02, Refugee Medical Assistance;
- Children who appear to be eligible for TP 56, Medically Needy with Spend Down; or
- Children who appear to be eligible for TP 32, Medically Needy with Spend Down – Emergency.

Reports
Revised September 1, 2014

A Data-Mart report captures resources information that was a condition of eligibility for TP 02, TP 56, and TP 32.

Effective Date
Revised September 1, 2014

Changes to policy are effective September 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on the collection of resources will be presented as web-based training available on the Program Area Learning Management System (PALMS).

Financial Eligibility Verifications

Current Policy

Verification is required for all countable income used to determine eligibility. Verification of income is required at initial application, redetermination, and when a household reports a change. **Exception:** If the income amount reported makes the household ineligible, no verification of income is required.

Advisors must not ask an individual to provide additional proof if:

- Verification is available through TWC inquiry, BVS, TALX, Child Support Inquiry, or other automated systems that are acceptable verification sources, and accessible to the advisor, or if the individual indicates that verification is readily available in the electronic case record.
- The information is sufficient to establish current eligibility.

Before taking adverse action, allow the individual an opportunity to resolve any discrepancy by providing documentary proof or designating a suitable collateral source.

New Policy
Revised June 1, 2014

The only additions to income verification policy are verification sources for the new income types and expenses under MAGI rules.

As is current policy, advisors must attempt to verify client eligibility criteria using information from electronic sources. Advisors may not request additional information or documentation from clients unless such information is not available electronically or the information obtained electronically is not consistent with the information provided by the client. See TWH A-1370 Verification Requirements and TWH A-1355.2 How to Use Texas Workforce Commission (TWC) Quarterly Wage Information to Budget Earned Income for current policy.

For the following individuals:

- Adults age 19 or older, and
- Who are included on an application or renewal by someone who is unable to apply or renew for them. (See Application Processing for more information on who can apply together on an application.)

Written or verbal consent is needed before:

- Requesting information from electronic data sources, such as Data Broker or SOLQ, or
- Using the individual's information from TIERS if that adult has a case with HHSC (SNAP, TANF, Medicaid or CHIP).

The signature of the person submitting the application or renewal does not provide permission for adults described above. Advisors must attempt to contact the individual whose permission is needed by phone.

When consent is given, advisors may use a Data Broker report and/or information from a known system case. However, advisors must continue to follow the verification policy to ensure the information is not outdated. For more information on verification policy see Verification of Income and Nonfinancial Eligibility Verifications.

If the advisors cannot obtain consent to use Data Broker or existing HHSC data, advisors must deny the application for the individual whose eligibility is being determined.

For example: If a non-custodial parent applies on behalf of a child, information may be needed from the custodial parent to determine that child's eligibility, to include income for the custodial parent. Advisors must obtain consent from the custodial parent before pulling electronic data on that individual, even if the custodial parent's information is available in the system. If the advisor cannot get consent from the custodial parent, request the missing information needed from the custodial parent using Form H1213, Children's health-care benefits: More facts needed from the

parent who has custody. If the custodial parent does not provide consent to use electronic data, deny the child's application.

Verification of Income
Revised December 13, 2014

For all MAGI Programs, verification is required for all countable income used to determine eligibility. Verification of income is required at initial application, redetermination, and when a recipient reports a change in income.

Exception: If the income amount reported makes the recipient ineligible, no verification of income is required.

Staff may only request additional financial verification or documentation from applicants or clients if:

- Verification is not available through electronic data sources, or
- Information obtained electronically is not reasonably compatible with the individual's statement of income provided on the application or at redetermination.

Income from electronic data sources is considered reasonably compatible with income reported by an individual when both the income reported by the individual and electronic data are at or below the applicable income limit. The system will determine whether an applicant's or client's income is reasonably compatible with available electronic data sources.

If the applicant or client statement of income is not determined to be reasonably compatible with electronic data, income must be verified using existing HHSC verification policy (TWH C-900, Verification and Documentation). An individual's statement of income would not be reasonably compatible with electronic data if:

- Applicant or client statement of income is above the applicable FPIL.
- Applicant or client statement of income is below the applicable FPIL, however, electronic data indicate that income may be above the applicable FPIL.
- Applicant or client has unverified countable expenses that need to be verified in order for the individual to be determined income eligible.
- Applicant or client did not provide sufficient information to calculate a monthly income. The individual must provide the income type, income frequency, and income amount.
- Applicant or client has provided more income sources than are available from electronic data.
- Applicant or client has unverified countable income other than earned income, RSDI, or unemployment.
- TIERS is unable to access a third-party system to acquire electronic data, or electronic data was insufficient to complete reasonable compatibility.

For both earned and unearned income verification, do not require the household to provide verification of any pay amount that is older than two months before the interview date for TP 08 or the date action is initiated for all other programs.

Advisors must not require an individual to provide additional verification if:

- Verification is available through, TWC inquiry, BVS, TALX, or other automated systems that are acceptable verification sources, and accessible to the advisor, or if the individual indicates that verification is readily available in the electronic case record.
- The information is sufficient to establish current eligibility.

Because a DataBroker report cannot be requested by TIERS for children under age 16, advisors may request additional verification from the client if earned income is reported by a child under the age of 16 and other electronic data sources are unavailable.

The tables below feature all valid verification sources for all income types under MAGI rules. This includes current verification sources that will continue to be valid under MAGI rules and the new verification sources for the new MAGI income types. As is current policy, verification requirements for income for Children's Medicaid, CHIP and CHIP Perinatal are less restrictive. Valid verification sources for income for all other MAGI Medicaid programs are also considered valid for Children's Medicaid, CHIP and CHIP Perinatal.

Income Verification Sources Under MAGI Rules:
Children's Medicaid, CHIP, and CHIP Perinatal

Those with an asterisk (*) are valid verification sources under current policy (on or before December 31, 2013).

Earned Income and Unearned Income (advisors may accept a copy of one of more of these)	***TALX – The Work Number System
	*TWC wage records, see A-1355.2, How to Use TWC Quarterly Wage Information to Budget Earned Income
	*Paycheck stub issued in the last 60 days
	*Previous year's tax return
	*Most recent Social Security statement or check
	*Proof of self-employment
	*Letter from an employer verifying current income and frequency of payment
	*Most recent proof of other income received

Income Verification Sources Under MAGI Rules:
All Medicaid MAGI Programs (except Children's Medicaid)

Those with an asterisk (*) are valid verification sources under current policy (on or before December 31, 2013).

Contributions	*Statement from person or agency providing the money or making payment for the individual
	*Contribution check or copy of check
	*Cancelled check of person making contribution
Earned Income	*TALX – The Work Number System
	*TWC wage records, see A-1355.2, How to Use TWC Quarterly Wage Information to Budget Earned Income
	*Obtain Form H1028, Employment Verification, completed by the employer. Ensure that all items are completed and the information is consistent. Resolve any discrepancies.

	*View at least two pay amounts in the time period beginning 45 days before the file date through the interview date (or the date the EDG is being processed if an interview is not required). Verify and document any breaks in pay periods. Do not use pay stubs as the only source of verification if the individual: • Began employment in the application or interview month, • Reported new employment after certification, or • Terminated employment in the application month.
	*Contact the employer
	*Use Form H2583, Choices Information Transmittal, if the form is complete and indicates the information was verified with the employer
	*Statement, letter, or records from: • Schools, and • Organizations, clubs, or agencies providing benefits.
Other Income	*Check or copy of check
	*Statement from bank paying dividends and interest
	*Statement from company or union providing pensions or union benefits
	*Form H1050, Check Verification
Other Government Benefits	*Current award notice, letter, or official written statement
	*Check or copy of check
	*Agency contract/record
	*DFPS advisor/representative statement
RSDI	*WTPY/SOLQ
	*Check or copy of check
	*Current award notice, letter, or statement from SSA
	*Direct deposit slip
	*Computer inquiry to Bendex file, if it is consistent with the individual's statement
	*Form H1050, Check Verification
	*SSA, Form 1610, Public Assistance Agency Information Request (if no other source is readily available)
Self-employment	*Previous year's IRS tax return or business records, for self-employment income received less often than monthly
	*Most recent business records and receipts
	*Form H1049, Client's Statement of Self-Employment Income, completed and signed by the individual (Note: Use Form H1049 alone only if collateral contacts or documentary information cannot otherwise verify the income and expenses)
	*Statement of estimated earnings
	*Tax Guide for Small Business
	*Receipts for goods/services provided

Unemployment Compensation	*Check or copy of check
	*Current award notice, letter, or statement from TWC (Note: Other forms of verification must be used in conjunction with Form B-11, Benefits Claim Determination)
	*Former employer
	*TWC inquiry
	*Statement from TWC verifying the primary wage earner's application for unemployment insurance benefits
Unearned Income (capital gains, cancelled debts, court awards, and jury duty)	Statement or official correspondence from company, agency, or organization that provided payment
	Checks, award letters, or check stubs
	Bank statements/deposit slips
	Previous year's tax return
	For voluntary child support, attorney records, a copy of check or check stub, a statement from provider, or support agreement
Approved AI/AN Disbursements	Previous year's tax return (Note: If client does not provide verification, process the case without allowing the income exemption.)

Verification of Expenses
Revised March 1, 2014

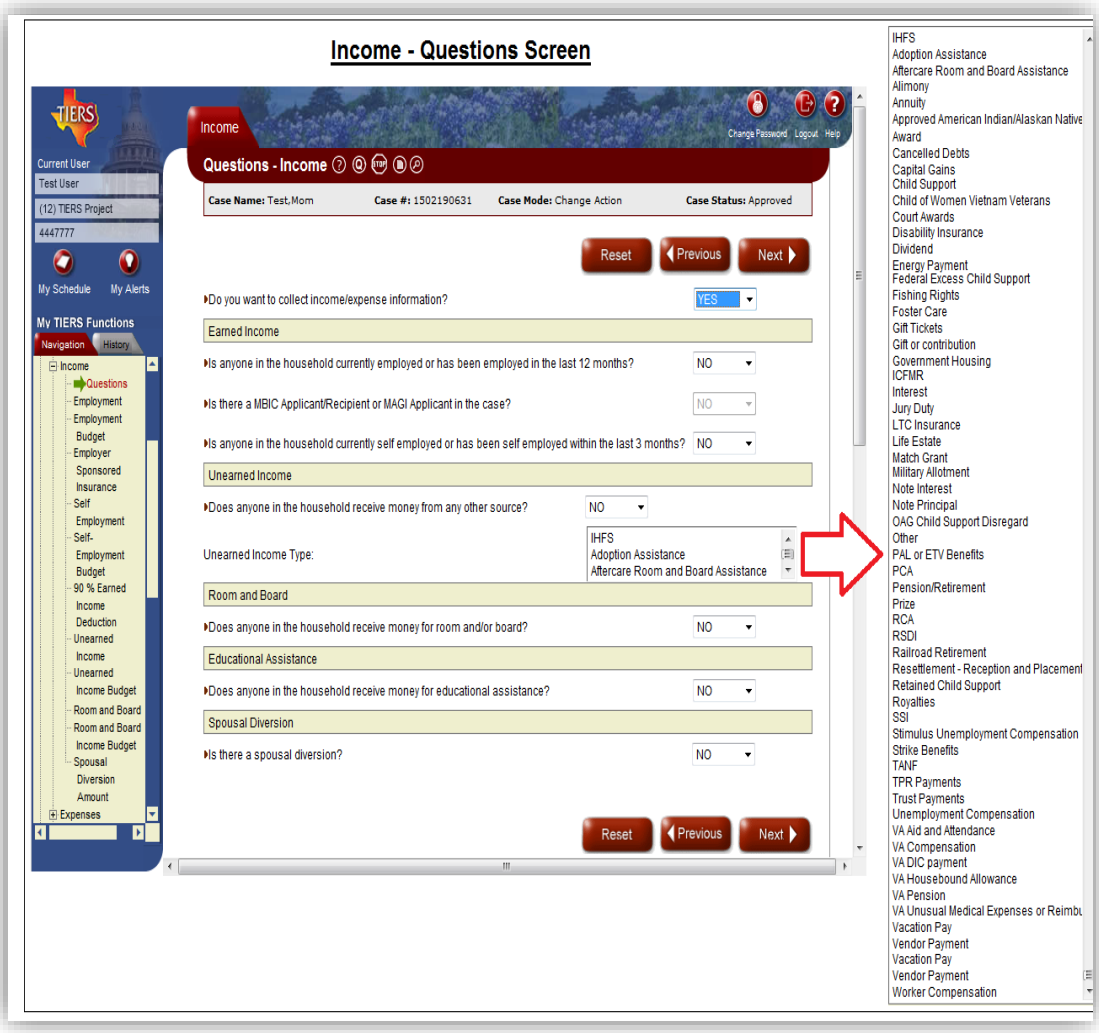
The applicant's or recipient's federal income tax return from the previous year is the only valid verification source that can be used to verify all MAGI expenses except for alimony paid. Applicants or recipients can provide acceptable alimony paid verification sources under TANF policy in TWH A-1441, Verification Sources.

A federal income tax return from the previous year is valid verification for MAGI expenses until the client files a new federal income tax return but no later than April 15 of the following year. If an individual files an extension and submits proof of an extension, the previous year's federal income tax return is valid until October 15. If an applicant or recipient does not file federal income taxes, he or she will not be able to provide verification and, therefore, will not be able to claim any MAGI expenses other than alimony paid.

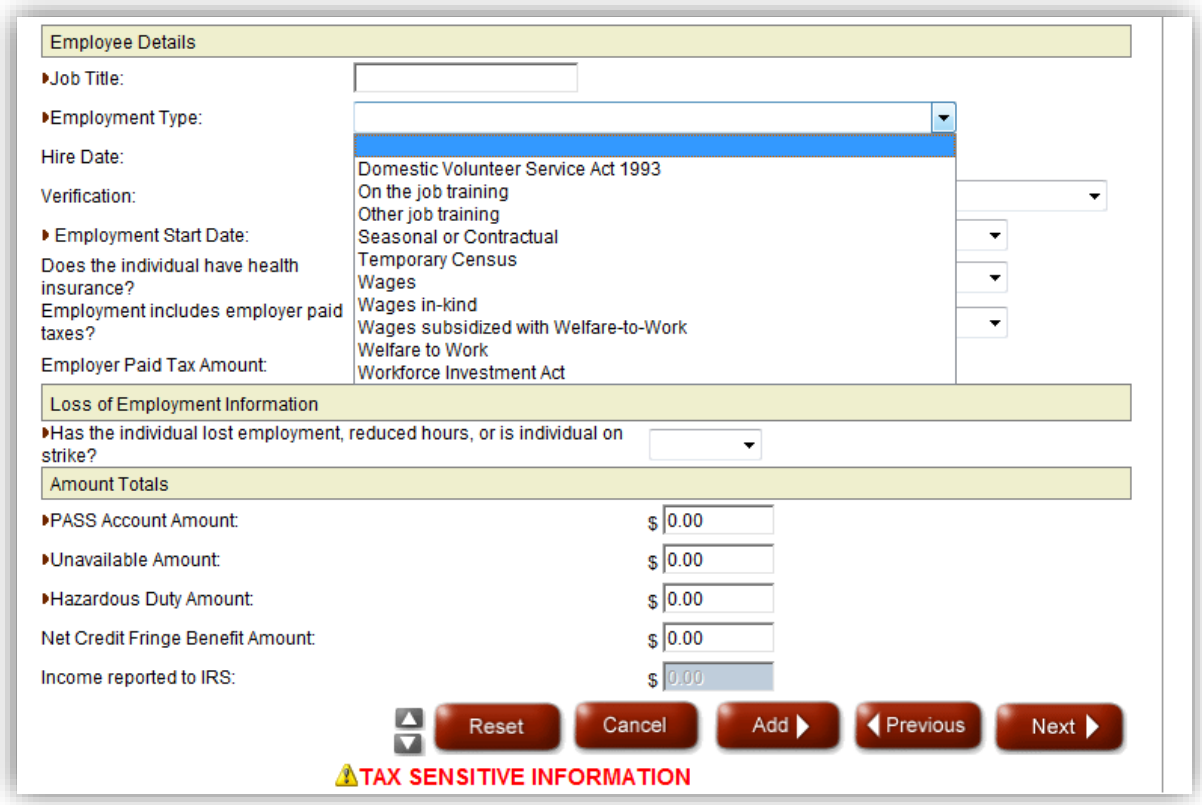
If an applicant or recipient does not provide verification for any MAGI Expenses, process the case without allowing the expense.

Automation
Revised September 1, 2015

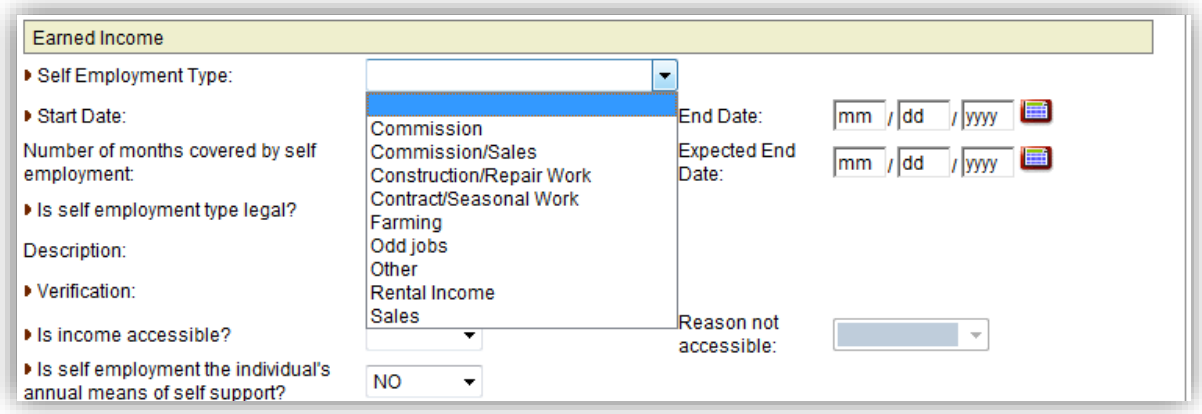
New countable unearned income types have been added in the list on the Income Question Screen. Examples of the income question screens are on the following pages.



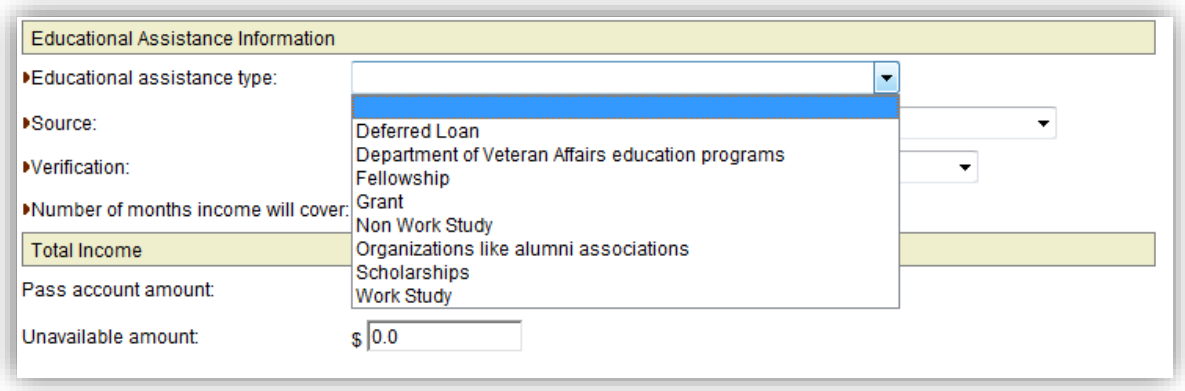
Income Type: Employment – Employment



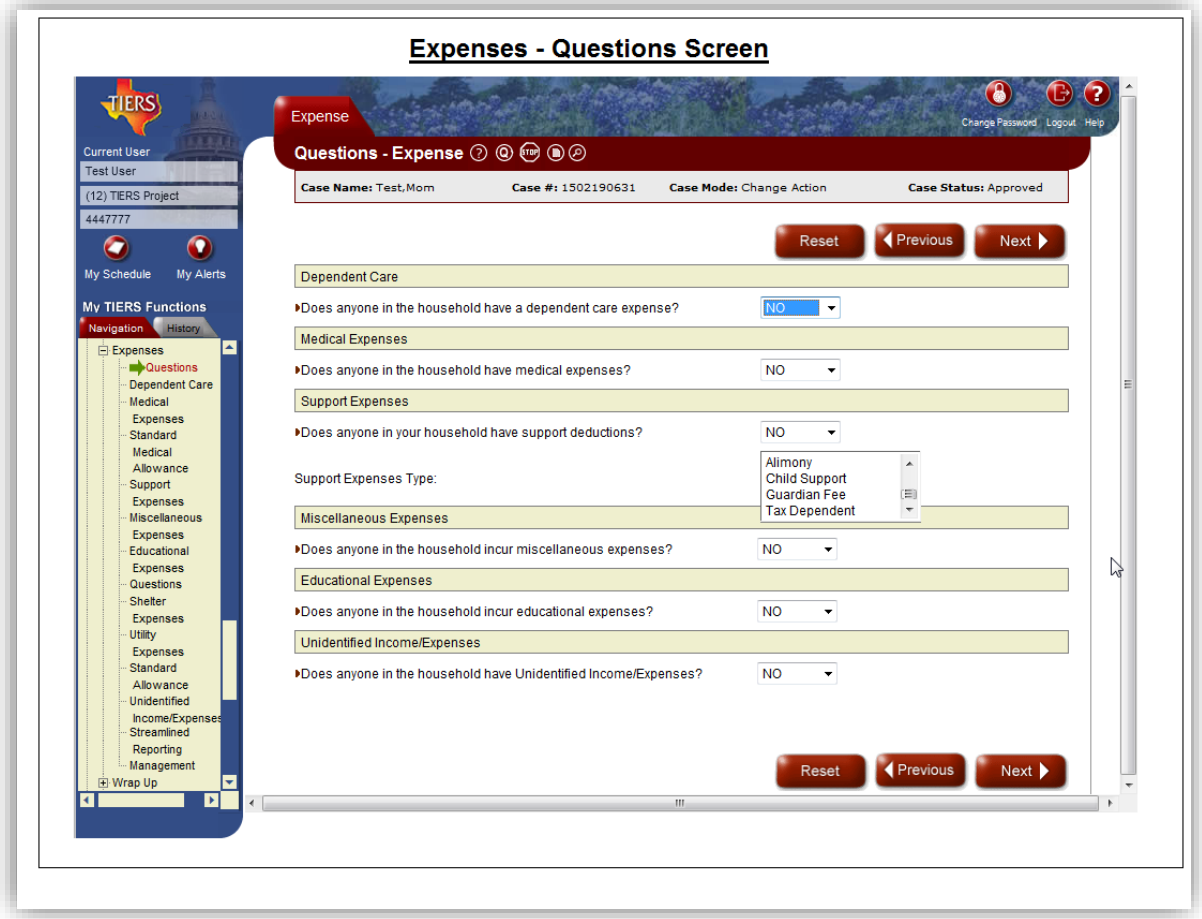
Income Type: Self-employment



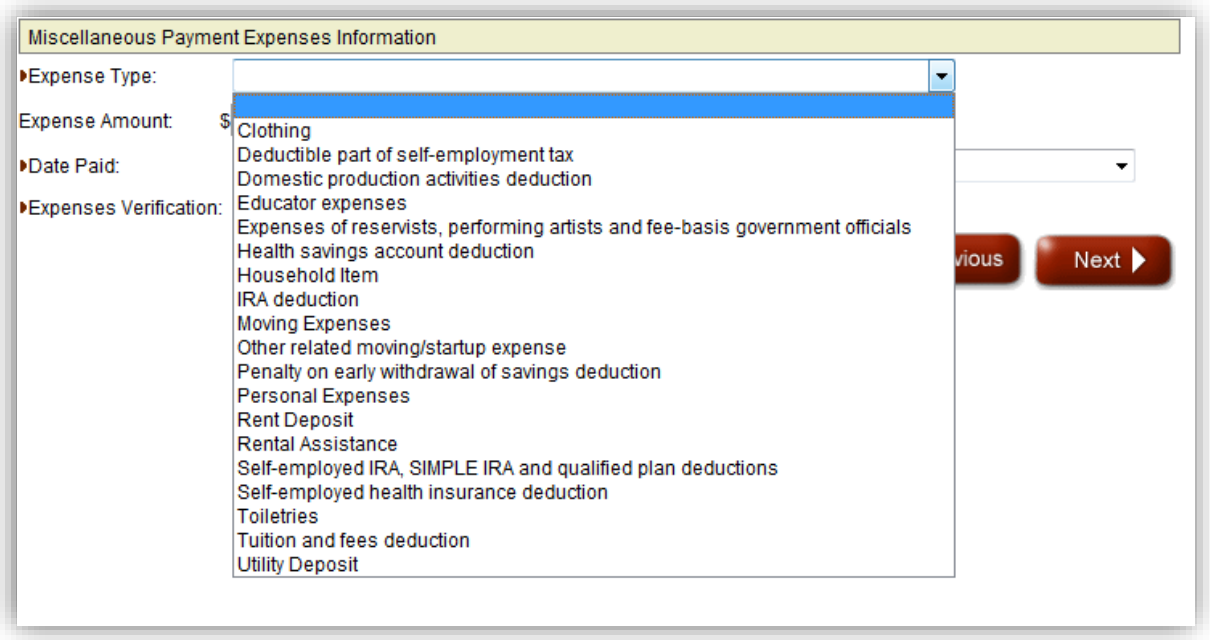
Income Type: Educational Assistance



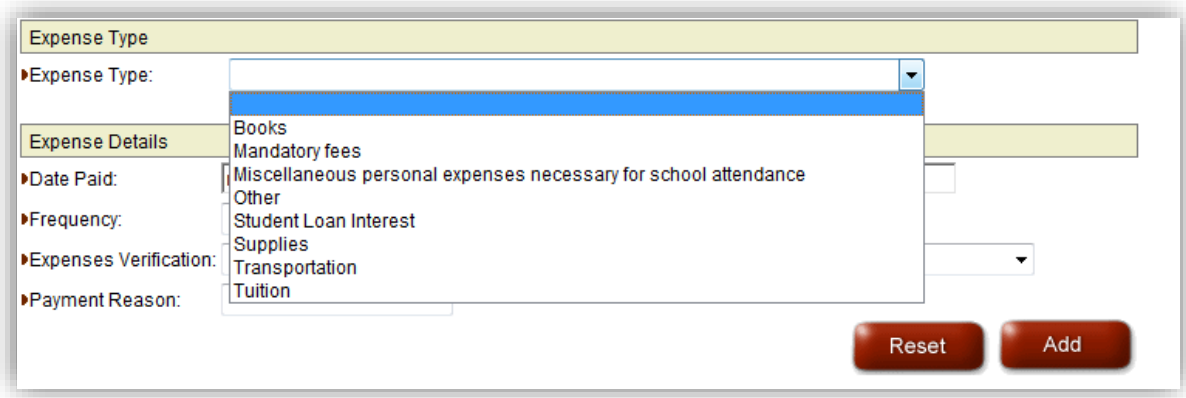
New expenses captured under MAGI rules have also been added to TIERS.



Expense Type: Miscellaneous



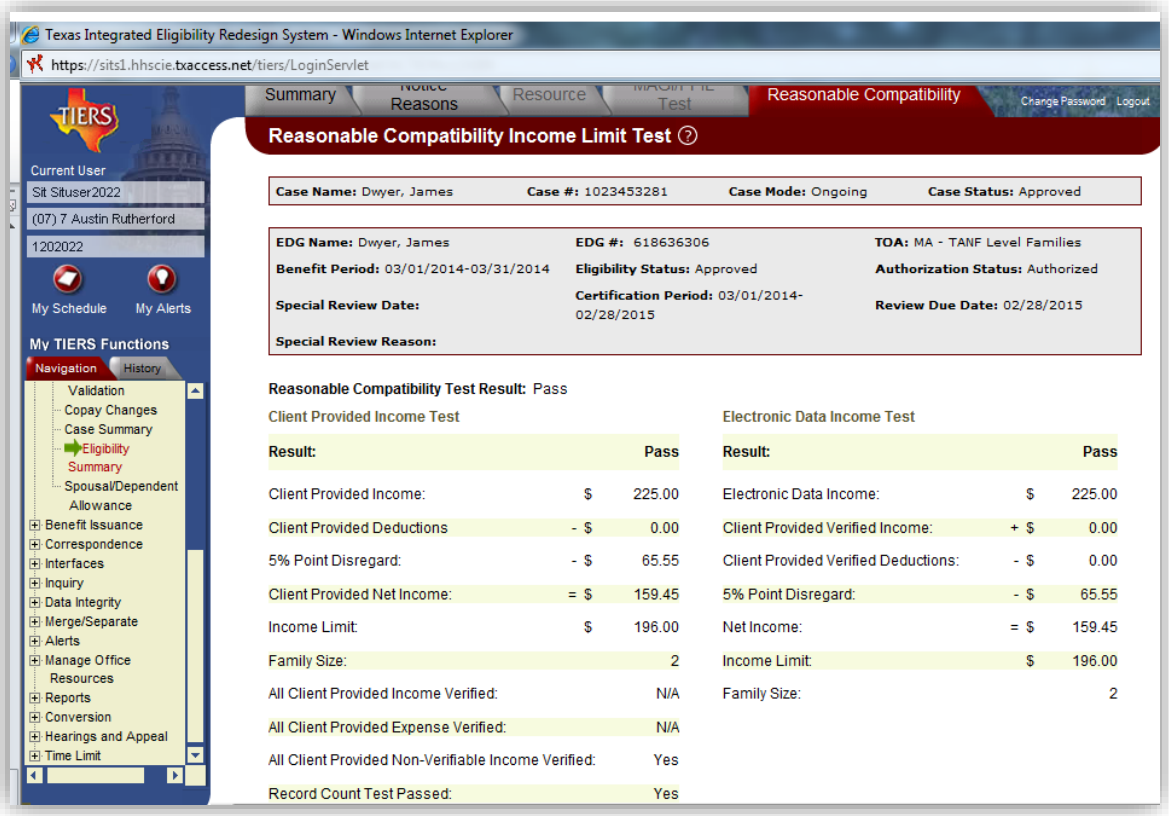
Expense Type: Educational Expenses



The RC Current Client Provided Income/Expense Information LUW collects the applicant's or client's statement of income and expenses.

Two new questions – "Did the client indicate that they have MAGI Countable income?" and "Did the client indicate that they have MAGI Countable expenses?" – have been added to the RC LUW. These questions must be answered before an advisor can dispose a case.

A new LUW has been added to TIERS to display the results of the Reasonable Compatibility calculation for income verification.



There are eight possible results for the Reasonable Compatibility calculation, described in the following table.

TIERS Reasonable Compatibility Calculation Results

TIERS Result	Meaning
"Pass"	Applicant or client statement of income is considered reasonably compatible with electronic data.
"Fail"	Applicant or client statement of income is above the applicable FPIL.
"Need Info because ELDS above limit"	Applicant or client statement of income is below the applicable FPIL.
	Electronic data indicate that income may be above the applicable FPIL.
"Need Info for Expense"	Applicant or client has unverified countable expenses that need to be verified in order for the applicant or client to be determined income eligible.
"Need Info for Incomplete Client Income"	Applicant or client did not provide sufficient information to calculate a monthly income (i.e. the client did not provide the income type, frequency, and/or amount).
"Need Info for Client Income"	Applicant or client has provided more income sources than are available from electronic data.

"Need Info for Non-Verifiable Income"	Applicant or client has unverified countable income other than earned income, RSDI, or unemployment.
"Process Failure"	TIERS is unable to access a third-party system to acquire electronic data, or electronic data was insufficient to complete reasonable compatibility.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on financial verifications will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

MAGI Cascade

Current Policy

Client eligibility is determined using the full eligibility cascade logic at application, redetermination, and while processing a change. The full eligibility cascade is a hierarchical list of all Texas Works Medicaid and MEPD programs. That list is used to build EDGs and evaluate eligibility for HHSC programs and types of assistance. The EDG is built and eligibility is established at the highest level.

New Policy
Revised June 1, 2014

A limited driver flow has been created for applications requesting eligibility only in MAGI Programs. Do not use the limited MAGI driver flow if the applicant is requesting other benefits, including SNAP, TANF, or other medical programs that are not subject to MAGI rules.

This limited driver flow for MAGI programs is enabled when:

- MAGI is selected as a Special Driver Flow.
- The case has only pending or approved MAGI Medicaid or CHIP EDGs.

This minimizes the need to go through LUWs not used in MAGI determinations.

With the implementation of CHIP into TIERS, a limited cascade was previously used when the sub-program request is Children's Insurance. Stop using this limited cascade for Children's Insurance and instead use the MAGI Cascade.

When an application is received and there is a request that indicates MAGI-only benefits, TIERS will support the use of a new Sub Program Code called "MAGI." TIERS will display the MAGI

Sub Program Code value in the Application Registration **Register Program – Program** page in the Sub Program Code field. The MAGI Sub Program Code value is only enabled when the Medicaid programs option is selected. Once the advisor has selected MAGI as the Sub Program Code, TIERS uses the MAGI Cascade to determine eligibility.

Note: If a clerk enters "MAGI" as the Sub Program Code, the advisor can subsequently change the programs, but is not currently able to change the Sub Program Code after Application Registration.

Once eligibility is established, the MAGI cascade continues to be used for redeterminations and while processing a change. Under new federal rules, clients certified on a MAGI TOA must be tested for eligibility for all MAGI TOAs before being determined ineligible for Medicaid and CHIP eligibility. Client eligibility will continue to be determined using the MAGI cascade at application, redetermination, and while processing a change.

Individuals determined ineligible for Medicaid and CHIP will be sent to the Marketplace for an eligibility determination for new federal health care coverage programs. To qualify for the new federal health care coverage programs, all individuals must first be determined ineligible for Medicaid and CHIP. Therefore, it is important to test whether an individual is eligible for all MAGI TOAs. The MAGI cascade does this automatically for most clients, but the advisor must manually request that TIERS run through the MAGI cascade from the beginning for the following clients:

- Minor parents aging out of CHIP
- Minor parents aging out of TP 44, Children Ages 6-18
- A recipient under TP 40, Pregnant Women, once her certification period ends
- An individual terminated from TP 07, TP 20, or TP 37, Transitional Medicaid

All other clients will flow through the MAGI cascade to either the next available program (for example, a child aging out of TP 48 will automatically be tested for TP 44) or will be referred to the Marketplace if determined ineligible for other MAGI programs (for example, a non-parent child aging out of TP 44).

For the manual scenarios, TIERS will trigger an alert to create a TLM task that allows the advisor to re-run the MAGI cascade. The following tasks will be generated on the first day of the last month of the individual's active certification period:

- Minor parents aging out of CHIP:
  - Task Name: Alert 819 CHIP Child Aging Out Test MAGI
  - Routing Location: CCC/CCC-TANF

- Minor parents aging out of TP 44, Children Ages 6-18:
  - Task Name: 823 MA Child Aging Out Test MAGI
  - Routing Location: CCC/CCC-TANF

- A recipient under TP 40, Pregnant Women Medicaid, once her certification period ends:
  - Task Name: Alert 824 Pregnancy Ending Test MAGI
  - Routing Location: CCC/CCC-TANF

- An individual terminated from TP 07, TP 20, or TP 37, Transitional Medicaid:
  - Task Name: Alert 825 Transitional MA Ending Test MAGI
  - Routing Location: CCC/CCC-TANF

TIERS will not terminate enrollment of a minor parent aging out of TP 44 or CHIP, a pregnant woman from TP 40 at the end of the certification period, or an individual at the end of the Transitional Medicaid certification period. Action must be taken by the advisor via the TLM task to review the EDG and re-run eligibility using the MAGI cascade to determine potential eligibility for other MAGI TOAs. To complete the TLM task, advisors must process the manual test for these individuals by entering Data Collection in Complete Action mode. The date that the task is generated is the new file date. This date should be the first of the last month of the current certification period.

The remaining individuals in the client's MAGI household composition are not re-evaluated for eligibility during a continuous eligibility period. Changes to MAGI household composition for the aging out of minors, end of pregnancy, or termination of Transitional Medicaid coverage will be acted upon once the individuals transition from a continuous eligibility period to a non-continuous eligibility period.

Advisors should treat these cases like a redetermination without an actual renewal form. Except in the case of TP 40 where there may be a renewal form and advisors would process the case as they do redeterminations with renewal forms. Advisors must verify information as is currently done in the redetermination process.

Note: An interview is required when testing for TP 08. Please refer to the job aids that were created for both CCC and Local Offices.

Automation

A limited driver flow to make a MAGI determination will be scheduled when MAGI is selected as the Special Driver Flow:

A limited driver flow to make a MAGI determination will be scheduled when the case has only pending or approved MAGI Medicaid programs:

If the advisor receives a statement on the screen like in the screenshot above, unselect MAGI and work the case as is currently done. If there are other pending programs, select the appropriate interview mode.

To manually request the abbreviated MAGI cascade from the beginning of the hierarchy, check the box labeled Re-Evaluate Medicaid. Tasks will be system-generated for the following types of clients:

- Minor parents aging out of CHIP
- Minor parents aging out of TP 44, Children Ages 6-18
- A recipient under TP 40, Pregnant Women, once her certification period ends
- An individual terminated from TP 07, TP 20, or TP 37, Transitional Medicaid

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on the changes to the TOA hierarchy will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

OTHER POLICY

CHIP 90-Day Waiting Periods

Added June 1, 2014

Current Policy

The coverage start date for TA 84, CHIP, is 90 days (three calendar months) after the last month in which a child was covered by a third-party health benefits plan. This waiting period only applies to children who were covered by a third-party health benefits plan (private health insurance) at any time during the 90 days (three calendar months) before the date of application for CHIP. Good cause exemptions apply to children subject to the waiting period.

Applicants for TA 85, CHIP perinatal, are not subject to the 90-day waiting period.

Good Cause Exemptions

The 90-day waiting period for CHIP enrollment may be waived if the household claims one of the following good cause exemptions:

- A parent's employment was terminated due to layoff, reduction in force or the closure of a business;
- The loss of Medicaid eligibility (due to income, resources or the child ages out of Medicaid);
- Dependent coverage was terminated by an employer;
- A parent's insurance benefit under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1984 was terminated;
- The change in a parent's marital status;
- The child is no longer covered by the Texas Employee Retirement System;
- A loss of CHIP eligibility from another state;
- The health insurance coverage for the child(ren) costs 10% or more of the household's net income;
- Other circumstances similar to those described that result in an involuntary loss of insurance coverage; or
- HHSC determines that good cause exists based on information provided by the applicant or information otherwise obtained by HHSC.

Note: A child does not meet a good cause exemption to the 90-day waiting period if the child's Medicaid was terminated due to failure to submit a redetermination application or failure to provide information to complete the redetermination.

A household may declare good cause at any point during the application processing or after eligibility is determined. A household can claim a good cause exemption via:

- Checked boxes on the application. Most of the good cause exemption criteria are captured on the CHIP and Children's Medicaid application. If the household checks "Other," but both the "Date the health coverage ended" and "cost of insurance" sections are blank, do not grant a good cause exemption.
- Telephone or in writing. Accept the household's self-declaration of a good cause exemption to the CHIP 90-day waiting period.

Children exempt from the 90-day waiting period, whose households subsequently report a change that nullifies the exemptions, become subject to the 90-day waiting period. The child(ren)'s scheduled coverage date is determined from the date the eligibility determination is made.

New Policy

Good Cause Exemptions

Children are not subject to the 90-day waiting period for CHIP enrollment if the household meets the following good cause exemptions:

- A parent's insurance benefit under COBRA was terminated;
- A change in a parent's marital status;
- The child is no longer covered by the Texas Employee Retirement System;
- A loss of CHIP eligibility from another state;
- *Involuntary loss of insurance coverage;
- *The employer stopped offering health insurance coverage for dependents (or any coverage);
- *A change in employment, including involuntary separation, resulted in the child's loss of coverage (other than through full payment of the premium by the parent under COBRA);
- *The loss of Medicaid coverage for any reason;
- *The loss of coverage in any insurance affordability program, including APTCs, CSRs, Medicaid, and CHIP;
- *The premium paid by the family for coverage of the child under the group health plan is more than 5 percent of the MAGI household income;
- *The premium that a family pays for the family's coverage that includes the child is more than 9.5 percent of the MAGI household net income;
- *Death of a parent;
- *The child has special health care needs;
- HHSC determines that good cause exists based on information provided by the applicant or information otherwise obtained by the agency; or
- *HHSC Directive—other reasons for an exemption that has not yet been defined by HHSC.

Note: The exemptions marked with an ***** are new or expanded exemptions, and are effective June 1, 2014.

An applicant may declare an exemption at any point during the application processing or after eligibility is determined. An applicant can claim a good cause exemption as follows:

- On the Form H1010, Your Texas Benefits
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs
- On the Form H1010-M, Applying for or Renewing Medicaid or CHIP?.
  - Addendum, Section 5 – Insurance Offered Through Your Job; and
  - Appendix A, Health Coverage From Jobs
- On the Form H1205, Texas Streamlined Application

  - Step 5 – Your Family's Health Coverage; and
  - Appendix A, Health Coverage From Jobs
- By SSP
- By telephone
- In writing

Accept the client's self-declaration of a good cause exemption to the CHIP 90-day waiting period, except as follows.

Do not grant the applicant or client a good cause exemption to the CHIP 90-day waiting period if all of the following are true:

- Selects "other" as the reason the insurance from job ended,
- The end date of the health insurance coverage from a job is left blank, and
- The cost of the insurance coverage from a job is left blank.

Children exempt from the 90-day waiting period, who subsequently report a change that nullifies the exemptions, become subject to the 90-day waiting period. The child(ren)'s scheduled coverage date is determined from the date the eligibility determination is made.

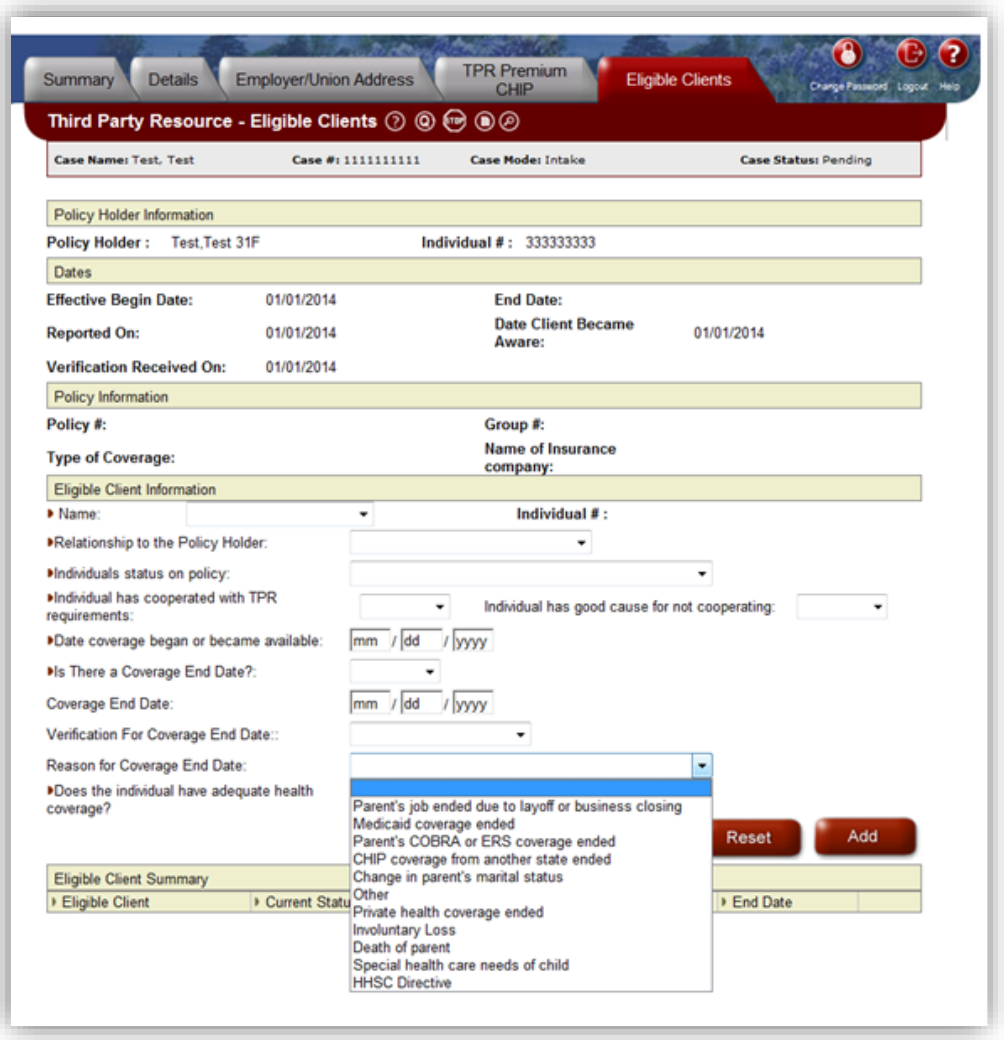
CHIP perinatal applicants are not subject to the 90-day waiting period.

Account Transfers

If a client is determined eligible for CHIP but is subject to the 90-day waiting period, HHSC will transfer that individual's account information to the Marketplace to be assessed for eligibility for other health care coverage programs. This is done to allow the individual access to coverage during the 90-day waiting period and to avoid sanctions for failing to acquire health coverage.

Automation

CHIP 90-Day waiting period exemptions have been added/updated in TIERS, as can be seen on the following screenshot.



Effective Date

Changes to policy are effective June 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Nonfinancial Eligibility Verifications

New federally-required eligibility rules require advisors to attempt to verify client eligibility criteria for Medicaid programs and CHIP using information from electronic sources. Advisors may not request additional information or documentation from applicants or clients unless such information is not available electronically or the information obtained electronically is not consistent with the information on the application.

Advisors cannot ask an individual to provide additional proof if:

- Verification is available through TIERS inquiry, TWC inquiry, BVS, TALX, Child Support Inquiry, or other automated systems that are acceptable verification sources, and accessible to the advisor, or if the individual indicates that verification is readily available in the electronic case record; and
- The information is sufficient to establish eligibility.

Although this has previously been agency policy, it is now required by federal law.

Verifications Provided by the Marketplace

Current Policy

HHSC does not currently transfer applicant information to/from the Marketplace.

New Policy

When an applicant submits an application to the Marketplace and that application is sent to HHSC via an account transfer, a PDF will be populated with information provided by the applicant on the Marketplace application. The information provided on the PDF should be entered into TIERS in the same manner as information provided on an application from YourTexasBenefit.com.

For Marketplace account transfers, the PDF will also include a "Verifications" section. Advisors should use the verification section as follows:

- If the Marketplace has verified the applicant's SSN or citizenship status using data from SSA, advisors can identity that information in TIERS as "Verified by SSA."
- If the Marketplace has verified the applicant's alien status using data from DHS, advisors can identity that information in TIERS as "Verified by DHS."
- All other applicant information, such as income, must be verified by an HHSC advisor, regardless of whether the Marketplace has identified the information as verified.

For more information on Marketplace account transfers, please see Coordinating With the Marketplace.

Automation

Automation changes are discussed in the Marketplace Automation section.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to TIERS.

Citizenship and Social Security Number

Current Policy

All applicants must provide an SSN—except for Emergency Medicaid (TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36)—or apply for one through SSA before certification—except for TP 45, Newborn Children, and TA 85, CHIP-P.

Citizenship for all Medicaid programs and CHIP must be verified—except for Emergency Medicaid.

Current Medicare and SSI recipients are exempt from the verification requirement. Individuals who are receiving RSDI based on disability, and are in a 24-month waiting period to receive Medicare, are considered Medicare recipients for the citizenship, and identity verification requirement.

New Policy

Revised September 1, 2015

All applicants must provide an SSN, and advisors must verify citizenship and SSN at application for applicants/recipients of MAGI Programs and Non-MAGI Programs, except for the following:

- TP 45, Newborn Children
- TA 85, CHIP-P
- TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36, Emergency Medicaid

If an applicant cannot provide an SSN, the advisor must verify that the applicant applied for an SSN or meets a good cause reason. If the individual has an SSN, the advisor uses SSA records to verify citizenship and the individual's SSN in real time through SOLQ. If the SOLQ system is unresponsive or unavailable due to system failure, the advisor must attempt to verify using WTPY.

Applicants do not need to provide an SSN if they meet any of the following good cause reasons:

- They are not eligible to receive an SSN;
- They do not have an SSN and may only be issued an SSN for a valid non-work reason; or
- They refuse to obtain an SSN because of a well-established religious objection. A well-established religious objection exists when the applicant:
    - Is a member of a recognized religious sect or division of the sect; and
    - Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

Form H1106, Enumeration Referral, completed by SSA, is the acceptable verification source for not providing an SSN due to ineligibility to receive an SSN or eligibility to receive an SSN only for a valid non-work reason. Advisors must review the response provided by SSA on the Form H1106 to determine which good cause reason the applicant meets.

Acceptable sources of verification for a well-established religious objection include:

- An approved IRS Form 4029 – Application for Exemption from Social Security and Medicare Taxes and Waiver of Benefits; or
- A letter from a leader of the religious organization, a document setting out the tenets of the religious organization which justify the good cause reason, or a similar document.

Note: If the source of verification for a religious exemption is questionable, advisors must contact their supervisor who will coordinate with the HHSC Regional Attorneys to ensure the documentation is sufficient.

Non-applicants are not required to provide an SSN or proof of an application for an SSN. Undocumented aliens applying for Emergency Medicaid are also not required to provide an SSN.

If the advisor is unable to verify the SSN using SOLQ or WTPY:

- Review the information entered into the SOLQ or WTPY request with the information provided by the applicant. If a typographical error is found, submit a new SOLQ or WTPY request with the correct information.
- If no typographical errors are found, contact the applicant by phone to ensure the information provided is accurate. If the applicant provides new information, submit another SOLQ or WTPY request with the correct information. Update the EDG record with the correct information.
- If unable to contact the applicant by phone, send the applicant Form H1020 to request verification of the applicant's SSN along with any additional information needed. Allow the individual 10 days to provide proof.
- If the individual fails to cooperate in clearing the discrepancy with the SSA, follow procedures in TWH A-420, Failure to Comply.

The system attempts to verify citizenship using SOLQ through ELDS. If the SOLQ system is unresponsive or unavailable due to system failure, advisors must attempt to verify using WTPY.

If the SSN is verified, WTPY provides a response code for verification of citizenship. Follow the steps in the chart below to determine the required advisor action for each response code. These response codes are only provided for Medicaid or CHIP requests.

If the WTPY response code is…	**then…**
A SSN is verified, there is no indication of death, and the allegation of citizenship is consistent with SSA data	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification dropdown menu 2. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the citizenship verification dropdown menu

B SSN is verified, there is no indication of death, and the allegation of citizenship is **NOT** consistent with SSA data	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification dropdown menu 2. See process **"If unable to verify citizenship (Code B)"** below
C SSN is verified, there is indication of death, and the allegation of citizenship is consistent with SSA data	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification dropdown menu 2. Treat the death information as a change using policy in TWH B-600 Changes
D SSN is verified, there is indication of death, and the allegation of citizenship is **NOT** consistent with SSA data	1. Select "Verified by SSA (SOLQ, WTPY, and HUB)" in the SSN verification dropdown menu 2. Treat the death information as a change using policy in TWH B-600 Changes

If unable to verify citizenship (Code B)…

Advisors should attempt to verify citizenship using BVS.

1. If unable to verify citizenship using BVS and additional information is required to determine eligibility, request the additional information and verification of citizenship, and allow the individual at least 10 days to provide proof.

    - If the client does not return the additional information by the final due date, deny the case for failure to provide required information.
    - If the client provides the additional information, but does not provide verification of citizenship, allow the individual a period of reasonable opportunity to provide the verification of citizenship.

2. If unable to verify citizenship using BVS and no other information is required to determine eligibility, allow the individual a period of reasonable opportunity to provide the verification without pending the EDG.

After allowing reasonable opportunity, if the recipient refuses or fails to provide proof, deny the individual until proof of citizenship is provided. See further information provided on Reasonable Opportunity.

SOLQ or WTPY responses may also include information on the receipt of SSI or RSDI. Refer to the MAGI Calculation section for more information on the treatment of RSDI and SSI income.

If the WTPY system is unresponsive or unavailable due to system failure, advisors must not deny or delay certification of Medicaid or CHIP coverage for failure to verify SSN or citizenship. If the WTPY system is unresponsive or presents an error message advisors must:

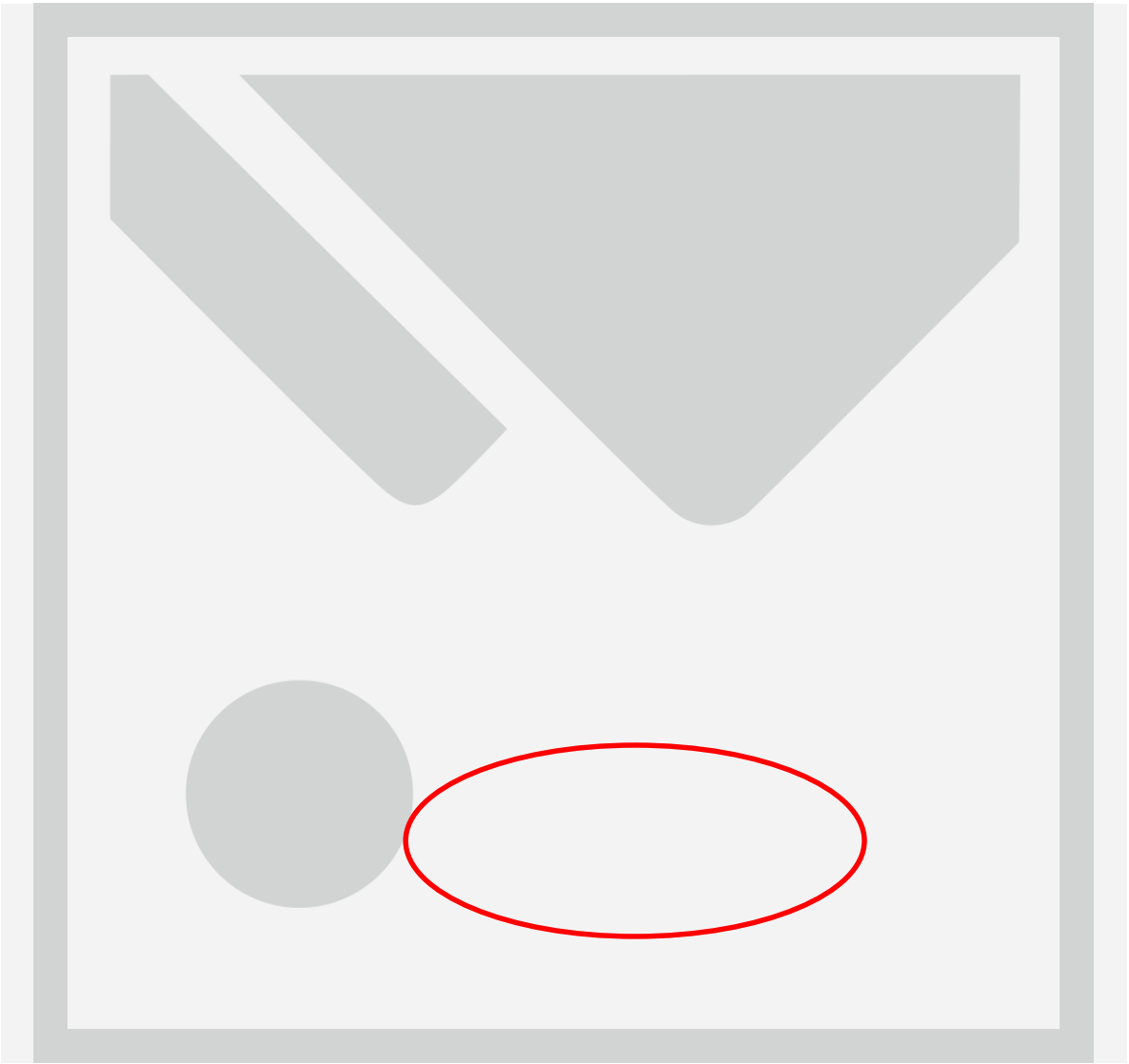
- Enter the SSN as provided by the applicant into TIERS and allow the automated SSA interface to verify the SSN.
- Allow the individual a period of Reasonable Opportunity to provide the verification of citizenship.

Automation
Revised September 1, 2015

TIERS will allow advisors to select "Verified by SSA (SOLQ, WTPY, HUB)" in the SSN Verification dropdown when the SSN was verified using SOLQ or WTPY. When the advisor selects this value, the "Validated by SSA" checkbox will be automatically selected.

TIERS will continue to verify any unverified SSNs through the SSA interface. Validation of an SSN through the SSA interface will also be identified by the "Validated by SSA" checkbox.

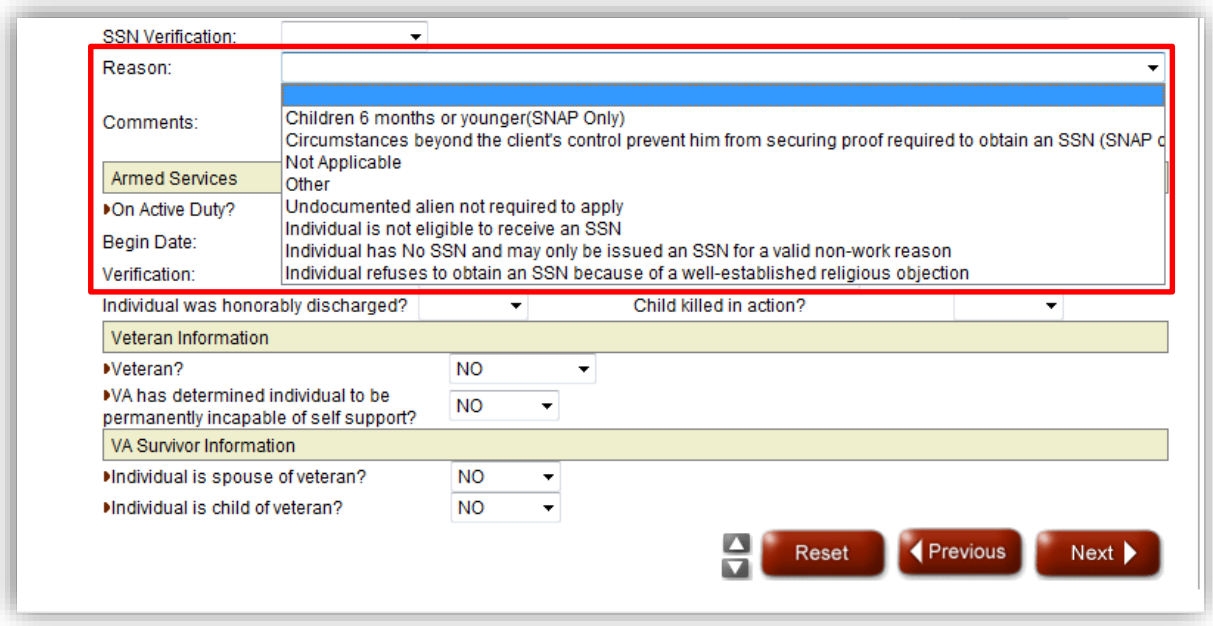
TIERS will also allow advisors to select "Verified by SSA (SOLQ, WTPY, HUB)" in the Citizenship Verification dropdown when citizenship was verified using SOLQ or WTPY.



A “Reason” field has been added to the **Individual Demographics-SSN/Armed Services** page to allow advisors to select good cause when the individual cannot provide an SSN for one of the reasons listed.

When the advisor selects any of the following new good cause reasons they will be required to document in the “Comments” text box how the good cause reason was verified:

- Individual is not eligible to receive an SSN;
- Individual has no SSN and may only be issued an SSN for a valid non-work reason; or
- Individual refuses to obtain an SSN because of a well-established religious objection.



Effective Date

Changes to policy are effective October 1, 2015.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on verifications will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Training on new good cause exemptions to providing an SSN will be presented in the web-based course titled “Course R94-2 – SSN Requirements.”

Reasonable Opportunity

Current Policy

Medicaid and CHIP applicants or recipients who declare themselves to be U.S. citizens, have applied for an SSN but have not been issued one, and do not provide verification of citizenship must be allowed a period of reasonable opportunity to provide verification of citizenship.

Reasonable opportunity is defined as the period of time from the certification date until the next complete eligibility determination.

For TP 40, Pregnant Women, the reasonable opportunity period is the period from the file date until 30 days from the application file date.

New Policy
Revised September 1, 2014

The following programs require verification of citizenship or alien status and are affected by this section:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 40, Pregnant Women
- TP 70, Medicaid for Transitioning Foster Care Youth
- TA 82, Former Foster Care Children
- TA 84, CHIP

Reasonable opportunity is defined as the 95-day period an individual is allowed to provide another source of citizenship or alien status verification. Medicaid and CHIP applicants or recipients who declare themselves to be U.S. citizens or declare an alien status, but for whom verification of citizenship or alien status is unavailable, must be allowed a period of reasonable opportunity to provide verification of citizenship or alien status.

Applicants for TP 40 must also be given a reasonable opportunity period of 95 days.

All new applicants must be given a period of reasonable opportunity regardless of whether they have received a reasonable opportunity period on a previous application.

The reasonable opportunity period may be triggered under the following conditions:

- The individual is unable to provide an SSN needed to electronically verify citizenship with SSA.
- There is an inconsistency between the data available from an electronic source and the individual’s declaration of citizenship or alien status.
- Electronic verification is unsuccessful, including agency efforts to resolve any inconsistencies, and additional documentation is still needed.

At application, redetermination, and when adding a person, if the individual does not provide proof of citizenship or alien status and no other information is required to determine eligibility, certify the individual for Medicaid if all other eligibility requirements are met. The TF0001, Notice

of Case Action, informs the applicant citizenship or alien status verification is required within 95 days and lists the names of each individual who must provide citizenship or alien status verification. The 95 day period begins when the TF0001 is generated.

If additional information is required to determine eligibility, request the additional information and verification of citizenship or alien status. If citizenship or alien status verification is the only information that is not provided, do not delay certification or deny the application. The TF0001 informs the applicant that citizenship verification will be required within 95 days and lists the names of each individual who must provide citizenship or alien status verification.

The day the reasonable opportunity period expires (the 95th day), TIERS will generate an alert that will create a task. Deny the individual if the individual has not provided citizenship verification.

The new reasonable opportunity period replaces the WTPY Citizenship Verification Period. Advisors should not allow a WTPY Citizenship Verification Resolution Period. Instead, the advisor should certify the case and allow a reasonable opportunity period for the client to verify citizenship.

For MTFCY and FFCC applicants received via the DFPS interface, the citizenship and alien status of most individuals has been verified.

For MTFCY and FFCC applicants who were not received via the DFPS interface, if citizenship or alien status is not verified, a period of reasonable opportunity may be granted if necessary. For more information, see the section on Medicaid for Transitioning Foster Care Youth (MTFCY).

Automation
Revised March 1, 2014

TIERS will trigger an alert with a corresponding TLM task (Alert 796 Reasonable Opportunity Period Has Expired for EDG XXXXX TX Works: - Route to CCC / CC-TANF) for all Medicaid and CHIP TOAs that require citizenship verification when the 95 days of reasonable opportunity is met for an individual. The alert will be set on the date the reasonable opportunity period expires (the 95th day). Deny or disqualify the individual if the individual has not provided citizenship verification.

When reasonable opportunity is being provided for verification of citizenship, staff can select "Not Verified" or "Client Statement" as the verification source. When reasonable opportunity is being provided for verification of alien status, staff must select "Other Acceptable" as the verification source. For both situations, staff must document in TIERS Case Comments that the reason those verification sources are being used is because they are granting reasonable opportunity.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on verifications will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Citizenship and Identity

Current Policy

Verification sources are divided into four levels: primary, second, third, and fourth. Primary sources establish both citizenship and identity. Sources that establish only citizenship are divided into second, third, and fourth levels based on the reliability of the source.

If using a source from the second, third, or fourth levels, the individual must also provide an additional source from the Medicaid and CHIP identity verification sources. Do not use the same source to verify identity that was used to verify citizenship and vice versa.

New Policy

The following programs are affected by this section:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 40, Pregnant Women Medicaid
- TP 70, MTFCY
- TA 82, FFCC
- TA 84, CHIP; and TA 85, CHIP-P

Verification sources are divided into two levels: Level 1 and Level 2. Level 1 sources establish both citizenship and identity. Level 2 sources only establish citizenship.

If using a source from the Level 2, the individual must also provide an additional source from the Medicaid and CHIP identity verification sources. Do not use the same source to verify identity that was used to verify citizenship.

	Current Policy	New Policy	
Primary Level	SOLQ/ WTPY	Same	Level 1
	U.S. passport	Same	
	Certificate of Naturalization (DHS Forms N-550 or N-570)	Same	

Certificate of U.S. citizenship (DHS Forms N-560 or N-561)	Same
SDX for denied SSI recipients when the denial reason is for any reason other than citizenship	Same
Evidence of membership or enrollment in a federally recognized tribe	Same
SOLQ/ WTPY and documentation on reason for Medicare denial	Same
Inquiry reflecting a current or denied TP 45 Medicaid EDG	Same
CHIP-P inquiry reflecting a current or denied CHIP-P case for the child	Same

Second Level

A U.S. public birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (if born on or after Jan. 13, 1941)*, Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after Jan. 17, 1917), American Samoa, Swain's Island or the Northern Mariana Islands (after Nov. 4, 1986)*	Same
Vital Statistics Unit certificate	BVS Inquiry
Report of Birth Abroad of a U.S. Citizen (FS-240)	Same
Certification of Birth Abroad (FS 545 or DS-1350)	Same
U.S. Citizen identification card (Form I-179 or I-197)	Same
Northern Mariana identification card (I-873)	Same
Final adoption decree showing the child's name and U.S. place of birth	Same
Evidence of U.S. Civil Service employment before June 1, 1976	Same
U.S. military record showing a U.S. place of birth (Example: DD-214)	Same
SAVE for naturalized citizens	Same

Level 2

	If a child has not yet received a Certificate of Citizenship, N-560 or N-561, evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000, which includes: • Proof that at least one parent of the child is a U.S. citizen, by birth or naturalization; • Proof that the child is under age 18; • Proof that the child is residing in the U.S. in the legal and physical custody of the U.S. citizen parent; • I-551, Permanent Resident card; and • I-551 with annotation of IR-3 or IR-4, if an adopted child.	Same
Third Level	Hospital record of birth showing a U.S. place of birth	Same
	Life, health, or other insurance record showing a U.S. place of birth	Same
	Religious record of birth recorded in the U.S. or its territories within three months of birth, which indicates a U.S. place of birth showing either the date of birth or the individual's age at the time the record was made	Same
	Early school record (preschool or daycare) showing a U.S. place of birth	Same
Fourth Level	Federal or state census record showing U.S. citizenship or a U.S. place of birth.	Same
	Vital Statistics Unit official notification of birth registration showing a U.S. place of birth	Removed
	Institutional admission papers from a nursing facility, skilled care facility or other institution showing a U.S. place of birth	Same
	Medical (clinic, doctor, or hospital) record, excluding an immunization record, showing a U.S. place of birth	Same
	Statement showing a U.S. place of birth signed by the physician or midwife who was in attendance at the time of birth	**NEW:** An affidavit signed by another individual, regardless of blood relationship to the individual, under penalty of perjury who can reasonably declare to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. Use only as a last resort when other evidence is not available.
	Form H1097, Affidavit for Citizenship/Identity, from two adults regardless of blood relationship to the individual. The individual may be a U.S. citizen by birth or naturalization. Use only as a last resort when other evidence is not available.	

Copies of the document used to verify citizenship must be legible and non-questionable. Submit a copy of the document for imaging.

*Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. See TWH C-932, Advisor Responsibility for Verifying Information, for information regarding assisting an individual in obtaining birth verification from Puerto Rico.

Advisors should not re-verify citizenship after initial application.

Sources Used to Verify Identity Only

- One of the following is acceptable, if the document has a photograph or other identifying information such as, but not limited to, name, age, sex, race, height, weight, eye color, or address:
  - Driver's license issued by a state or territory;
  - School identification card;
  - U.S. military card or draft record;
  - Identification card issued by the federal, state, or local government with the same information included on driver's licenses;
  - Military dependent's identification card; or
  - U.S. Coast Guard Merchant Mariner card;
- Native American Tribal document;
- Signed application for Medicaid (including the signature of an authorized representative acting on the individual's behalf):
  - This is applicable for all individuals on the application except the signee (no person may declare to their own identity);
- Two or more corroborating documents (examples include, but are not limited to, marriage licenses, divorce decrees, or high school diplomas);
- For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records; or
- Form H1097, Affidavit for Citizenship/Identity, signed by another individual, regardless of blood relationship to the individual, under penalty of perjury who can reasonably declare to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. Use only as a last resort when other evidence is not available.

If using a document from this list, the individual must also provide an additional document from the list of Medicaid and CHIP citizenship verification sources. Do not use the same document to verify identity that was used to verify citizenship and vice versa.

Individuals born in Puerto Rico must provide a birth certificate issued on or after July 1, 2010, unless certified previously using a birth certificate issued before July 1, 2010. See TWH-932 Advisor Responsibility for Verifying Information for information regarding assisting an individual in obtaining birth verification from Puerto Rico.

There are no changes to acceptable verification for alien status for Medicaid or CHIP. See TWH-300 Citizenship and Alien Status for information regarding acceptable verification for alien status.

American Indian/Alaska Natives (AI/AN)

Individuals can still self-declare AI/AN status. Form H1205, Texas Streamlined Application, and Form H1010, Texas Works Application for Assistance – Your Texas Benefits, include a general question asking whether anyone in the household is an American Indian or Alaska Native

member of a federally recognized tribe. There may be instances where “yes” is selected on the application for this question but information is never provided by the applicant in Appendix B-*American Indian or Alaska Native Family Member (AI/AN*) identifying the member of the MAGI household composition to whom the status applies. If the name of the individual claiming AI/AN status is not provided, AI/AN status is considered not verified.

If the applicant reports that someone living at that physical address receives AI/AN income and includes an amount, but does not provide the name of the individual receiving the AI/AN income, TIERS will pend for missing information:

- If the applicant fails to provide the missing information by the final due date, the EDG will be denied for failure to provide information.
- If the applicant provides the name of the individual receiving the AI/AN income, but does not provide verification for the income type, the income will be counted instead of being exempt. However, the EDG will not be denied for failure to provide information. The applicant will still be eligible for exemptions from cost-sharing if they are eligible for CHIP.

If the applicant indicates someone is eligible to receive services from Tribal/Indian Health Services, but the name of the individual receiving services is not included, TIERS will pend for the name. If the name is not provided by the final due date, the EDG will not be denied, but the exemption will not be allowed for cost sharing if the applicant is eligible for CHIP.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on verifications will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Case Disposition

Certification Periods

Current Policy

TP 08, Parents and Caretaker Relatives Medicaid, does not have certification periods. Instead, TP 08 remain open until denied. The TANF and TP 08 periodic review due date is calculated from the date the advisor disposes the EDG as follows:

- Applications:
  - Eleven months for payee EDGs with income of less than $3.
  - Five months for other EDGs.

- Reviews:
  - Twelve months for payee cases with income of less than $3.
  - Six months for other cases.

For TP 43, TP 44, and TP 48, the review due date is calculated from the date the advisor disposes the EDG as follows:

- Applications – five months.
- Redeterminations – six months from the last review date.

Children under age 19 are continuously eligible for TP 43, TP 44, TP 47, and TP 48 for six months or through the month of their 19th birthday, whichever is earlier.

Children enrolled in CHIP and CHIP-P are enrolled for 12 months of continuous coverage. If a household reports a change in household size or income that would otherwise impact the household's eligibility, there is no disruption to the child's eligibility. CHIP households with income above 185 percent FPIL are subject to the six-month income check.

New Policy

Effective January 1, 2014, the ACA requires eligibility redeterminations of clients in MAGI Programs to occur every 12 months. Therefore, most MAGI groups will receive a 12-month certification period.

Certification periods for the following type programs are not changing as a result of MAGI rules, and are not addressed in this bulletin:

- TP 40, Pregnant Women
- TA 31, TP 32, TP 33, TP 34, TP 35, and TP 36, Emergency Medicaid
- TP 45, Newborn Children
- TP 02, Refugee Medical Assistance
- TA 84, CHIP
- TA 85, CHIP-P
- TP 70, Medicaid for Transitioning Foster Care Youth

TP 08, Parents and Caretaker Relatives Medicaid, has a 12-month certification period that will remain non-continuous. The estimated eligibility end date is estimated from the date the advisor disposes the EDG as follows:

- Applications – eleven months.
- Redeterminations – 12 months from the last review date.

The certification period for a child certified for TP 43, TP 44, and TP 48, is the earliest of:

- Twelve months, or
- Through the month of the child's 19th birthday.

For these TOAs, the first six-month period is a continuous eligibility period and the second six-month period is a non-continuous eligibility period. The estimated eligibility end date is estimated from the date the advisor disposes the EDG as follows:

- Applications – 11 months.
- Redeterminations – 12 months from the last review date.

For more information on continuous eligibility, see the Changes section.

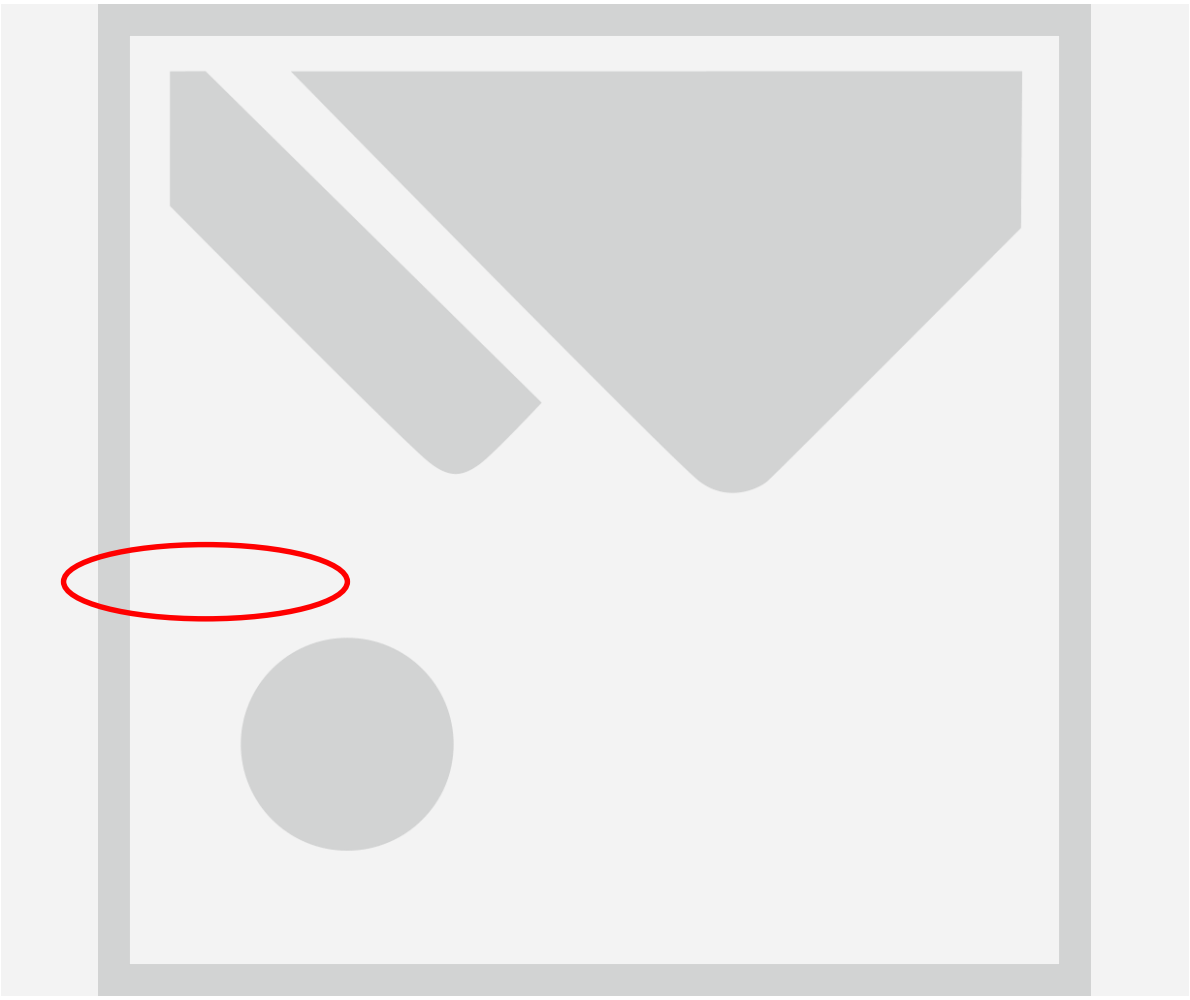
Children will no longer be certified on TP 08 beginning on January 1, 2014; therefore, there is no need for TP 47, Children Denied TANF with Applied Income. For more information on the changes to TP 08, see the TP 08 – Parents and Caretaker Relatives Medicaid section.

Automation
Revised March 1, 2014

TIERS will display an indicator to designate if a MAGI EDG is currently in a continuous/non-continuous eligibility period. The continuous/non-continuous eligibility indicator will be displayed under the MAGI-EDG Summary Screen. TIERS will establish the new certification periods when the case is renewed.

TIERS will check Texas Health Steps at the first redetermination which will be at the end of the 12-month certification period.

The indicator for continuous eligibility on the inquiry screen updates based on the date of inquiry.



The continuous/non-continuous eligibility indicator will also be displayed on the EDG inquiry page (**EDG – Search/Summary**).

This information will also show in PT Inquiry. The label in PT Inquiry will be “Continuous.” When the client is approved for continuous eligibility the label will be “Y” and when in the non-continuous eligibility period, the label will be “N.”

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Retroactive Coverage

Current Policy

A person applies for three months prior Medicaid coverage by completing Form H1113, Application for Prior Medicaid Coverage. Advisors give this form to applicants who indicate on their application or during the application interview that the family has unpaid medical bills incurred during the three months before the application month. **Exception:** For Children's Medicaid, Form H1113 is not required if the family provides enough information to determine eligibility for prior months.

When advisors determine eligibility for each prior month, only the needs and income of people who would have been considered if the household had applied for benefits in that month are included. Actual income and expenses are used to determine eligibility for each month in which there are unpaid medical bills. The household is also required to report resources that were available during each month in which there are unpaid medical bills, but are not available any more.

Note: For EDGs with annual or seasonal self-employment income, annualized income is used.

New Policy

Under new federal income rules, income calculation will be determined using MAGI rules for retroactive coverage requested on or after January 1, 2014. The needs and income of people who would have been considered in the client's MAGI household composition for each month the client's MAGI household composition has unpaid medical bills are included. Previous deductions and resources are no longer counted for an eligibility determination; therefore, clients will no longer be required to report resources that were available during each month in which there are unpaid medical bills.

Retroactive coverage will continue to use the eligibility rules that are in place in the month for which an individual is requesting eligibility. During the transition to the new MAGI rules beginning January 1, 2014, applicants may have some months that were determined using current rules and some months using MAGI rules.

For example, an applicant applies in February 2014 and requests three months of retroactive coverage for unpaid medical bills. January 2014 would be tested using MAGI rules, while December and November 2013 would be tested using current eligibility rules.

Form H1113, Application for Prior Medicaid Coverage, will be updated to reflect the new policy and will be available through the Texas Works Handbook on January 1, 2014, but will be added to TIERS at a later date.

Retroactive Medicaid Coverage for Abandoned Children

If applicable, income calculation will also be determined based on MAGI rules for abandoned children; however, the process of how the certification is established will continue to be the same. CBS advisors provide retroactive Medicaid coverage for these children. More information on this topic can be found in the Three Months Prior FFCC Eligibility.

Automation

TIERS will trigger the correct financial eligibility rules depending on the month being assessed for prior month's coverage. Automation will allow the system to apply current rules for months December 2013 and prior and MAGI rules for months beginning in January 2014. Automation changes will be implemented with Release 89 scheduled for December 2013.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be provided as part of an instructor led training series titled ACA – Overview of MAGI Changes.

Changes

Changes

Current Policy

Advisors must inform all households of their responsibility to report changes in their circumstances. Households are required to report certain changes for medical programs within 10 days of the occurrence. Those changes are outlined below.

Recipients receiving TP 08, TANF-Level Families Medicaid, must report changes in:

- Residence
- Source of income
- Household composition
- Ownership of a licensed vehicle
- Wage rate or status (full-time to part-time or vice versa as defined by the employer) for employed household members
- The amount of non-exempt unearned income of any household member
- Private medical insurance coverage
- Address, job, or other information related to the absent parent
- Available cash, stocks, bonds, or money in a bank or savings account if the total is over $1,000 for TANF households or $2,000 ($3,000 for some households) or more for applicable medical program households

Recipients receiving TP 40, Pregnant Women, and TA 85, CHIP-P, must report:

- Termination of the pregnancy
- Change of address

For TP 45, Newborn Children, households must report if the child no longer resides in Texas.

Recipients receiving TP 43, Children Under Age One; TP 44, Children Ages 6-18; TP 48, Children Ages 1-5; and TP 47, Children Denied TANF with Applied Income, must report:

- Change of address
- Whether a certified child left the home, is institutionalized, or dies
- The addition of a child to the household, if the household wants Medicaid for the child

For Children's Medicaid, advisors are only required to act on changes the household is required to report during the continuous eligibility period. All other changes, including agency-generated changes are processed at the household's next redetermination unless the household has associated EDGs.

Recipients receiving TP 70, MTFCY, must report:

- Change of address
- Voluntary withdrawal by the individual
- Receipt of health insurance
- If the individual moves out of state

All other changes, including agency-generated changes, are processed at the next redetermination.

Recipients receiving TP 02, Refugee Medical Assistance, must report:

- Change of address
- Voluntary withdrawal by the individual
- If the individual moves out of state

For CHIP and CHIP-P, households are instructed that they must report:

- Change of address
- Whether a certified child leaves the home, is institutionalized, or dies
- Pregnancy termination
- Addition of a child to the household, if the household wants health care coverage for the child

Action must be taken on reported changes in household composition and address.

CCC staff is responsible for processing most client-reported changes; however, staff at local offices also process changes.

New Policy
Revised September 1, 2015

Recipients of MAGI Programs will be required to report all changes that are required under current policy. The new MAGI rules no longer require resource information for an eligibility determination; however, resource tests still apply to TP 02, Refugee Medical Assistance; children in TP 56, Medically Needy with Spend Down; and children in TP 32, Medically Needy with Spend Down - Emergency.

Individuals will be required to report any new types of income or expenses and any changes to MAGI income, expenses, or household composition. All other change requirements are still applicable and recipients will be required to report them within 10 days of the occurrence. The new types of changes are outlined below:

- New Income:
  - Capital gains
  - Canceled debts
  - Court awards
  - Jury duty pay
  - Approved AI/AN disbursements
- New allowable MAGI Expenses:
  - Student loan interest
  - Moving expenses
  - Tuition or GI Bill
  - Educator expenses
  - Expenses of reservists, performing artists, and fee-based government officials
  - Health savings account deduction
  - Deductible part of self-employment tax
  - Self-employed IRA, SIMPLE IRA, and qualified plan deductions
  - Self-employed health insurance deduction

- Penalty on early withdrawal of savings deduction
- IRA deduction
- Domestic production activities deduction

Recipients must continue to report changes in MAGI household composition. Advisors are required to act on the types of reported changes listed above regardless if the recipient is not required to report the change during a continuous eligibility period.

For example: Recipients need to report if someone left the home. Under MAGI household composition rules, an individual leaving the home may or may not affect eligibility depending on that person's tax status, tax relationships, and family relationships.

Tax status and tax relationships are a new type of eligibility criteria under MAGI rules; however, a client is not required to report a change on this type of status during the certification period because tax status and tax relationships are self-declared based on what the clients expects to happen on their federal income taxes. If a change is reported, it should be documented in case comments and it will be addressed at the time of redetermination. However, if multiple individuals self-declare to claiming the same person as a tax dependent, the advisor must clear the discrepancy with all individuals attempting to claim the same person as a tax dependent and update the tax statuses as a change in TIERS if necessary.

For example: A change is reported that a child certified on Children's Medicaid will no longer be claimed as a tax dependent. This change will be addressed at redetermination.

For non-financial changes reported during a period of continuous eligibility, advisors must set a special review in the first week of the 6th month before cutoff and must process the change before cutoff, as long as nothing else is needed to process the change. This will ensure that the change is effective in the 7th month, which is when the non-continuous eligibility period begins. A special review is not needed for financial changes, as these will be processed during a periodic income check.

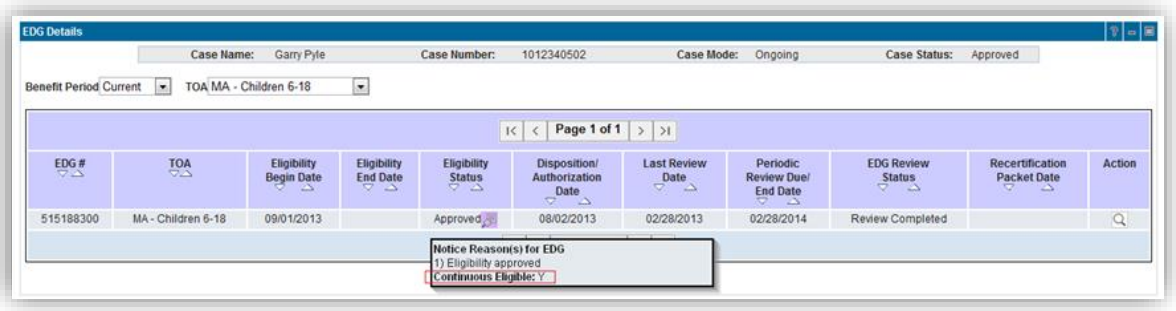
For all changes (non-financial or financial) reported by recipients of MAGI programs during a non-continuous eligibility period, the system uses the Reasonable Compatibility calculation to automatically attempt to verify client reported income and expenses. For more information, see the section on Financial Eligibility Verifications.

Automation
Revised June 1, 2014

Once the change is processed and the advisor runs EDBC, TIERS will determine which MAGI programs and what periods of eligibility (continuous or non-continuous) will be affected.

TIERS will display an indicator to designate if a MAGI EDG is currently in a continuous or non-continuous eligibility period. Advisors will be able to see the indicator under the MAGI – EDG Summary Screen and under inquiry, **EDG – Search/Summary** page. See the Certified Periods Automation section for screenshots of these pages.

The PT inquiry tab will display the same indicator to designate if a MAGI EDG is currently in continuous or non-continuous eligibility period. The label in the PT inquiry tab will be "Continuous: ___." When the client is approved for continuous eligibility the label will be "Y" and when the client is in non-continuous eligibility period, the label will be "N."



The indicator for a continuous/non-continuous eligibility period will provide advisors with information on whether or not the change will affect eligibility for each EDG.

For example: In March 2014, a parent is certified on TP 08 and a child is certified on TP 44. In May 2014, the parent reports a change in income; an advisor processes the change and runs EDBC. If the change only impacts the TP 08 EDG's eligibility but not the TP 44 EDG, the indicator flag would let the advisor know that the TP 44 EDG's eligibility was not affected because the EDG was in continuous eligibility.

Effective Date

Changes to policy are effective September 19, 2015.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Training on enhancements to change reporting will be presented in a web-based course titled "Course R94-1 – Change Reporting."

Changes Reported on or after January 1, 2014, for Clients with File Dates before January 1, 2014

Current Policy

There is no current policy on this topic.

New Policy

For Medicaid and CHIP EDGs that are in a non-continuous eligibility period and were certified on or prior to December 31, 2013, changes reported on or after January 1, 2014, must be processed using eligibility policies in place on December 31, 2013.

If the client remains eligible after processing the reported change, the client will continue on the original certification period. If the client is ineligible based on the reported change, the client will be provided Form H1205, Texas Streamlined Application, and will be given the opportunity to have an eligibility determined under MAGI rules. The advisor must request via STP to mail Form H1205, Texas Streamlined Application, to the client.

The following programs are affected by this section:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 70, Medicaid for Transitioning Foster Care Youth
- TA 84, CHIP; and TA 85, CHIP-P
- TP 07, TP 20, and TP 37, Transitional Medicaid

The following text will be included on Form TF0001 to inform clients of the denial and what steps to take so that they can have an eligibility determination made under MAGI rules.

> *Our program rules have changed. To find out if you can get health-care benefits, you can apply either by: (1) going to YourTexasBenefits.com, or (2) filling out the application (H1205) we sent with this form.*
>
> *Cambiaron las reglas de nuestro programa. Para saber si puede recibir beneficios de atención médica puede solicitar: (1) en YourTexasBenefits.com, o (2) puede llenar la solicitud que le enviamos con esta carta (Formulario 1205).*

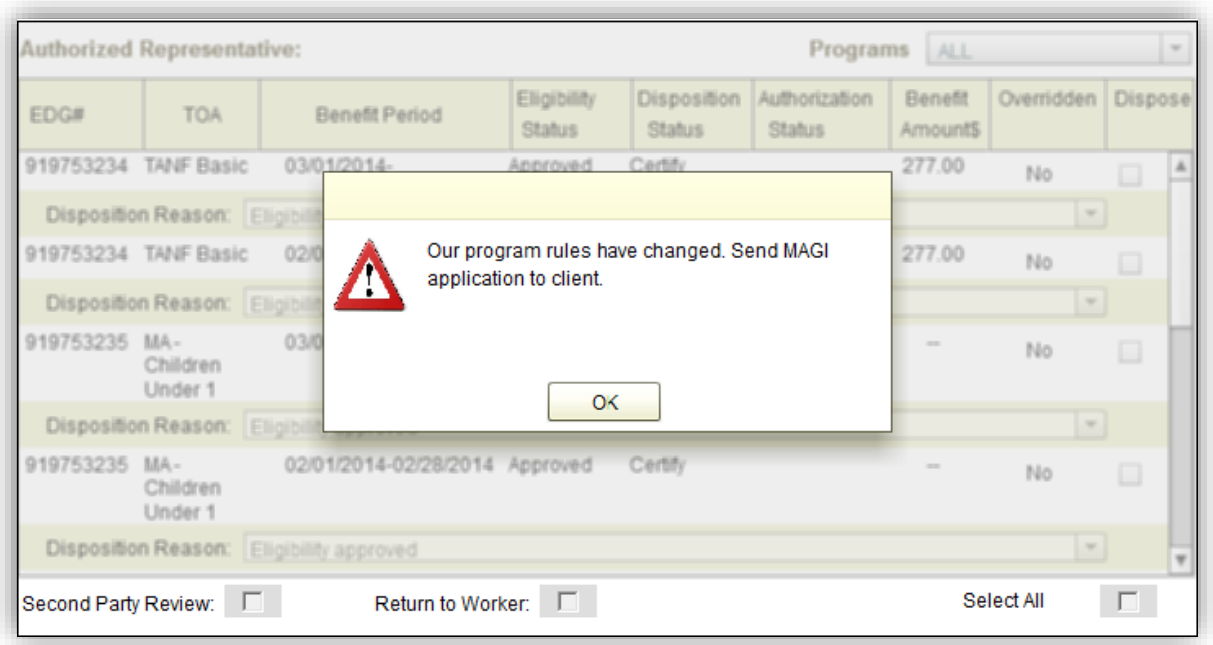
Form H1205 and TF0001 will be mailed separately.

Effective Date

Changes to policy are effective January 1, 2014.

Automation

For changes reported on or after January 1, 2014, that result in a denial based on pre-MAGI rules, TIERS will display the following warning text to notify the advisor to follow the manual process of requesting Form H1205, Texas Streamlined Application, via STP and to mail it to the client.



Existing appropriate denial reason codes will be used to terminate these EDGs. An indicator will be sent to correspondence by the disposition modules to print the special text on the notice. Automation changes will be implemented with Release 89 scheduled for December 2013.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs. Training will also be presented in a course titled ACA – Change Processing.

Redeterminations

Redeterminations

Removed October 1, 2014

Redeterminations January 1, 2014, through March 31, 2014 for Clients with File Dates before January 1, 2014

Removed September 1, 2014

Administrative Renewals

Added October 1, 2014

Current Policy

Effective January 1, 2014, the ACA requires HHSC to use MAGI rules to redetermine eligibility. A redetermination packet is sent in the 10th month of a 12-month eligibility period for the following programs:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TA 84, CHIP

Exception: MTFCY follows a different redetermination process.

For TP 43, TP 44, TP 48, and CHIP, if the client does not return his or her redetermination packet by the first calendar day in the 11th month of a 12-month eligibility period, HHSC will continue to send a reminder to the client to complete the redetermination.

Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, will be included with the following redetermination forms:

- Form H1010-R, Your Texas Benefits: Renewal Form
- Form H1014-R, Renewal Application for CHIP and Children's Medicaid
- Form H1014-A, Children's Health Care Benefits - Final Reminder

If the client returns the redetermination packet before January 1, 2014, the MAGI rules are not used to determine eligibility. The advisor does not enter the client information included on Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, because it is not needed to determine eligibility.

Redeterminations with a file date of January 1, 2014 or later must use the MAGI rules and the client information in Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, is required to determine eligibility.

New Policy

Effective October 1, 2014, the following programs use the Administrative Renewal policy:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 70, Medicaid for Transitioning Foster Care Youth (MTFCY)
- TA 84, Children's Health Insurance Program (CHIP)

Note: Effective September 2014, the Former Foster Care Children (FFCC) program uses the administrative renewal policy described in the following sections: Administrative Renewals for FFCC, Administrative Renewal Correspondence for FFCC, and Administrative Renewal Processing for FFCC. Effective October 1, 2014, the administrative renewal policy will also be used for Medicaid for the Elderly and People with Disabilities (MEPD), which will be discussed in a separate MEPD bulletin.

Beginning in October 2014, the automated and administrative renewal processes are for clients who were originally certified on MAGI Programs in February 2014 with renewal due dates in January 2015.

Automated Renewal Process

Initiating an administrative renewal requires no advisor action and uses the Automated Renewal Process to gather information from a client's existing case and from electronic data sources to determine if the client remains potentially eligible for Medicaid or CHIP benefits.

As part of the automated renewal process, electronic data is requested one month prior to the automated process. The electronic data is used by TIERS the weekend before cutoff in the 9th month of the certification period to gather available verifications required to renew Medicaid or CHIP benefits.

Verifications Required at Renewal
Revised September 1, 2015

During the automated renewal process, TIERS checks for the required verification by program.

Verifications Required by Type Program

TP 08, Parents and Caretaker Relatives Medicaid	• Residence • Income and Expenses • Immigration Status • Domicile • Full-time School Attendance when the only dependent child(ren) is(are) 18 years old
TP 43, Children Under Age One TP 44, Children Ages 6-18 TP 48, Children Ages 1-5	• Income and Expenses • Immigration status • Texas Health Steps (only for TP 44 and TP 48) • Health Care Orientation
TA 84, CHIP	• Income and Expenses • Immigration status

TP 70, Medicaid for Transitioning Foster Care Youth	• Income and Expenses • Immigration status • Tax Status when not provided
Note: Immigration status is only verified during the automated renewal process if the client's immigration document expires during the current certification period.	

Income Verification

TIERS uses the Reasonable Compatibility calculation to automatically attempt to verify income. The automated renewal process compares the client's income information in TIERS with income information available through electronic data sources. For more information, see the section on Financial Eligibility Verifications.

When there are no earned income electronic data sources (TWC or TALX) available for the client, TIERS checks to see if there is a New Hire Report. When a New Hire Report exists with an employer's name and hire date that is not currently included in the client's income, the client must provide verification of the information on the New Hire Report.

Once available verifications are assessed during the automated renewal process, the system runs eligibility. Below is a list of outcomes from the automated renewal process.

Automated Renewal Process: Eligibility Outcomes

Eligibility Potentially Approved	• All required eligibility information **can** be verified during the automated renewal process for the program. • No additional verification is required from a client. • Clients must review the information used to determine their eligibility. • Clients are only required to return a signed renewal form, Form H1206, Health-Care Benefits Renewal, if the information on the renewal form is incorrect or there are changes to the client's case.

Additional Information Needed	• This outcome may be the result from two scenarios that require additional verification to determine whether the client remains eligible:
	  ○ Electronic data sources indicate there is a change in income that **may** result in ineligibility for Medicaid or CHIP.
	  ▪ The reasonable compatibility calculation result is "Need Info because ELDS above limit" or verification required for information found on the New Hire Report.
	  ▪ The client must return a signed renewal form, Form H1206, Health-Care Benefits Renewal, and all required verification(s) within 30 days.
	  ○ No electronic data is available for the client.
	  ▪ The client must return a signed renewal form, Form H1206, and all requested verification(s).
	• SNAP or TANF benefits may be impacted if a member of the MAGI household is included in a SNAP or TANF budget group.

Eligibility Terminated	• This outcome may be the result from two scenarios:
	  ○ The previous eligibility outcome was "Additional Information Needed" and eligibility was terminated because the client:
	  ▪ Did not submit required verifications within 30 days to show that income is under the limit, or
	  ▪ Submitted verifications that showed that income was over the limit.
	  ○ The client reported a change in income that was over the income limit, and eligibility was terminated before the automated renewal process was triggered.

The automated renewal process generates client correspondence according to the eligibility outcome of the automated renewal process. For additional information on renewal correspondence, see the section for Administrative Renewal Correspondence.

For clients whose eligibility has not been determined using the MAGI rules, a redetermination packet will continue to be sent in the 10th month of a 12-month certification period. Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, will be included with the following redetermination forms:

- Form H1010-R, Your Texas Benefits: Renewal Form
- Form H1014-R, Renewal Application for CHIP and Children's Medicaid
- Form H1014-A, Children's Health Care Benefits - Final Reminder

Recipients of TP 40, Pregnant Women, and TA 85, CHIP Perinatal, will continue to receive application packets in the ninth month of eligibility because these programs are not renewed.

Interviews

At redetermination, clients receiving TP 08, Parents and Caretaker Relatives Medicaid, must complete an interview. Clients cannot be required to complete a face-to-face interview, but have the right to request one.

Note: Individuals are certified on their own EDG for MAGI programs. As a result, case alignment between all EDGs may not occur and redeterminations may not align if the EDGs were not previously aligned.

Texas Health Steps Compliance Requirement
Added March 1, 2015

In accordance with A-1531.5 TWH, if overdue dates are found at redetermination for a child, the advisor must attempt to contact the caretaker and subsequently send Form H1024, Self-Declaration Notice, to obtain information about Texas Health Steps compliance if the caretaker cannot be reached by telephone. If the household returns the Form H1024 indicating non-compliance, the advisor must schedule the individual for a telephone interview. Face-to-face interviews must not be required during the application or redetermination process, but clients may request to have the interview conducted face-to-face.

Impact to SNAP and TANF

Verification is required for SNAP and TANF during the automated renewal process when:

- The reasonable compatibility calculation result is “Need Info because ELDS above limit” or the client is required to provide verification of information found on a New Hire Report for a MAGI program; and
- An individual in the MAGI household is included in a SNAP or TANF budget group.

The client has 10 days to provide verification for SNAP and TANF. Based on the income type and electronic data source used during the automated income verification process, if the client does not provide verification by the 10th day, TIERS will automatically take the following action on the 11th day:

- **Deny** SNAP and TANF benefits for the following data sources:
  - Quarterly Wage data from TWC
  - New Hire Report data from OAG
- **Adjust** SNAP and TANF benefits using the most recent information from the following data sources:
  - Earned income data from TALX
  - Unearned RSDI income data from the SSA
  - Unearned unemployment data from TWC

See Alert #830, Review Income for SNAP/TANF for more information.

Note: Earned income data from TALX, unearned RSDI data from SSA, and unearned unemployment data from TWC are valid verifications for SNAP and TANF. Since Quarterly Wage data from TWC and New Hire Report data from OAG are not valid verifications for SNAP and TANF, the client must provide verification for these types of income.

Automation

Electronic Data Sources

TIERS begins requesting information from electronic data sources for each MAGI EDG in the 8th month of the certification period. TIERS must access data from electronic data sources within 31 days of using the data which is the weekend before cutoff in the 9th month. TIERS does not request additional data for an individual from a source that has been accessed within 31 days before cutoff in the 9th month.

Renewal Status
Revised September 1, 2015

The renewal status on the **EDG Search/Summary** page in TIERS inquiry changed to display the outcome of the automated renewal process.

When TIERS initiates an administrative renewal, the renewal status displays as one of the following:

- Review Required: Eligibility Approved,
- Review Required: Additional Information Needed, or
- Review Complete: Terminated.

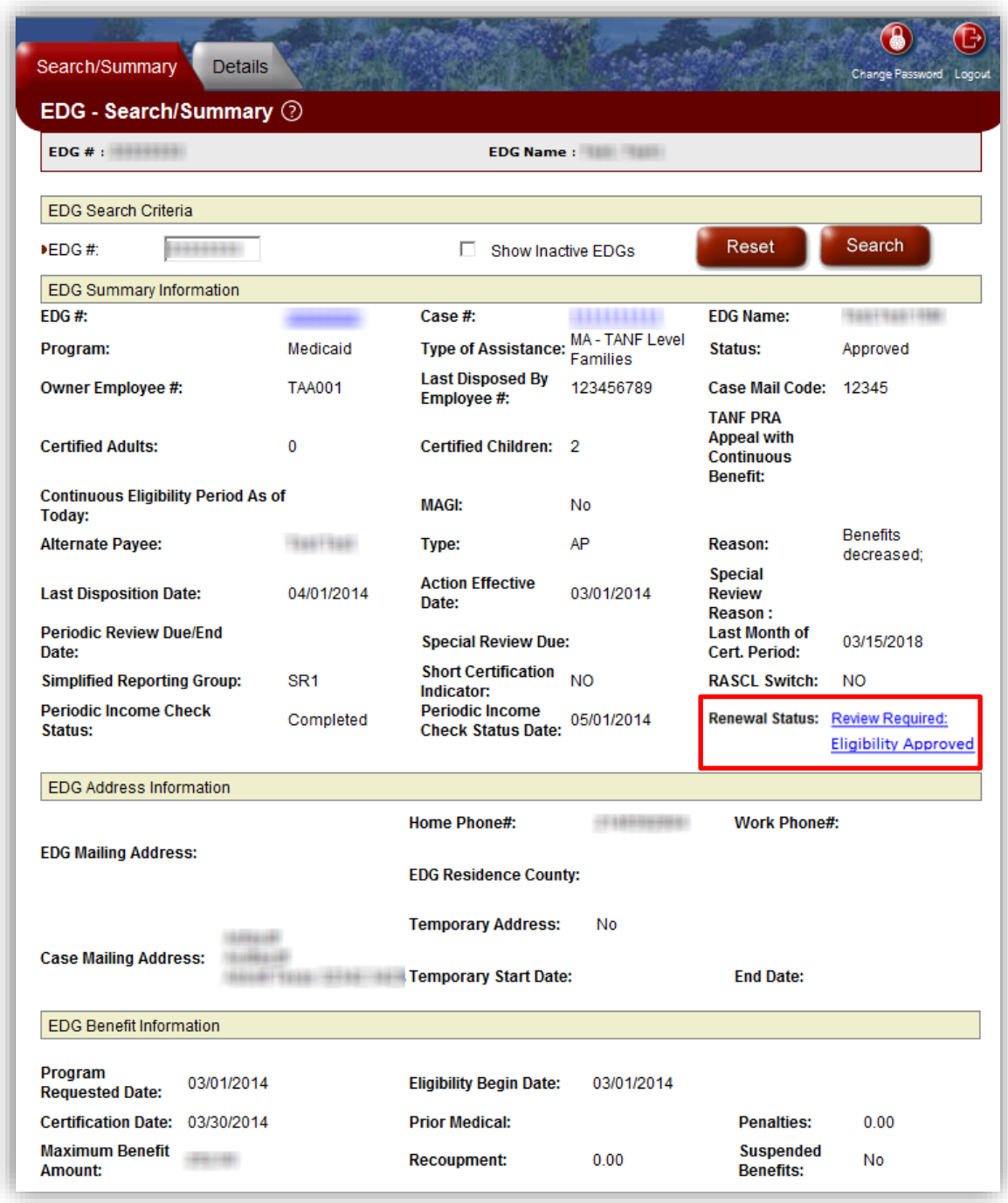
The following chart identifies the required advisor action and correspondence generated for the renewal statuses.

Renewal Status Outcomes

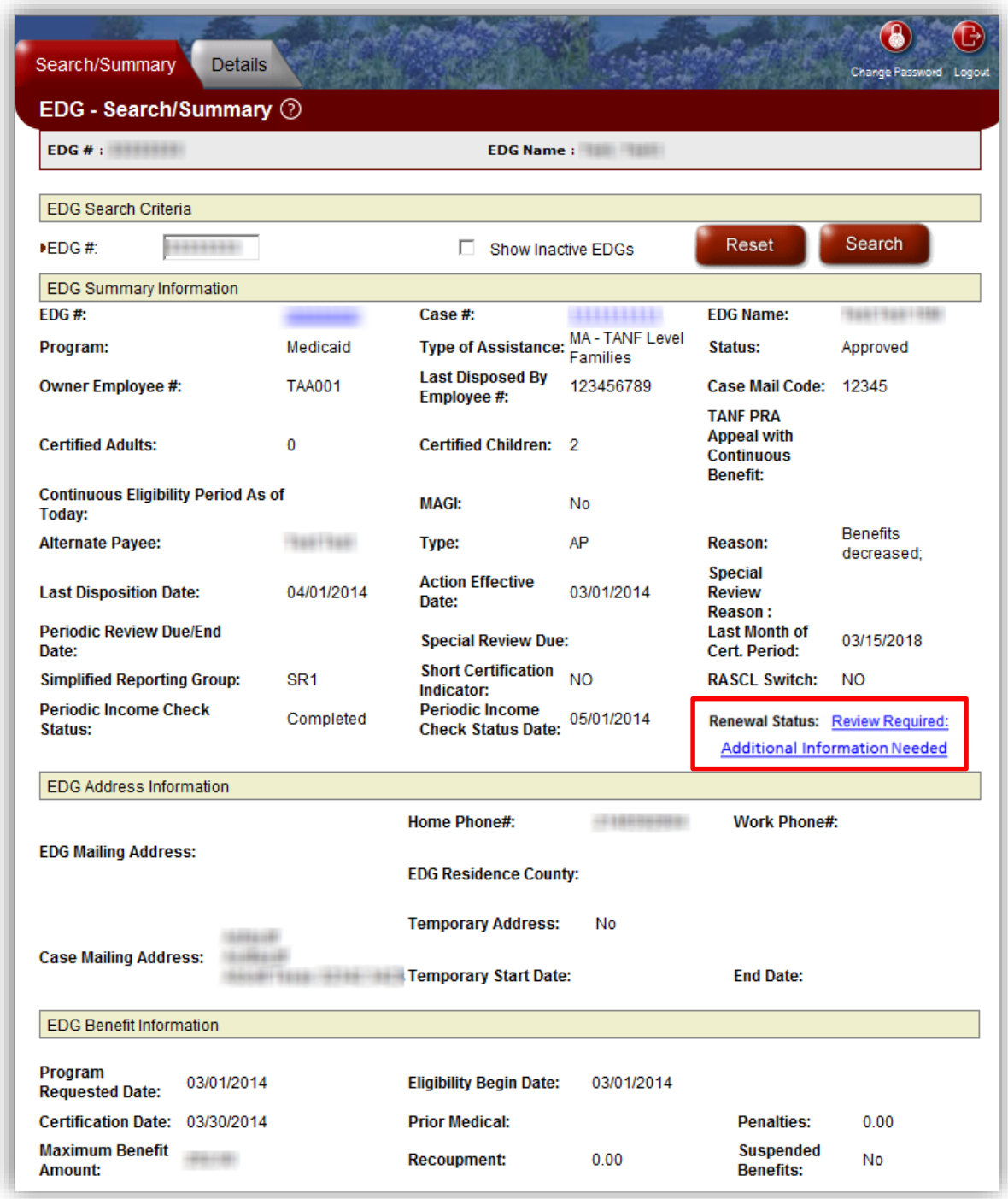
Renewal Status	Eligibility Outcome	EDG Status	Advisor Action and Correspondence
Review Required: Eligibility Approved	Eligibility potentially approved	Approved	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, is sent to the client and identifies that the client must review the information used to renew their eligibility. • The client is only required to return a signed renewal form if the information on the form is incorrect or there are changes to the client's case. • If the client **does not** return a renewal form, the system auto-approves the EDG. No advisor action is required. • If the client **does** return a renewal form, the advisor manually processes the renewal.
Review Required: Additional Information Needed	Additional Information Needed	Pending	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, is sent to the client and identifies that the client must return: o A signed renewal form, and o Required verification(s) to renew their Medicaid or CHIP benefits, outlined in the Form H1020 that is included with the renewal form.
Review Complete: Terminated	Eligibility Terminated	Terminated	• If additional information is needed and the client **does not** return a renewal form by the 30th day from the date the Form H1211 is mailed, the system auto-denies the EDG. No advisor action is needed. • If additional information is needed and the client **does** return a renewal form by the 30th day from the date the Form H1211 is mailed, the advisor manually processes the renewal.

The following screenshots show how the renewal status will be displayed in TIERS.

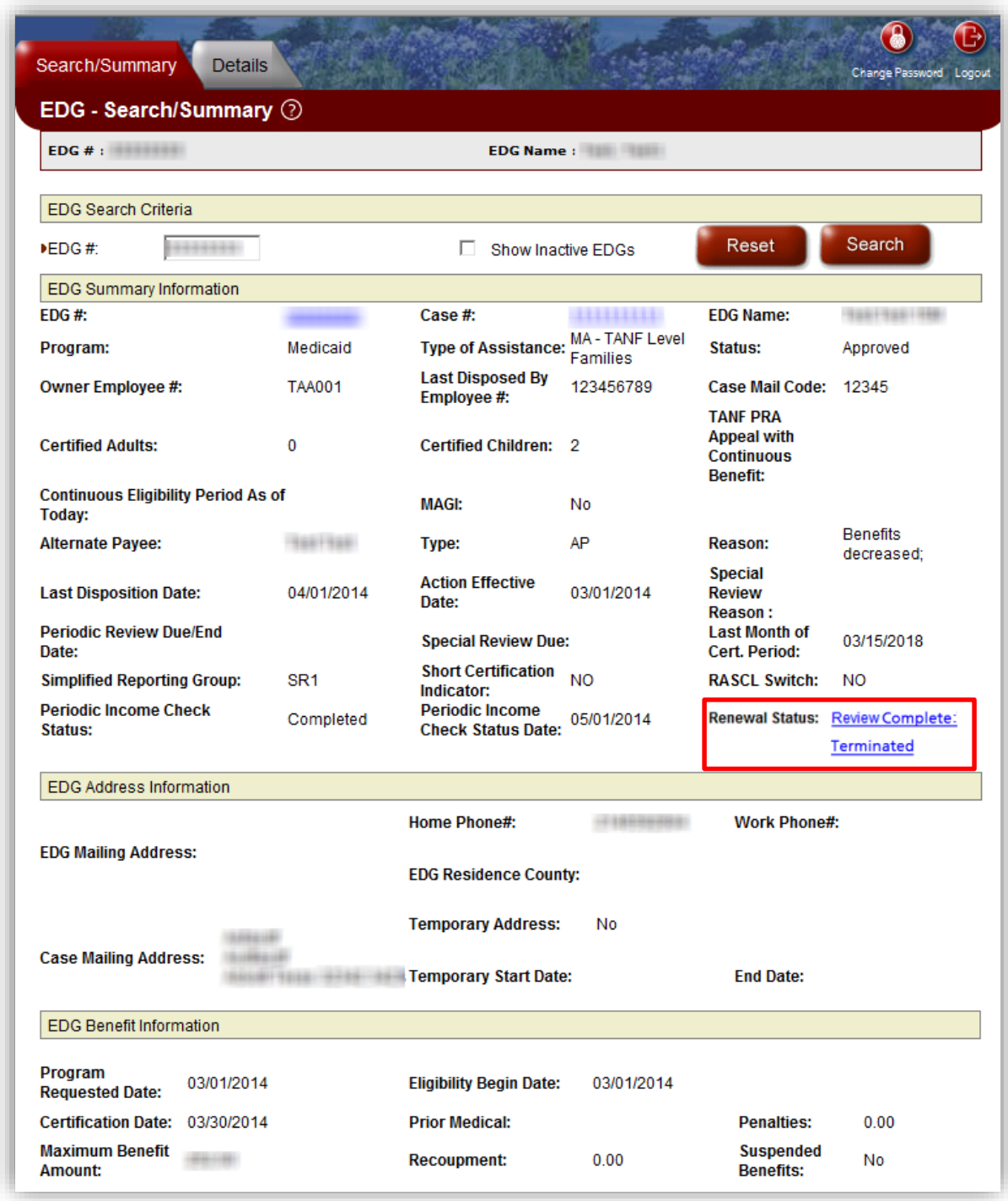
Review Required: Eligibility Approved



Review Required: Additional Information Needed



Review Complete: Terminated



Effective Date

Changes to policy are effective October 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled "Course AG10: ACA - Administrative Renewals" and "Course AG7: ACA - First Steps of Periodic Income Checks and Administrative Renewals for Advisors." Additional training will be delivered in the web-based courses titled "Course AG11: ACA - Administrative Renewals for MTFCY and FFCC" and "Course AG1: ACA - Overview of Administrative Renewals."

Administrative Renewal Correspondence

Added October 1, 2014

Current Policy

Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, is included with the following redetermination forms:

- Form H1010-R, Your Texas Benefits: Renewal Form
- Form H1014-R, Renewal Application for CHIP and Children's Medicaid
- Form H1014-A, Children's Health Care Benefits - Final Reminder

New Policy
Revised September 1, 2015

Effective October 1, 2014, the following programs use the Administrative Renewal policy:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 70, Medicaid for Transitioning Foster Care Youth (MTFCY)
- TA 84, CHIP

Note: Effective September 2014, the Former Foster Care Children (FFCC) program uses the administrative renewal policy described in the following sections: Administrative Renewals for FFCC, Administrative Renewal Correspondence for FFCC, and Administrative Renewal Processing for FFCC. Effective October 1, 2014, the administrative renewal policy will also be used for Medicaid for the Elderly and People with Disabilities (MEPD), which will be discussed in a separate MEPD bulletin.

The following administrative renewal client correspondence is generated during the automated renewal process:

Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter

Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client of:

- The eligibility outcome from the automated renewal process,
- The action needed to complete the renewal, and
- The types of changes that clients are required to report (for more information, see the section for Changes).

Form H1211 is dynamic based on the eligibility outcome and type program. TIERS generates and mails the Form H1211 to the client with no advisor action in the 9th month of the certification period.

The following chart shows the correspondence generated for each eligibility outcome and the required client response.

Eligibility Outcome	Correspondence and Required Client Response
Eligibility Potentially Approved	• The Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility on Form H1206, Health-Care Benefits Renewal. • The client is only required to return a signed renewal form, Form H1206, if the information on the form is incorrect or there are changes to the client's case. • Form M5017, Documents to Send with your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211. • A TF0001 is mailed to the client to notify him or her of the eligibility determination.

Additional Information Needed	• The Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter and Form H1020, Request for Missing Information or Action are sent to the client.
	• The Form H1211 notifies the client that they must return the following:
	  ○ Signed renewal form, Form H1206, and
	  ○ Required verification(s).
	• The Form H1020 identifies all the required verification(s) needed to complete the renewal
	• Form M5017, Documents to Send with your Renewal Application, is included with Form H1206.

Eligibility Terminated	• If additional information is needed and the client **does not** return a renewal form by the 30th day from the date the Form H1211 is mailed, the system auto-denies the EDG. No advisor action is needed. • If additional information is needed and the client **does** return a renewal form by the 30th day from the date the Form H1211 is mailed, the advisor manually processes the renewal. • A TF0001 is mailed to the client to notify him or her of the eligibility determination.

Form H1206, Health-Care Benefits Renewal

Form H1206, Health-Care Benefits Renewal, is pre-populated with information from the client's case and, and may also include information from electronic data sources. The system generates the Form H1206 but does not automatically mail it to the client. Clients can access the form H1206 through the following:

- Logging into YourTexasBenefits.com using a case access account and selecting the "Letters and forms" tab to view or print the form.
- Dialing 2-1-1, selecting option 2, and requesting that the Form 1206 be mailed to the client.
- Visiting a local office and receiving lobby assistance to access the form through YourTexasBenefits.com or having local office staff print a copy of the form.

Form H1206 is pre-populated with the following information for a client who needs to renew Medicaid or CHIP benefits:

- Contact, demographic, and case information
- Residency status and intent to reside in Texas
- Citizenship or immigration status
- Third-party resource information
- Income and expense information
- Resource information

There are different versions of this form depending on the type program in which the recipient is currently enrolled.

- Form H1206, Health-Care Benefits Renewal – MA is used for clients on:
  - TP 08, Parents and Caretaker Relatives Medicaid
  - TP 43, Children Under Age One
  - TP 44, Children Ages 6-18
  - TP 48, Children Ages 1-5
  - TA 84, CHIP

- Form H1206, Health-Care Benefits Renewal – MTFCY, is used for clients on:
  - TP 70, Medicaid for Transitioning Foster Care Youth (MTFCY)

Note: Form H1206 cannot be used to renew SNAP or TANF benefits. Clients must still use the Form H1010R, Your Texas Works Benefits: Renewal Form, to renew SNAP and TANF benefits.

Form M5017, Documents to Send with your Renewal Application

TIERS generates Form M5017, Documents to Send with your Renewal Application, and includes it with the Form H1206.

Form TF0001, Notice of Case Action

Form TF0001, Notice of Case Action, is sent when a final eligibility determination is made. Depending on the renewal status outcome and client action, final eligibility determinations may be made by advisors manually processing renewal documents or by the system automatically through mass update.

The TF0001 identifies the dates of the new certification period for Medicaid benefits, potential CHIP eligibility, or the denial reason for not recertifying Medicaid or CHIP benefits.

Form H1010-R, Your Texas Benefits: Renewal Form

For clients whose eligibility has not been determined using the MAGI rules, a redetermination packet will continue to be sent in the 10th month of a 12-month certification period. Form H1010-MR, Applying for or Renewing Medicaid or CHIP?, will be included with the following redetermination forms:

- Form H1010-R, Your Texas Benefits: Renewal Form
- Form H1014-R, Renewal Application for CHIP and Children's Medicaid
- Form H1014-A, Children's Health Care Benefits - Final Reminder

The Form H1010-R, Your Texas Benefits: Renewal Form, must be accepted as a valid renewal form if it contains the MAGI client information and a valid signature. The signature provided on the Form H1010-R is considered valid as long as it is provided by the certified client or an individual who is allowed to sign for the client. The advisor should enter the information provided on the Form H1010-R and pend for any information that cannot be verified through electronic data sources.

Form H1014-A, Children's Health Care Benefits - Final Reminder

Form H1014-A, Children's Health Care Benefits - Final Reminder, is sent if:

- The client does not return his or her redetermination packet by the first calendar day in the 11th month of a 12-month eligibility period, and
- The client is required to return the renewal form to complete the renewal.

The Form H1014-A is sent for the following programs:

- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TA 84, CHIP

Automation

An advisor can access a client's Form H1211 and the renewal packet that includes Forms H1206 and M5017 by selecting the "History Correspondence" from the Left Navigation (left nav.), and selecting the form number. This can only be done once the administrative renewal correspondence has been generated for the specific client. The Forms H1211 and H1206 are not available to be printed without client information because they are dynamic based on eligibility outcome and type program.

Effective Date

Changes to policy are effective October 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled "Course AG10: ACA - Administrative Renewals." Additional training will be delivered in the web-based courses titled "Course AG11: ACA - Administrative Renewals for MTFCY and FFCC," "Course AG2: ACA - Changes to Correspondence," and "Course AG3: ACA - Changes to YourTexasBenefits.com."

Administrative Renewal Processing

Added October 1, 2014

Current Policy

All renewals are processed by an advisor when the client returns a renewal packet.

New Policy

Effective October 1, 2014, the following programs use the Administrative Renewal policy:

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TP 70, Medicaid for Transitioning Foster Care Youth
- TA 84, CHIP

Note: Effective September 2014, the Former Foster Care Children (FFCC) program uses the administrative renewal policy described in the following sections: Administrative Renewals for FFCC, Administrative Renewal Correspondence for FFCC, and Administrative Renewal Processing for FFCC. Effective October 1, 2014, the administrative renewal policy will also be used for Medicaid for the Elderly and People with Disabilities (MEPD), which will be discussed in a separate MEPD bulletin.

Renewals that Require Advisor Action

If an individual returns a paper Form H1206, Health-Care Benefits Renewal - MA, the form is routed to local offices for processing.

If an individual returns a paper Form H1206, Health-Care Benefits Renewal – MTFCY, the form is routed to CBS for processing.

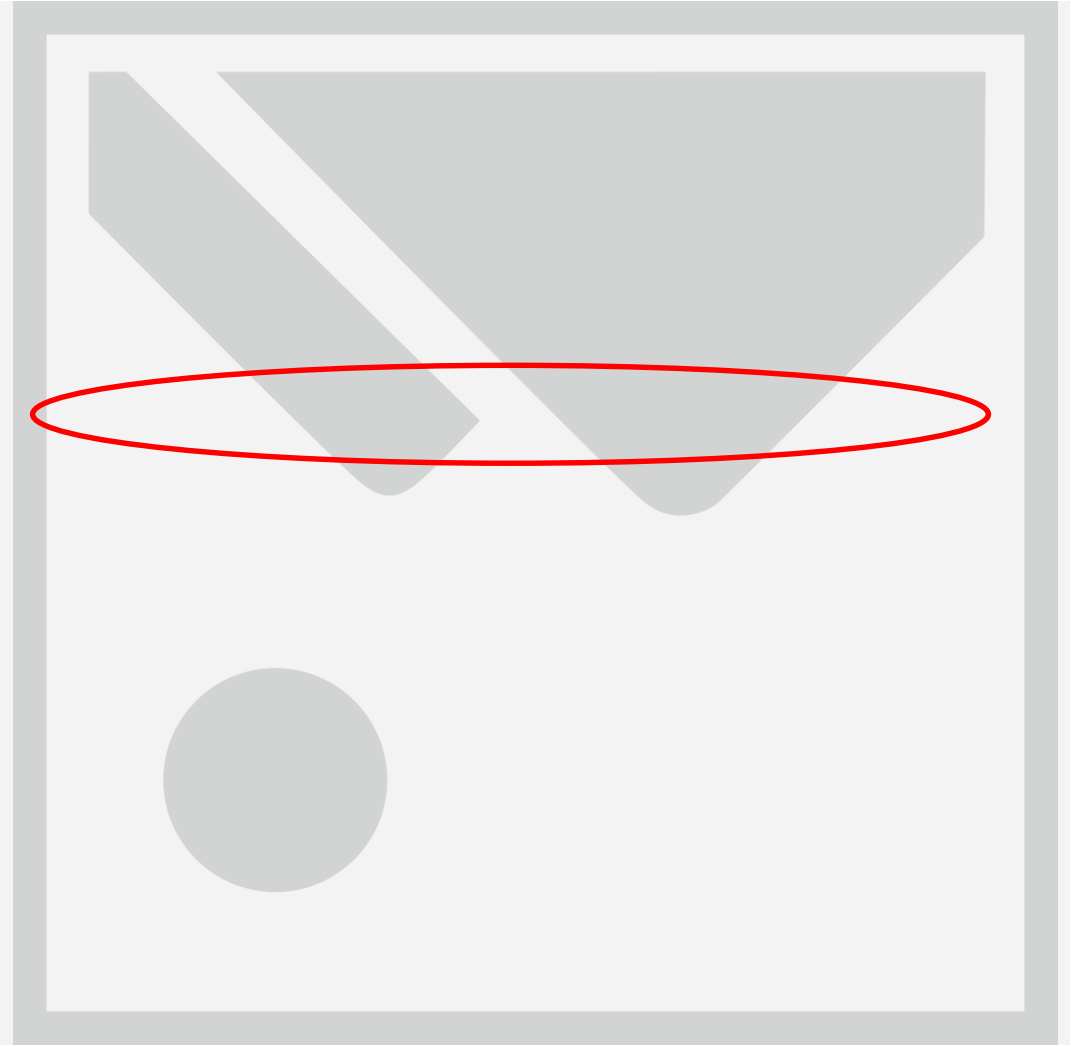
Processing a Manual Renewal

Advisors continue to follow the current procedure for Medicaid and CHIP renewal forms with the following exception. After the client returns the required information for an administrative

renewal, TIERS creates a task for an advisor to process the information. After all the income information has been entered the advisor must navigate back to the **Questions-Income** page and answer the question "Are all requested Periodic Income Check/Medicaid Renewal verifications received?" based on the income verification provided by the client.

If the individual has provided all the necessary verification and is eligible, select "Yes." Incorrectly selecting "No" will result in an invalid denial that may cause a gap in coverage.

The following screenshot shows where the new question will be displayed.



Note: A Form H1010-R, Your Texas Benefits: Renewal Form, must be accepted as a valid renewal form if it contains the form H1010-MR, MAGI Renewal Addendum, with MAGI client information and a valid signature.

File Date

The file date is the day that any local eligibility determination office receives the Form H1206, Health-Care Benefits Renewal – MA, or the Form H1206, Health-Care Benefits Renewal – MTFCY.

Interview

An interview is required for TP 08 to renew Medicaid benefits. During the interview, the advisor should remind the client to use YourTexasBenefits.com to:

- Create a case access account,
- Complete the renewal,
- Sign-up for e-mail reminders, and
- Find out when the next renewal is due.

Timeliness

Staff must process renewals for Medicaid EDGs, received timely or untimely, by the 30th day from the date the renewal packet is received or by cutoff of the last benefit month of the certification period, whichever is later.

Staff must process renewals for CHIP EDGs, received timely or untimely, by the 30th day from the file date or by cutoff of the 11th month of the certification period, whichever is later.

Verification and Pending Information

Verification previously provided can be used to renew eligibility. The advisor must check to see if there is any verification that can be used before requesting verification from the client. The household must be allowed at least 10 days to provide missing information, and the due date must fall on a workday.

All missing information must be received before the cutoff date of the 11th month of the certification period for CHIP EDGs or before the cutoff date of the 12th month of the certification period for Medicaid EDGs.

If the missing information is received:

- Before the date of denial in the 12th month, the EDG must be updated with the new information.
- After the date of denial in the 12th month of coverage, the denied EDG must be reopened, which may result in a gap in Medicaid coverage.

Renewal Form or Information Returned After Termination

Information or Verification Returned After Termination
Revised September 1, 2015

When a renewal is denied due to failure to provide information or verification and the information or verification is provided after the date of denial but by the 90th day after the last day of the last eligibility month, staff must reopen the EDG and not require a new application from the client. The date the information or verification is provided is the new file date.

Renewal Form Returned After Termination

If a renewal form is not received by the date of denial in the 12th month of the certification period, the EDG is denied for failure to return a renewal packet. A renewal form received after the last day of the 12-month certification period must be treated as an application using application processing time frames. The file date is the day that any local eligibility determination office receives the renewal form.

If the renewal form is received after the date of denial but before the last day of the 12th month of the certification period, reopen the Medicaid or CHIP EDG and process as a renewal. For CHIP, this may result in a gap in coverage.

Renewal Form Not Returned

Administrative Renewal Automatic Eligibility Determination
Revised September 1, 2015

When a renewal form is not returned, TIERS automatically makes an eligibility determination through mass update based on the eligibility outcome from the automated renewal process. This does not require the advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- "Eligibility Potentially Approved," the client is auto-disposed and approved without advisor action. The file date is the date the EDG is auto-disposed approved, and the client is granted a new 12-month certification period.
- "Additional Information Needed," the client is auto-disposed and denied without advisor action.

Verification Returned Without a Renewal Packet
Revised December 13, 2014

When an individual submits income or expense verification without a signed Form H1206, advisors manually process information as a change to determine ongoing eligibility for the remainder of the certification period if the client is in a non-continuous period. A signed Form H1206 is required if additional information was needed to complete the renewal.

TLM creates the Information Received Related to Income Expense task when the client returns income or expense information during an administrative renewal without a renewal packet.

TLM creates Alert # 831 – Information received related to Income/Expense when the client has returned missing information that affects a SNAP/TANF EDG when the individual is on a different case.

Mass Update Exceptions
Revised September 1, 2015

In some cases, an EDG may exception out of the mass update for the administrative renewal auto-disposition. When this occurs, TIERS creates a TLM task based on the eligibility outcome from the automated renewal process.

TLM creates Alert #840, Process Mass Update Exception—Approve, when the eligibility outcome is determined as "Eligibility Potentially Approved." This requires the advisor to process the task and approve the EDG. No additional verification is required because the automated renewal process verified all the required information. The file date is the date the auto-disposition should have occurred.

Advisors **manually approve** EDGs that exception out of the mass update auto-disposition for administrative renewals using these steps:

- Claim the task, Alert #840, Process Mass Update Exception—Approve.
- For approval during an administrative renewal:
  - Select the "Complete Action" mode from the "Interview Mode" drop down menu on the **Initiate Interview** page in Data Collection.
  - Use the disposition date (the date the task is claimed) as the "Packet Received Date."
  - Run EDBC and dispose the EDG.

TLM creates Alert #839, Process Mass Update Exception—Termination, when the eligibility outcome is determined as "Additional Information Needed." This requires the advisor to process the task and deny the EDG. The EDG is denied because the client has not returned the renewal packet by the final due date.

Advisors **manually terminate** EDGs that exception out of the mass update auto-disposition for administrative renewals using these steps:

- Claim the task, Alert #839, Process Mass Update Exception—Termination.
- Inquiry to ensure that the verification has not be submitted.
- For a termination during an administrative renewal:
  - Select the "Change Action" mode from the "Interview Mode" drop down menu on the **Initiate Interview** page in Data Collection.
  - Navigate to the **Run Eligibility** page through Left Nav.
  - Select "Manually Select Eligibility Determination Date?"
  - Enter the current month as the begin date.
  - Select "Next" on **Run Eligibility.**
  - Select "Run EDBC."

<u>Client Requesting and Submitting a Renewal Form</u>

Online

Clients can submit a renewal form online by logging into YourTexasBenefits.com using a case access account on any computer with internet access or at a local eligibility determination office to:

- Update incorrect information
- Make changes to case information
- Provide missing information
- Upload required verifications
- Renew online

Paper Form

Based on the eligibility outcome, if clients are required to update information, provide missing information, or sign the renewal form, they can access the paper form in one of the following ways:

- Print Form H1206 through YourTexasBenefits.com by logging in using a case access account and selecting the "Letters and forms" tab.
- Dial 2-1-1 and select option 2, to request that the Form H1206 be mailed.
- Go to a local office to:
  - Print the Form H1206 through YourTexasBenefits.com, or
  - Request that the Form H1206 be printed.

Effective Date

Changes to policy are effective October 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled "Course AG10: ACA - Administrative Renewals." Additional training will be delivered in the web-based courses titled "Course AG11: ACA - Administrative Renewals for MTFCY and FFCC," "Course AG3: ACA - Changes to YourTexasBenefits.com," and "Course AG15: ACA - Changes to Task List Manager (TLM)."

Periodic Income Checks

Added October 1, 2014

Current Policy

Effective January 1, 2014, advisors cannot request information from a client if there is no indication that there has been a change in the client's circumstance that may affect eligibility.

Children certified on TA 84, CHIP, with income above 185 percent FPIL have a six-month income check to determine whether the child remains financially eligible.

No Medicaid programs receive an income check.

New Policy

Effective October 1, 2014, the following MAGI programs receive periodic income checks (PIC):

- TP 08, Parents and Caretaker Relatives Medicaid
- TP 43, Children Under Age One
- TP 44, Children Ages 6-18
- TP 48, Children Ages 1-5
- TA 84, CHIP

Automated Income Check Process

Initiating a PIC requires no advisor action and uses the Automated Income Check Process to gather income information from a client's existing case and from electronic data sources to determine if there has been a change in the client's income that makes them potentially ineligible for Medicaid.

As part of the automated income check process, electronic income data is requested one month before it is used by TIERS. The electronic income data is used during the PIC.

TP 08, Parents and Caretaker Relatives Medicaid

An automated income check is initiated in months 3, 4, 5, 6, 7, and 8 of the certification period when the following conditions are met:

- The individual is certified using MAGI rules;
- Any of the following is true for at least one individual in the MAGI household for at least one countable income or expense source:
  - An income or expense is not verified;
  - One of the following income types uses "Verified by Reasonable Compatibility" as the verification source:
    - Employment Income,
    - Unemployment Compensation Income, or
    - RSDI Income;
  - The verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is more than 60 days old;
- The case is in Approved Ongoing mode; and
- There are no pending TLM tasks for the case.

TP 43, TP 44, and TP 48

TP 43, TP 44, and TP 48 receive an automated income check in months 5, 6, 7, and 8 of their certification period when the following conditions are met:

- The individual is certified using MAGI rules;
- The individual will not age out before or during the PIC review month;
- Any of the following is true for at least one individual in the MAGI household for at least one countable income or expense source:
  - An income or expense is not verified;
  - One of the following income types uses " Verified by Reasonable Compatibility" as the verification source:
    - Employment Income,
    - Unemployment Compensation Income, or
    - RSDI Income;
  - The verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is over 60 days old;
- The case is in Approved Ongoing mode; and
- There are no pending TLM tasks for the case.

The first time the result of an income check could impact eligibility for TP 43, TP 48, and TP 44 is the 7th month of the certification period because the first six months are continuous. For more information on this, see the section on Certification Periods.

TA 84, CHIP, Six-Month Income Check

Children certified on TA 84, CHIP, with income above 185 percent FPIL will have a six-month income check to determine whether the child remains financially eligible.

If a family has reported any income changes during the first six months of the certification period for CHIP, advisors must act on those changes to determine if the child(ren) remain financially eligible for CHIP.

An automated income check is run in the 5th month of the certification period when the following conditions have been met:

- The individual is certified using MAGI rules;
- The client's income at application was above 185 percent of FPIL;
- The individual will not age out before or during the 5th month;
- Any of the following is true for at least one individual in the MAGI household for at least one countable income or expense source:
  - An income or expense is not verified;
  - One of the following income types uses "Verified by Reasonable Compatibility" as the verification source:
    - Employment Income,
    - Unemployment Compensation Income, or
    - RSDI Income;
  - The verification source is anything other than "Verified by Reasonable Compatibility" and the verification received date is more than 60 days old;
- The case is in Approved Ongoing Mode; and
- There are no pending TLM tasks for the case.

The result of the income check may impact eligibility in the 7th month.

Income Check

TIERS uses the reasonable compatibility calculation to automatically attempt to check electronic data sources to determine whether there has been a change in income that could potentially impact eligibility for Medicaid or CHIP. The automated income check process compares the client's income information in TIERS with income information available through electronic data sources.

When there are no earned income electronic data sources (TWC or TALX) available for the client, TIERS checks to see if there is a New Hire Report. When a New Hire Report exists with an employer's name and hire date that is not currently included in the client's income, the client must provide verification of the information on the New Hire Report.

TIERS may be able to complete the entire PIC process (without any advisor action or correspondence sent to the client) if the PIC does not find an indication that there has been a change in the client's income that makes them potentially ineligible for Medicaid or CHIP.

Process Failure
Revised December 13, 2014

When TIERS receives the reasonable compatibility calculation result of "Process Failure" for TP 08, TP 43, TP 44, TP 48, and TA 84, the PIC is attempted again at the next scheduled PIC.

Impact on SNAP and TANF

Verification is required for SNAP and TANF during the automated income check process when:

- The reasonable compatibility calculation result is "Need Info because ELDS above limit" or the client is required to provide verification of information found on a New Hire Report for a MAGI program; and
- An individual in the MAGI household is included in a SNAP or TANF budget group.

The client has 10 days to provide the verification for SNAP and TANF. If the client does not provide verification by the 10th day, TIERS will automatically take the following action on the 11th day based on the income type and electronic data source used during the automated income verification process:

- **Deny** SNAP and TANF benefits for the following data sources:
  - Quarterly Wage data from TWC
  - New Hire Report data from OAG
- **Adjust** SNAP and TANF benefits using the most recent information from the following data sources:
  - Earned income data from TALX
  - Unearned RSDI income data from the SSA
  - Unearned unemployment data from TWC

See Alert #830, Review Income for SNAP/TANF for more information.

Note: Earned income data from TALX, unearned RSDI data from SSA, or unearned unemployment data from TWC are valid forms of verifications for SNAP and TANF. Since Quarterly Wage data from TWC and New Hire Report data from OAG are not valid forms of verifications for SNAP and TANF, the client must provide verification of the income.

Automation

Electronic Data Sources

TIERS begins requesting information from electronic data sources for an EDG one month prior to the month it will be used for a PIC. TIERS must access data from electronic data sources within 31 days from the date it will be used, which is the weekend before cutoff of the PIC month. TIERS will not request additional data for an individual from a source that has been accessed within 31 days from the date it will be used for a PIC.

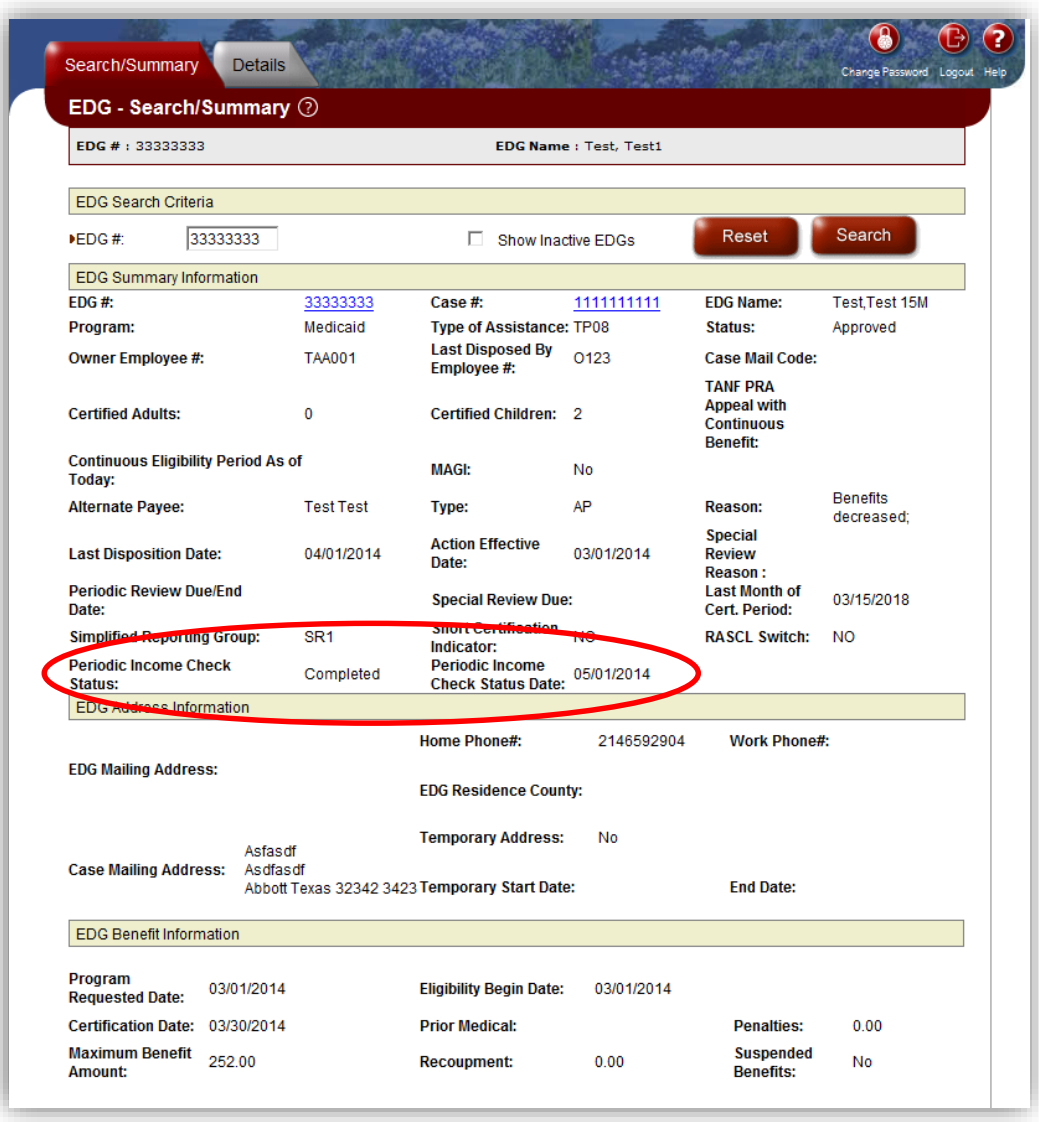
Period Income Check Status

Periodic Income Check Status Field in TIERS and PT inquiry

Not initiated	• When an EDG is certified on a MAGI program that receives a PIC and the first PIC has not yet run.
Initiated	• When an EDG meets the criteria to start the PIC process and TIERS has initiated a PIC. • The date the PIC process started in the system is displayed in the Periodic Income Check Status Date field.
Completed	• The PIC has already been processed for the EDG. • Depending on the program, the status will change if another PIC starts. • The date the PIC process finished is displayed in the Periodic Income Check Status Date field.

Not Applicable	• When the PIC process and PIC results do not apply to an EDG.
	• For example, this status displays for:
	  ○ Individuals certified before January 1, 2014 on pre-MAGI rules, or
	  ○ EDGs certified on a program that does not use the PIC process (e.g., Pregnant Women Medicaid, SNAP, or TANF).

Periodic Income Check Status and Periodic Income Check Status Date



Period Income Check Automatic Denial

When the PIC results in a pend and verification is not provided by the 10-day due date, the EDG is auto-disposed and denied without advisor action.

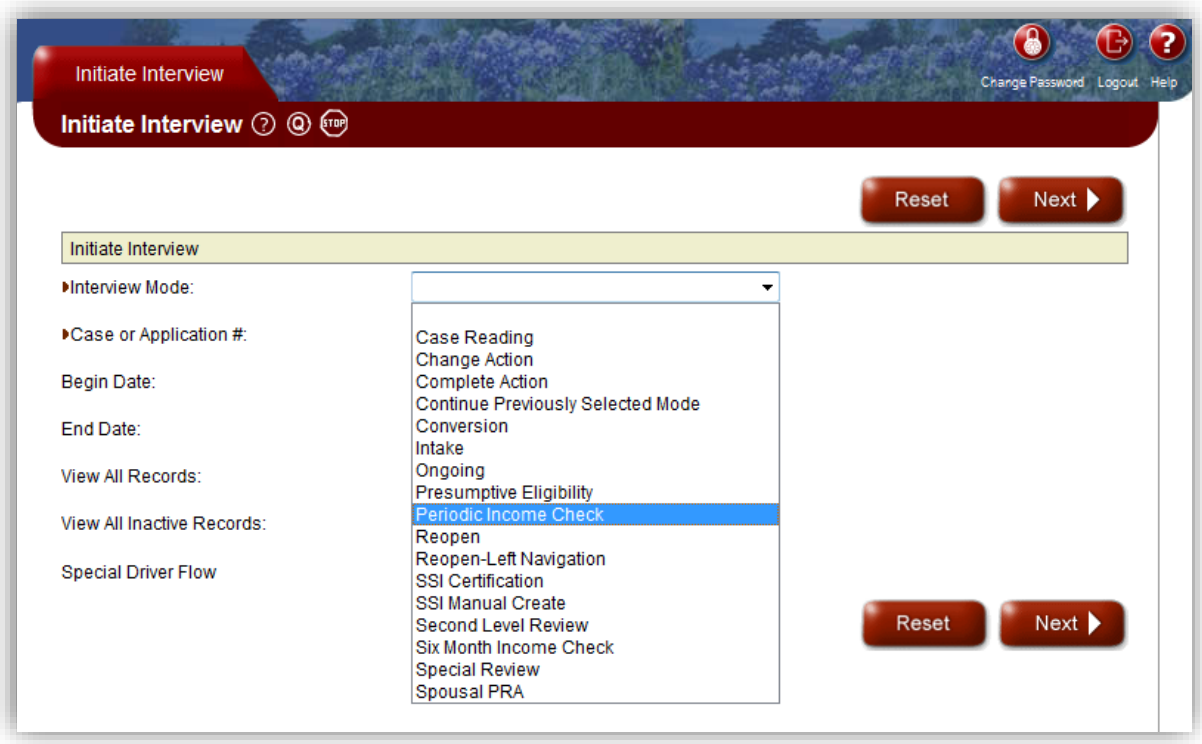
Manual Processing

When the PIC results in a pend and a client returns income or expense information, advisors must process in the Periodic Income Check Mode to complete the PIC.

Period Income Check Mode

The Periodic Income Check Mode should be used when a client returns information because of a missing information request during a PIC. The Periodic Income Check Mode is available in the dropdown of options for the Interview Mode question on the **Initiate Interview** page.

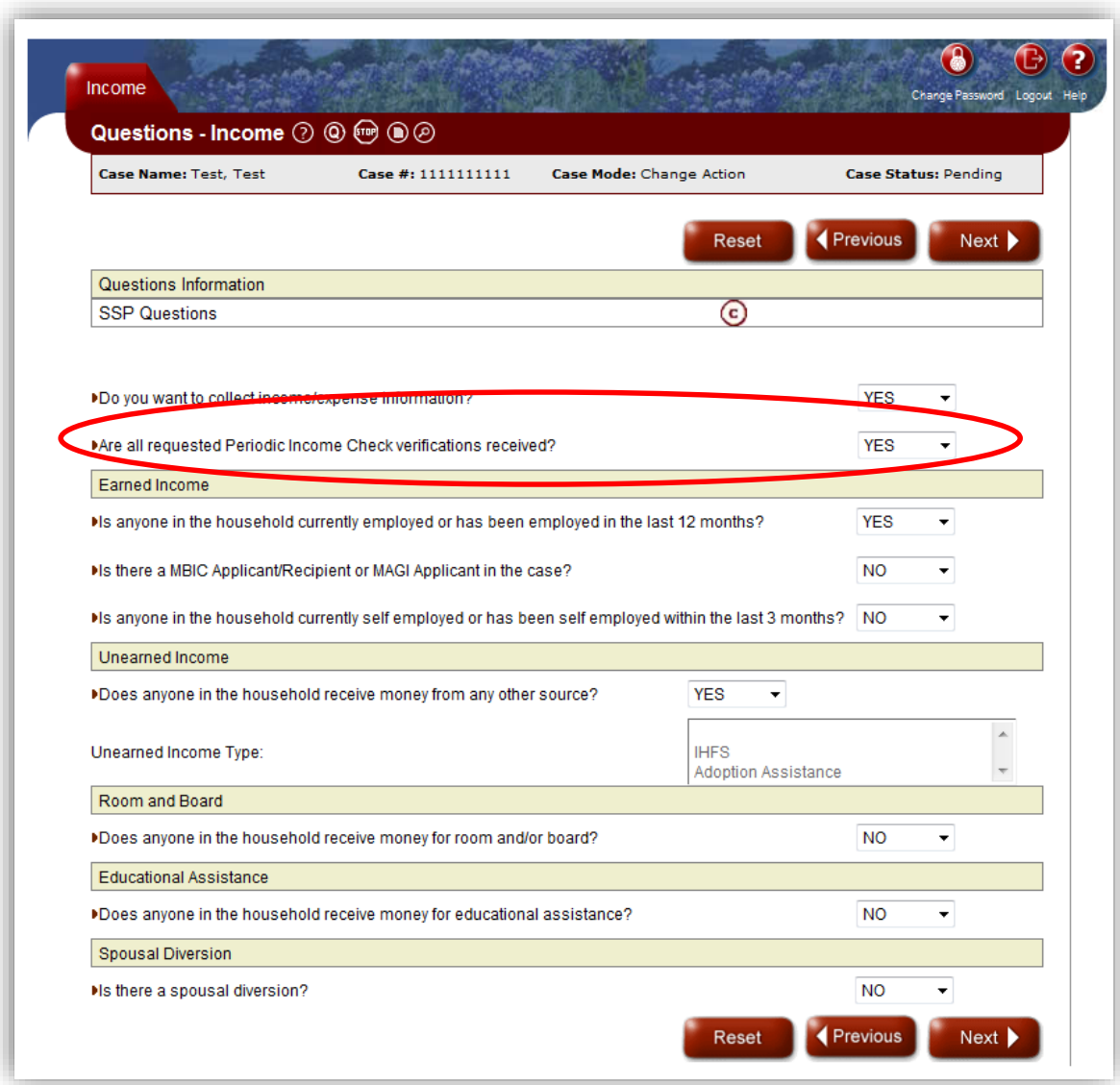
Initiate Interview - Period Income Check Mode



After the client returns information for a periodic income check, TIERS creates a task for an advisor to process the information. After all the income information has been entered the advisor must navigate back to the **Questions-Income** page and answer the question "Are all requested Periodic Income Check verifications received?" based on the income verification provided by the client.

If the individual has provided all the necessary verification and is eligible, select "Yes." Incorrectly selecting "No" will result in an invalid denial, and may cause a gap in coverage.

The following screenshot shows where the new question will be displayed.



Information Received Related to Income Expense Task

The Information Received Related to Income Expense Task is created when the client returns income or expense information during a PIC or an administrative renewal. This income or expense information is manually processed by advisors using the following steps:

- Claim the Information Received for Income/Expense task from TLM.
- Select the Periodic Income Check Mode from the dropdown menu for the Interview Mode question on the **Initiate Interview** page in Data Collection.
- Navigate through TIERS to address all income or expense verification provided by the client.
- Return to the **Questions-Income** page and answer "Are all Periodic Income Check/Medicaid Renewal verifications received?"
- Run EDBC for the Medicaid EDG.
  - If the income or expense verification provided by the client does not affect eligibility, the client remains eligible.
  - If the income or expense verification provided by the client makes the client ineligible, deny the EDG.
- Run EDBC (if applicable) for a SNAP/TANF EDG on the same case.
  - The income or expense verification provided by the client may also impact SNAP and TANF. These benefits must be sustained, adjusted, or denied based on the provided income or expense verification.
    - If the income or expense verification provided by the client does not affect eligibility, the client remains eligible for SNAP and TANF.
    - If the income or expense verification provided by the client impacts current benefits, adjust the benefits for SNAP and TANF.
    - If the income or expense verification provided by the client makes the client ineligible, deny the EDG for SNAP or TANF.

Alert #829, CHIP Periodic Income Check

Advisors manually complete the PIC using these steps:

- Claim the task, *Alert #829, CHIP Periodic Income Check.*
- Select the Periodic Income Check Mode from the dropdown menu for the Interview Mode question on **Initiate Interview** page in Data Collection.
- Manually request ELDS information and process the PIC for the CHIP EDG.

Alert #830, Review Income for SNAP/TANF

TLM creates Alert #830 - Review Income for SNAP/TANF when the 10-day due date passed and income information from TALX, RSDI, or Unemployment income was used to pend for SNAP or TANF.

Advisors manually update SNAP or TANF income information using these steps:

- Claim the task Alert #830.
- Work the case in Change Action Mode.
- Pull a Data Broker report for each individual in the Medicaid MAGI (budget) group requiring a report.

- Review the report and update applicable TIERS fields based on information obtained through Data Broker.
- Run EDBC and dispose or pend the SNAP/TANF EDG.
- Mark the task as Task Completed.

Alert #831, Information received related to Income/Expense
Added December 13, 2014

TLM creates Alert # 831 – Information received related to Income/Expense when a client returns missing information that affects a SNAP/TANF EDG when the individual is on a different case.

Advisors manually update SNAP or TANF income information using these steps:

- Claim the task Alert #831.
- Work the case in Change Action Mode.
- Enter all missing information provided by the client.
- Run EDBC:
  - If the missing information provided by the client does not affect eligibility, the client remains eligible.
  - If the missing information provided by the client impacts current benefits, adjust the benefits.
  - If the missing information provided by the client makes the client ineligible, deny the EDG.

Mass Update Exception

TLM creates Alert #839, Process Mass Update Exception—Termination, when the eligibility outcome is determined as "Additional Information Needed." In this case, the advisor must process the task and deny the EDG because the client has not returned the pended income verification by the final due date.

Advisors manually terminate EDGs that exception out of the mass update auto-disposition for PIC using these steps:

- Claim the task, Alert #839, Process Mass Update Exception—Termination.
- Inquiry to ensure that the required information has not been provided.
- For a termination during a PIC:
  - Select the Change Action Mode from the dropdown menu for the Interview Mode question on the **Initiate Interview** page in Data Collection.
  - Rerun EDBC and dispose the EDG.

<u>Correspondence</u>

Form H1020, Request for Missing Information or Action, is sent to the client when the PIC's RC result is "Need Info because ELDS above limit" or a client must provide verification of the information found on a New Hire Report for a MAGI program.

Effective Date

Changes to policy are effective October 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled “Course AG7 ACA—First Steps of Periodic Income Checks for Advisors” and “AG8: ACA—Periodic Income Checks.” Additional training will be delivered in the web-based courses titled “Course AG-5 ACA—Impact of Periodic Income Checks on HHSC Programs,” “Course AG6: ACA - First Steps of Periodic Income Checks for Clerks,” and “Course AG15: ACA - Changes to Task List Manager (TLM).”

CHIP Six-Month Income Checks

Removed October 1, 2014

PROGRAMS

TP 08 – Parents and Caretaker Relatives Medicaid

Current Policy

A family with a parent or relative caring for a Medicaid dependent child under age 19 may receive Medicaid coverage under TP 08, TANF-Level Families Medicaid, when the household's income is at or below TANF-recognizable needs. Recipients of TP 08 are required to renew coverage every six months.

Those who receive coverage may also qualify for assistance from TANF. Families can choose if they want to receive one or both types of benefits.

New Policy

A parent or caretaker relative caring for a dependent child who receives Medicaid may receive health care coverage through Medicaid when his or her MAGI household income is at or below the MAGI income standard for TP 08, now titled Parents and Caretaker Relatives Medicaid. Current income limits and MAGI-converted income limits can be found for all programs in the Federal Poverty Income Limits section.

Children will no longer be covered under this type program. Children eligible for Medicaid will be certified on a separate Children's Medicaid EDG. In order to transition children currently receiving Medicaid on a TP 08 EDG to a Children's Medicaid EDG, children will be removed from TP 08 cases and assessed for eligibility for Children's Medicaid at their next redetermination after January 1, 2014.

Relationship
Revised September 1, 2015

In order to qualify for TP 08, an individual must be a relative of a dependent child of whom they have care and control. The caretaker must be a:

- Parent
- Stepparent
- Sibling
- Step-sibling
- Grandparent
- Uncle or aunt
- Nephew or niece
- First cousin
- First cousin once removed

To be considered a dependent child, the child must be under age 18, or if age 18, attends school (high school, technical, vocational, trade, or home school) full-time and is reasonably expected to graduate before, or in, the month of the child's 19th birthday.

Note: A child who will not graduate until after the month of the child's 19th birthday is not considered a dependent child after the month of the child's 18th birthday.

Advisors must verify full-time school attendance when the only dependent child(ren) turn(s) 18 years of age or is(are) 18 years of age at application or redetermination. When an individual on TP 08 has dependent children younger than 18 years of age, no verification is required for the 18 year olds' school attendance.

During the summer months, advisors must determine whether the dependent child met the requirement at the end of the previous school year and confirm that the child intends to meet the requirement when school begins.

Example 1: If there are two dependent children, one child is age 6 and the other child is age 18, and their parent is applying for TP 08, school attendance requirements do not apply to the child who is age 18 since there is another dependent child, age 6, for the TP 08 parent or caretaker relative to claim.

Example 2: If there are two dependent children, both age 18, and their parent is applying for TP 08, school attendance requirements apply to both children because both children are age 18 and there are no other dependent children for the TP 08 parent or caretaker relative to claim.

The following sources currently used for school attendance verification for TANF are acceptable for verifying school attendance for TP 08 requirements:

- School attendance registrar records
- A current report card
- Form H1086, School Attendance Verification
- A statement from the individual indicating the child is home schooled, if not questionable (Note: If the individual's statement is questionable, have the individual provide copies of their curriculum, study materials, or other proof of coursework.)

Deprivation
Revised September 1, 2015

Deprivation no longer applies when making an eligibility determination for TP 08.

Domicile

The dependent child must live with the parent or caretaker relative, but the dependent child does not need to be included in the MAGI household composition of the parent or caretaker relative.

Example: A grandfather is living with his grandchild, but the grandchild is claimed as a tax dependent by a non-custodial parent. The grandchild would not be included in the grandfather's MAGI household composition. However, the grandfather would meet the domicile requirement if the grandchild lives in the same household and meets the care and control requirements. For more information, see the Household Composition section.

In general, for a caretaker to be considered as having care and control of a child, the child must live in the home with the relative. A home is the family setting maintained or being established, as evidenced by continuation of responsibility for day-to-day care of the child by the relative with whom the child is living.

Policies listed in TWH A-900 Domicile related to domicile of a child still apply in the determination of a caretaker's eligibility for TP 08, Parents and Caretaker Relatives Medicaid. This includes all exceptions for children temporarily living outside of the home.

Financial Eligibility

In order to be eligible for Parents and Caretaker Relatives Medicaid, the individual's MAGI household income must be at or below the applicable income standard for TP 08 based on family size. Family size and income for TP 08 cases will be determined using MAGI rules.

Note: As a result of the change to income calculation rules for TP 08, an individual who is eligible for Parents and Caretaker Relatives Medicaid may or may not be eligible for TANF cash assistance. A person may be eligible to receive both types of assistance; however, eligibility for one does not necessarily guarantee eligibility for the other and they must apply for the desired program or programs.

Automation

TLM will create a task when TIERS triggers Alert 818 (TP 08/TA 31 in EDG XXXXX). The alert is generated to dispose a TP 08/TA 31 EDG after the eligible child's EDG on a separate case has been disposed.

School Attendance
Added September 1, 2015

The following new (non-mandatory) fields have been added to the **Education – Details** page to capture whether school attendance was verified for a dependent child who is 18 years of age:

- Status
- Expected Graduation Date
- Enrollment Status
- Type of Educational Institution

For each new field, TIERS allows advisors to select a verification source from the corresponding verification drop down menu and enter the date the information is verified. The possible selections include:

- Client Statement
- School
- Report card (current)
- Form H1086 – School Attendance Verification
- Not Verified
- School or day care records
- Other Acceptable

When the only dependent child associated with the TP 08 EDG turns 18 years old during the certification period, TIERS triggers Alert 850 (Only Dependent Child(ren) is 18 - Verify School Attendance) and a task is created requiring the advisor to verify school attendance.

Effective Date

Changes to policy are effective September 19, 2015.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on TP 08, Parents and Caretaker Relatives Medicaid, will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Training on 18-year-old School Attendance verification will be presented in a web-based course titled “Course R94-3 – 18 Year Old Students.”

Transitional Medical Assistance

Current Policy

Some TP 08-certified household members may be eligible for Transitional Medicaid. There are three Transitional Medicaid type programs: TP 07, TP 37, and TP 20. TP 08-certified household members are eligible for Transitional Medicaid if the denial of TP 08 is due to:

- New or an increase in earnings (TP 07)
- Loss of the 90 percent earned income deduction (TP 37)
- New or increased child support income (TP 20)

TP 07 and TP 37

Households certified under TP 07 and TP 37 receive a 12-month certification period for Transitional Medicaid and are required to report certain changes during the 4th, 7th, and 10th months of the transitional period.

Form H1146, Medicaid Report, is computer-generated and is sent to the household at cutoff in the 3rd, 6th, and 9th months. Form H1146:

- Informs the household of the availability of continuing transitional coverage
- Provides information about the change reporting requirements
- Provides a way to report the required information

During any of the reporting periods, the household is required to report changes in:

- The household members' gross monthly earnings
- Child care expenses necessary for the employment of the parent or caretaker relative
- Household composition

If the household does not return Form H1146, no action is required.

New Policy

TP 07 and TP 37

Under new federal income rules, an eligibility determination for TP 07 or TP 37 will be based on whether a parent or caretaker relative is certified for TP 08, Parents and Caretaker Relatives Medicaid. Effective January 1, 2014, children will be certified for Children's Medicaid. If a parent or caretaker relative certified for TP 08 coverage is eligible for Transitional Medicaid, his or her children will be eligible as well. Each individual will be certified on an individual Transitional Medicaid EDG for the duration of the certification period.

For example: The MAGI household composition consists of mom, dad, and two mutual children. Mom and dad each are certified on an individual TP 08 EDG and each child on an individual Children's Medicaid EDG. Dad has an increase in income that makes him eligible for TP 07. Dad is then certified on an individual TP 07 EDG. Mom and the two children will be certified on individual TP 07 EDGs each with the same certification period as the dad.

Applicants certified for TP 08 coverage prior to January 1, 2014, who are eligible for TP 07 or TP 37 coverage will continue to be certified on a single TP 07 or TP 37 EDG since the eligibility determination was made using the rules prior to January 1, 2014.

Clients receiving TP 07 or TP 37 coverage will only be required to report the following changes during the 4th, 7th, and 10th months of the transitional period:

- Changes in the household members' gross monthly earnings
- Changes in the MAGI household composition

Clients are no longer required to report changes in child care expenses since they are no longer applicable.

As with current policy, if the household does not return Form H1146, no action is required.

Since previous deduction types are no longer applicable, applicants certified for TP 08 effective January 1, 2014, will no longer be eligible for TP 37 coverage. Applicants certified for TP 08 prior to January 1, 2014, may be eligible for TP 37 coverage if the denial of the TP 08 is due to the loss of the 90 percent income deduction.

TP 20

Child support income is no longer a countable type of income under new federal rules; however, spousal support will continue to be a countable type of income. TP 20 will continue for clients denied TP 08 because of new or increased spousal support. Determination of TP 20 eligibility will be based on a parent or caretaker relative certified for TP 08. If eligible, an individual Transitional Medicaid EDG will be created for each parent or caretaker relative and one for each child as well. The certification period remains at four months following the last month of TP 08 eligibility.

Automation

No automation changes are necessary.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be provided as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Income Limits for Children Ages 6-18

Current Policy

Children ages 6 through 18 with household income equal to or less than 100 percent FPIL are eligible for TP 44, Children Ages 6-18, and children ages 6 through 18 with household income above the Medicaid income limit up to 200 percent FPIL for children.

New Policy

Children ages six through 18 with MAGI household income at or below 133 percent FPIL are now eligible for TP 44, Children Ages 6-18. As a result of this increase in the income limit for this age group, effective January 1, 2014, children whose MAGI household income is above 100 up to and including 133 percent FPIL will be determined eligible for Medicaid, rather than CHIP, provided that all other eligibility criteria are met.

Any children who are currently receiving CHIP with income above 100 percent FPIL up to 133 percent FPIL will remain in CHIP until their next regularly scheduled redetermination. At redetermination the child's eligibility will be assessed based on the new income rules. The MAGI cascade will automatically place children in the correct program on or after January 1, 2014.

There will not be a mass update to move children currently certified under CHIP to Medicaid.

Automation

No automation changes are necessary.

Effective Date

Changes to policy are effective January 1, 2014. All application and redeterminations processed on or after January 1, 2014, will be impacted by this change.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on the change in Children's Medicaid income limits will be presented as part of an instructor led training series titled ACA – Changes to Texas Works Programs.

Former Foster Care Changes

Former Foster Care Children (FFCC)

Current Policy

Currently, there are two programs for which individuals who age out of foster care may be eligible:

- Medicaid for Transitioning Foster Care Youth (MTFCY) from age 18 up to 21

- Former Foster Care in Higher Education (FFCHE) for individuals enrolled in higher education from ages 21 up to 23

New Policy
Revised September 1, 2014

Effective January 1, 2014, under ACA, a new Medicaid category is available for former foster care youth who meet all of the following conditions:

- Aged out of foster care or the Unaccompanied Refugee Minor Resettlement Program in the state of Texas at age 18 or older
- Ages 18 up to 26
- Received federally funded Medicaid when they aged out of foster care
- Meet all other Medicaid eligibility criteria such as U.S. citizenship, alien status, and Texas residency

There is no income or resource test requirement for FFCC.

Individuals currently receiving MTFCY and FFCHE as of December 2013 who meet the criteria just listed will automatically transition to FFCC January 1, 2014. Individuals receiving MTFCY or FFCHE who do not qualify for FFCC will remain on MTFCY or FFCHE until they reach the age limit of the medical program.

CBS staff is responsible for processing all FFCC applications and redeterminations, along with any other associated active EDGs. The FFCC program is identified in TIERS as TA 82, Medicaid for Former Foster Care Children.

CCC staff is responsible for processing changes for FFCC.

Application Processing

The majority of FFCC applications will be received through the current DFPS interface when the individual ages out of foster care. This is consistent with the current process for MTFCY. In addition to the interface with DFPS an individual can apply for FFCC using the following channels:

- Fax or mail:
  - Form H1010, Texas Works Application for Assistance – Your Texas Benefits, or
  - The new Form H1205, Texas Streamlined Application
- Online at YourTexasBenefits.com
- Through the Marketplace at HealthCare.gov
- Call 2-1-1, and after selecting a language select Option 2

If an applicant is not eligible for FFCC the application will be evaluated for other Medicaid programs.

File Date

The file date is the day an application is received in one of the following ways:

- By an HHSC eligibility determination office
- Through the SSP

- By a call center vendor
- Through an account transfer from the Marketplace

The file date for cases received through the DFPS interface is the date the interface is received. To be a valid application, it must contain the applicant's name, address, and appropriate signature/electronic signature. This is day zero in the application process.

Interviews

An interview is not required when applying for or renewing FFCC.

Certification Periods

FFCC has a 12-month certification period but cannot go beyond the month of the individual's 26th birthday. When the individual reaches the maximum age, the EDG is automatically denied effective the end of the month of the individual's 26th birthday.

An individual does not receive 12 months of coverage if the following happens prior to the end of the certification period. The individual:

- Dies
- Voluntarily withdraws
- Moves out-of-state
- No longer meets the eligibility criteria for FFCC

Three Months Prior FFCC Eligibility

FFCC applicants are eligible for three months prior coverage. Three month prior coverage under FFCC cannot precede January 1, 2014. If eligible under another Medicaid program, an individual can receive three months prior coverage for months requested prior to January 1, 2014, on the Medicaid program for which the individual would have qualified prior to January 1, 2014. Coverage from January 1, 2014, forward will be under the FFCC program.

Household Composition

The certified group consists of only the individual. Household composition is self-declared.

Medicaid Eligibility

An individual is ineligible for FFCC if they aged of foster care in any state other than Texas. TIERS will perform the verification of receipt of Medicaid in Texas if the answer in the **Individual Information** page is "Texas" for **If Yes, State:** and **Verification** is "Not Verified." If the state is blank, select "Texas" and "Not Verified," allowing TIERS to perform the verification.

Citizenship and Alien Status
Revised June 1, 2014

Verify citizenship and alien status following the new policy detailed in the Citizenship and Identity section. Individuals who are U.S. citizens and certain legally-admitted alien residents are eligible for FFCC if they meet all other Medicaid eligibility criteria.

The alien status policy for FFCC programs follows Chart D for MTFCY in TWH A-342 TANF and Medical Programs Alien Status Eligibility Charts. Individuals are no longer eligible for FFCC the month after their 21st birthday if they no longer qualify under Chart D. For individuals 21 and older, continue eligibility if they are otherwise eligible based on Charts A, B, and C. FFCC applicants must receive a reasonable opportunity to verify their citizenship or alien status. See the Reasonable Opportunity section for further details.

The DFPS interface provides the following information pre-populated into TIERS for individuals with an alien status:

- Document Type - I-551 or I-94
- Annotation/Category (conditionally based on document type)
- USCIS Documented US Entry Date
- Alien Status Expiration Date
- Alien Registration Number (the “A” number)

Verification of alien status is required when the information received via the interface does not match the information in TIERS or when the document type is marked “other.” Do not request verification from the individual until efforts to verify alien status through DFPS have been attempted. Staff must request an image of the alien status documentation from DFPS to verify the alien status.

Within 10 days of receiving the task, staff must email the DFPS FC-ADO Mailbox, fcadomedex@dfps.state.tx.us and copy tonya.eason@dfps.state.tx.us to request the image of the alien documentation. The email must include the individual’s name, date of birth, and SSN and must be encrypted. **Do not** include any client information in the subject line of the email. DFPS should reply to this request within five work days. If the DFPS image does not provide sufficient information to verify alien status, then FFCC applicants must receive a reasonable opportunity to verify their alien status.

Social Security Number

All applicants must provide an SSN or apply for one through SSA before certification. For more information, see the Citizenship and Social Security Number section.

Age

The applicant is eligible to receive benefits beginning the month of his or her 18th birthday through the end of the month of his or her 26th birthday.

Exception: An individual is no longer eligible for FFCC the month after his or her 21st birthday if the individual no longer qualifies due to alien status.

Identity

Follow TWH A-600 Identity policy for identity.

At the initial certification, verify the identity of the individual applying for FFCC. Once identity has been verified, do not re-verify at redetermination.

Verify identity following the new policy in Citizenship and Identity section**.**

Residence

Use policy in TWH A-700 Residence, for Medicaid, verification policies found in TWH A-760 Verification Requirements, under All Programs, and TWH A-761 Verification Sources, for All Programs to determine residence eligibility.

Self-declaration of intent to reside in Texas is acceptable verification.

Third Party Resource
Revised June 1, 2014

Use policy in TWH A-860 Third Party Resources (TPR) under Medical Programs. TPR does not affect eligibility. FFCC recipients with TPR must cooperate in providing details of the TPR.

The TPR information has been verified when the "NHIC" box is checked and greyed out. Staff cannot end/terminate the coverage. If the individual has TPR and the "NHIC" box is greyed out, this information has already been verified by the Office of Inspector General – Third Party Liability area.

Pend for verification if:

- The individual indicates the individual has TPR, and
- Required TPR information has not been verified.

Some former foster care individual's parents may have TPR coverage for the applicant without the individual being aware of this coverage. If the individual states they are not aware of the TPR or do not know the details of the TPR, but the TPR has been verified by TMHP, advise the applicant to call the TMHP Third Party Liability Customer Service Line at 800-846-7307 and select option 2. This will allow the individual to obtain information regarding the TPR.

If the TPR information in TIERS has been verified by TMHP but needs to be updated, fax the completed Form H1039, Medical Insurance Input, to TMHP at 512-514-4215.

Eligibility Begin Dates

Use policy in TWH A-820 Regular Medicaid Coverage to determine the correct eligibility begin dates. The applicant is eligible the first day of the application month if all eligibility criteria are met. Certified applicants are eligible to receive benefits beginning the month of their 18th birthday through the end of the month of their 26th birthday.

The MED cannot precede:

- January 1, 2014, the program effective date, or
- The month of the individual's 18th birthday.

Health Plan Coverage

FFCC recipients will be automatically enrolled in STAR Health through the month of their 21st birthday. STAR Health provides a full range of Medicaid covered medical and behavioral health services for DFPS clients. Individuals may opt out of STAR Health for STAR, which allows for a choice of health plans.

Once an FFCC recipient attains the age of 21, coverage will transfer to STAR. STAR provides a full range of Medicaid covered medical and other services for many children and adults.

Other Policies

The following eligibility requirements do not apply to FFCC individuals:

- Domicile
- Deprivation
- Requirements to pursue child and medical support
- Resource test
- Income test
- Deductions
- School Attendance
- Management
- Employment Services

Case Disposition

When processing an individual's application, redetermination, or change, the individual must be provided with one or more of the following notices if the case is pended, certified, sustained, or denied.

Notice to Applicants

TF0001, Notice of Case Action

TF0001 informs the individual of their:

- Benefit begin date, or
- Date of denial and right to a fair hearing to appeal a case action

Note: A one-time TF0001 will be sent after December 23, 2013, and prior to January 1, 2014, to current MTFCY and FFCHE recipients who are eligible for FFCC informing them of the change in coverage.

Form H1020, Request for Information or Action

Form H1020 informs the individual the:

- Reason the case is pending
- Action the client or advisor must take
- Date by which the client or advisor must take action
- Date the advisor must deny the application/case if the client does not take action, if applicable

When verification of information is needed, allow the household at least 10 days to provide verification. The due date must be a workday. If the applicant has any active or inactive TIERS EDG(s), check to see if any verification previously provided for the other EDG(s) can be used to determine eligibility for FFCC.

Note: Do not use verification over 90 days old from the FFCC file date.

Changes

An individual must report the following changes:

- Moves out-of-state
- An address change
- Enrollment in health insurance

FFCC individuals can report changes:

- At YourTexasBenefits.com
- By calling or visiting a local eligibility office
- In writing by mail or fax, such as by completing Form H1019, Report of Change
- By calling 2-1-1

Note: When a change is reported by telephone, staff must verify that the person speaking is the individual or an authorized representative. See TWH A-2000 Identifying Applicants Interviewed by Phone and Prevention of Duplicate Participation for details on verifying identity by telephone.

Fair Hearings and Appeals

Use policies found in section TWH B-1000 Fair Hearings when an individual requests an appeal. Individuals have the right to appeal within 90 days from the effective date of any HHSC action. The individual's request may be oral or in writing.

Time Frames

Use policies found in section TWH M-2100 Processing Time Frames for processing timeframes. Staff must make an eligibility determination by the 45th day from the file date. Provide Form TF0001, Notice of Case Action, the same day eligibility is determined for an application but no later than 45 days from the file date.

Redeterminations
Revised September 1, 2014

MTFCY and FFCHE individuals who transition to FFCC on January 1, 2014 will maintain the same redetermination date. **For example:** If a current MTFCY recipient has a renewal date of May, that person is eligible and transitions to FFCC on January 1, the next renewal will occur May 2015.

There may have been renewal packets mailed prior to the transition. If any redetermination packets are received, staff must only record changes of address or alien status changes. No further action is necessary.

Effective September 1, 2014, renewals for FFCC clients will follow a new policy. Please see the sections for Administrative Renewals for FFCC, Administrative Renewal Correspondence for FFCC, and Administrative Renewal Processing for FFCC.

Automation

Automation changes will be implemented with Release 89 scheduled for December 2013.

The FFCC TOA will be identified as “FFCC” on all related correspondence, in the STP, in TLM, and the screens in TIERS.

TLM and Alerts

With the exception of the alerts discussed below, existing alerts for MTFCY and FFCHE are applicable for FFCC. Some of the tasks associated with FFCC include:

- Process a FFCC Application
- MI (Missing Information) Requested on a FFCC Application
- Change for a FFCC Case
- MI Requested on a Change for a FFCC Case
- Duplicate FFCC Application
- MI Requested for a FFCC Duplicate Application

The following new alerts create a TLM task to CBS staff at application and redetermination:

Alert 826: FFCC Has Not Been Disposed - For FFCC EDGs when another EDG is being processed by an advisor with a non-CBS user role and the FFCC EDG does not meet the auto-disposition criteria.

Alert 821: FFCC Citizenship/Alien Status Exception - Task to process an FFCC EDG when the following exceptions are received:

- Citizenship does not match with TIERS
- Alien status does not match with TIERS
- Valid verification not received for citizenship and alien status
- Document Type is ‘Other’

When this task is received, staff must verify citizenship/alien status as detailed under FFCC Citizenship/Alien Status section of this document.

Alert 820: FFCC Mass Update Exception - Task to process FFCC exceptions received from the DFPS interface when attempting to process mass updates. Task Comments will display with language providing staff with instructions to clear the exception.

Appeals for FFCC will be supported in TLM and STP.

Forms
Revised March 1, 2014

The following forms have been modified to support FFCC:

Form H1010, Texas Works Application for Assistance

The following questions were added:

- Were you in foster care at age 18 or older? ___Yes ___ No If yes, in which state?
- Were you in an approved Unaccompanied Refugee Minor's Resettlement program at age 18 or older? ____ Yes ____No If yes, in which state?_____

To be considered for FFCC, the applicant must answer yes to one of the above questions and be under the age of 26.

Form H1010-MR, MAGI Renewal Addendum

Form H1010-MR, MAGI Renewal Addendum, will also contain the FFCC questions. When included with the H1010-R and either of the FFCC questions is marked yes and the individual is under the age of 26. CBS staff will evaluate whether the individual is eligible for FFCC and dispose any associated renewals also included within the H1010-R.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on FFCC will be provided in November and December 2013.

Medicaid for Transitioning Foster Care Youth (MTFCY)

New Policy

Due to ACA, there are changes to the MTFCY program:

- Eligibility must now be determined using the MAGI rules.
- The program will cover individuals who do not qualify for FFCC, specifically those who did not receive federally funded Medicaid when they aged out of foster care.
- Individuals who age out of foster care in a state other than Texas are no longer eligible.
- There is no longer is a resource test when determining eligibility.

Individuals receiving MTFCY as of December 2013 who are eligible for FFCC coverage will automatically transition to FFCC January 1, 2014.

Household Composition

MAGI rules are used in determining MAGI household composition for MTFCY. This means that now an individual on MTFCY may have a MAGI household size larger than one. For more information on MAGI household composition rules, see the Household Composition section.

Exception: An individual received via the DFPS interface will continue to have a MAGI household size of one. MAGI household size may change at the time of redetermination if

additional information is received indicating that additional people should be included in the MAGI household composition.

Financial Eligibility

Staff must use MAGI Calculation when determining eligibility for MTFCY.

Resources
Revised September 1, 2014

There will no longer be a resource test.

Medicaid Eligibility

Currently, individuals who aged out of foster care from another state are eligible for MTFCY. Effective January 1, 2014, individuals who aged out of foster care in a state other than Texas will no longer qualify for MTFCY.

Individuals certified under MTFCY on or before December 31, 2013, who aged out from another state, will continue to receive MTFCY until they age out.

Application Processing

Form H1011, Application for Medicaid for Youth Transitioning from Foster Care or an Approved Unaccompanied Refugee Minor's Resettlement Program, will be discontinued effective January 1, 2014.

As is the current process, most individuals who age out of foster care are received through an interface with DFPS. In addition to the interface, an individual can now apply for MTFCY using the following channels:

- Fax or mail :
  - Form H1010, Texas Works Application for Assistance – Your Texas Benefits, or
  - Form H1205, Texas Streamlined Application
- Online at YourTexasBenefits.com
- Through the Marketplace at HealthCare.gov
- Call 2-1-1, and after selecting a language, select Option 2

One of the following questions must be marked "**Yes"** on the application for eligibility to be considered for MTFCY.

- Were you in foster care at age 18 or older?
- Were you in an approved Unaccompanied Refugee Minor's Resettlement Program at age 18 or older?

If ineligible, eligibility will be considered under other Medicaid programs.

Continue to process any Form H1011s received on or after the effective date. Staff must pend for MAGI information using Form H1010-M, Applying for or Renewing Medicaid or CHIP?

Form H1011-A, Medical Renewal Form for Youth Transitioned from Foster Care or an Approved Unaccompanied Refugee Minor's Resettlement Program, will continue to exist for those individuals ineligible for FFCC.

Note: A one-time TF0001 will be sent after December 23, 2013, and prior to January 1, 2014, to current MTFCY recipients who are determined eligible for FFCC and transferred to FFCC informing them of the change in coverage.

Redetermination
Revised October 1, 2014

MTFCY uses the Administrative Renewal policy. For more information, see the sections on Administrative Renewals, Administrative Renewal Correspondence, and Administrative Renewal Processing.

Third Party Resources
Revised June 1, 2014

An individual is not eligible for MTFCY if they currently have adequate health coverage as defined by HHSC.

If staff receive a task with information that the individual has TPR and the NHIC box is greyed out, do not pend the EDG. Deny the EDG. This information has already been verified by the Office of Inspector General – Third Party Liability area.

The TF0001 denial due to adequate health care coverage was modified to include the following language:

"We found that you already have private health insurance. To learn more about the insurance you already get, call toll-free 1-800-846-7307 (after you pick a language, press 2)."

In some instances, the parents of MTFCY recipients have TPR coverage for them without the individual knowing. If the individual states they are not aware of the TPR, advise them to call the TMHP Third Party Liability Customer Service Line at 800-846-7307 and select option 2. This will allow the individual to obtain information regarding their TPR.

If the TPR information in TIERS has been verified by TMHP but needs to be updated, fax the completed Form H1039, Medical Insurance Input to TMHP at 512-514-4215.

Automation

Implementation of automation changes will occur in Release 89 scheduled for December 2013.

TLM and Alerts

The following new alerts create a TLM task to CBS staff at application and redetermination:

Alert 822: MTFCY Citizenship/Alien Status Exception - Task to process an FFCC EDG when the following exceptions are received:

- Citizenship does not match with TIERS
- Alien status does not match with TIERS

- Valid verification not received for citizenship and alien status
- Document Type is “Other”

When this task is received, staff must verify citizenship/alien status as detailed under the FFCC Citizenship/Alien Status section of this document.

Alert 827: MTFCY Mass Update Exception - Task to process MTFCY exceptions received from the DFPS interface when Mass Updates occur. Task Comments will display with language providing staff with instructions to clear the exception.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on MTFCY will be provided in November and December 2013.

Former Foster Care in Higher Education (FFCHE)

New Policy

Effective January 1, 2014, no new individuals will be certified for FFCHE. Individuals receiving FFCHE as of December 2013 and eligible for FFCC will transition to FFCC January 1, 2014. Applications and redeterminations disposed on or after January 1, 2014, will be reviewed for FFCC eligibility. Those individuals not eligible for FFCC will continue to receive FFCHE until they age out of the program or are no longer eligible, whichever comes first.

Form H1868, Applications for Health Care Benefits, will be discontinued. Any Form H1868s received after this transition will be evaluated for FFCC. If an application for FFCHE is received after January 1, 2014, and the individual is not eligible for FFCC, the application will be denied.

Until FFCHE is discontinued, FFCHE redeterminations will continue as passive redeterminations processed by CBS staff.

Note: A one-time TF0001 will be sent after December 23, 2013, and prior to January 1, 2014, to current FFCHE recipients who are eligible for FFCC informing them of the change in coverage to FFCC.

Effective Date

Changes to policy are effective January 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training on FFCHE will be provided in November and December 2013.

Administrative Renewals for FFCC

Added September 1, 2014

Current Policy

Effective January 1, 2014, the ACA requires HHSC to determine eligibility for TA 82, Former Foster Care Children (FFCC). The first renewals for FFCC are due in December 2014.

HHSC does not currently have a renewal policy for FFCC.

New Policy

Effective September 1, 2014, Administrative Renewal policy begins for FFCC. The renewal correspondence generated beginning in September 2014 is for clients who were originally certified on FFCC in January 2014 with renewal due dates in December 2014. CBS advisors process FFCC renewals.

Automated Renewal Process

Initiating an administrative renewal requires no advisor action and uses the Automated Renewal Process to gather information from a client's existing case and from electronic data sources to determine if the client remains potentially eligible for Medicaid benefits.

As part of the automated renewal process, electronic data is requested one month before it is used by TIERS. The electronic data is used the weekend before cutoff in the 9th month of the certification period to gather available verifications required to renew Medicaid benefits.

For FFCC, these include:

- Residency (See the section for FFCC Residence), and
- Immigration Status (See the section for FFCC Citizenship and Alien Status).

Once available verifications are pulled into the automated renewal process, the system runs eligibility. Below is a list of possible automated renewal process outcomes.

FFCC Automated Renewal Process Outcomes

"Eligibility Potentially Approved"	• All required eligibility information **can** be verified during the automated renewal process and no additional verification is needed from a client. • Clients must review the information used to determine their eligibility but are only required to return a signed renewal form, Form H1206, if the information used to

	renew their Medicaid benefits was incorrect or there has been a change to their case.
"Additional Information Needed"	• All required information **cannot** be verified during the automated renewal process and additional verification is needed from the client. • The client must return a signed renewal form, Form H1206, and all requested verification(s).

The automated renewal process generates client correspondence depending on the eligibility outcome of the automated renewal process. For additional information on renewal correspondence, see the section for Administrative Renewal Correspondence for FFCC.

Automation

Electronic Data Sources

TIERS begins requesting information from electronic data sources for an EDG in the 8th month of the certification period. TIERS must access data from electronic data sources within 31 days from the date it will be used, which is the weekend before cutoff in the 9th month. TIERS will not request data for an individual from a source that has been accessed within 31 days before cutoff in the 9th month.

Renewal Status
Revised September 1, 2015

The renewal status on the **EDG Search/Summary** page in TIERS inquiry has been updated to display the outcome of the automated renewal process.

When TIERS initiates an administrative renewal, the renewal status for FFCC must display as one of the following:

- Review Required: Eligibility Approved, or
- Review Required: Additional Information Needed.

The following chart provides the resulting required advisor action and generated correspondence for both renewal statuses.

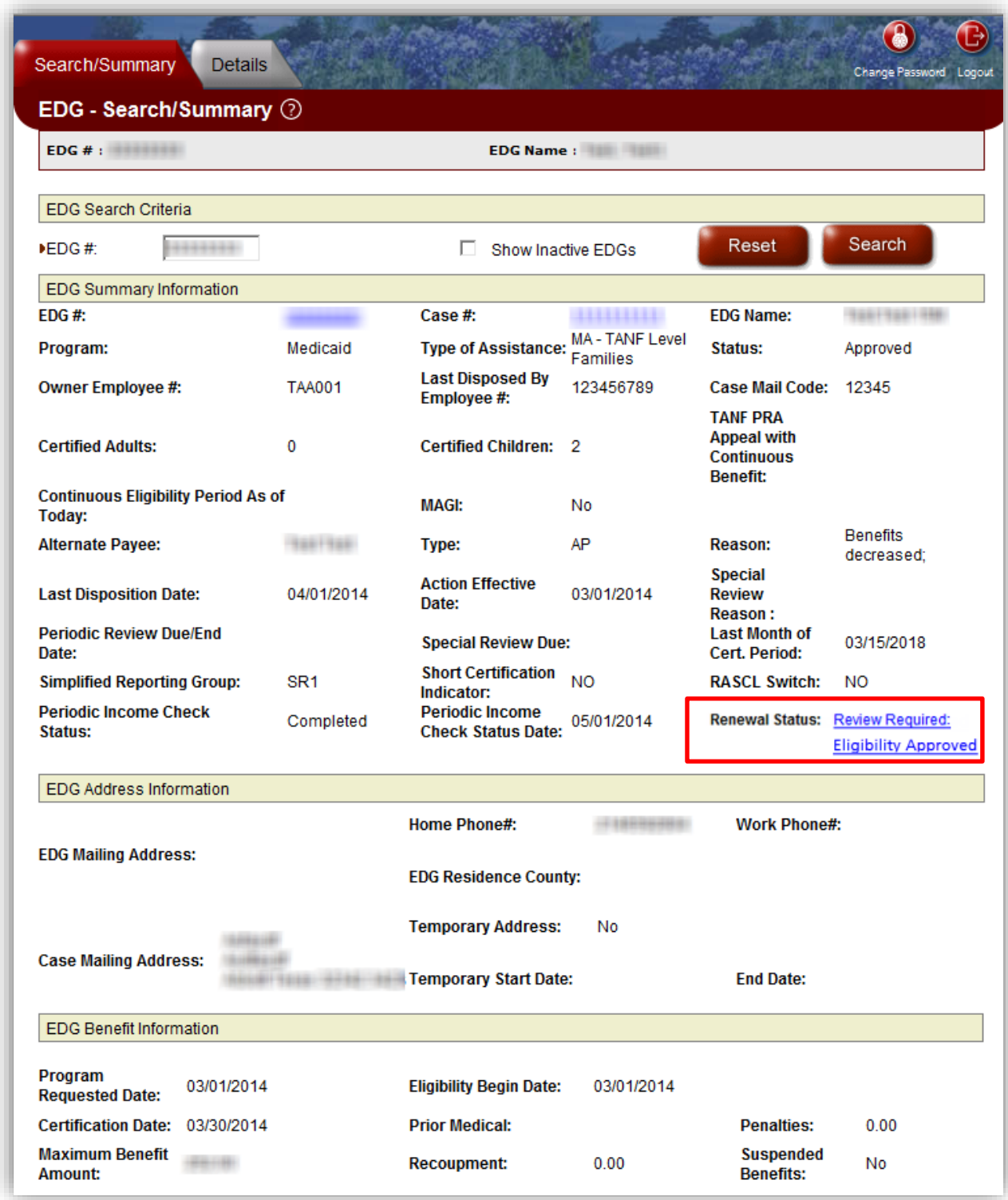
FFCC Renewal Status Outcomes

Renewal Status	Eligibility Outcome	Advisor Action and Correspondence

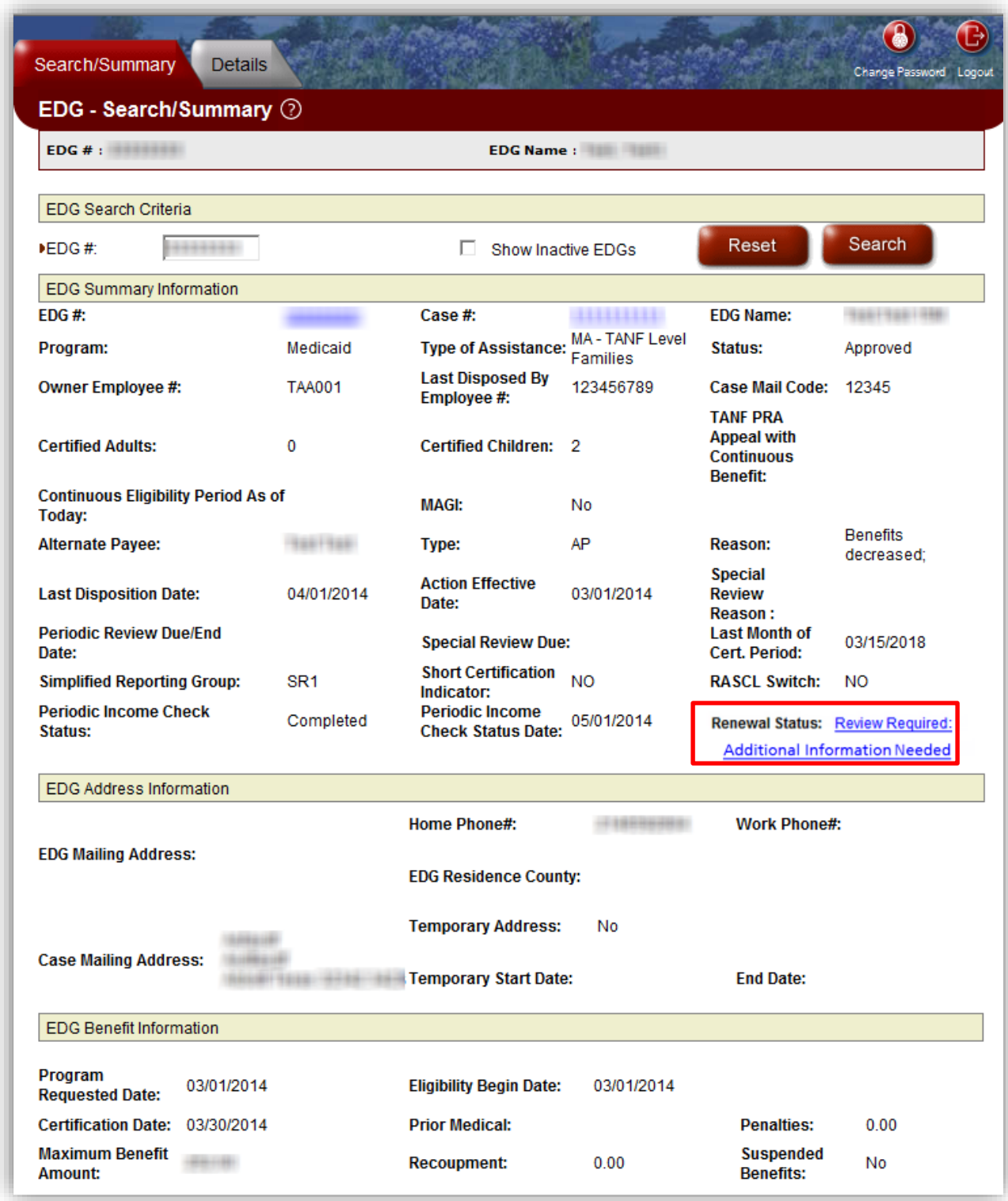
"Review Required: Eligibility Approved"	*Eligibility potentially approved* (TIERS had sufficient information to determine the client potentially eligible.)	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, is sent to the client, informing them that they must review the information used to renew their eligibility and are required to return a signed renewal form only if the information on the form was incorrect or there has been a change to their case. • If the client: ○ **Does not** return a renewal form, the system auto-approves the EDG. ○ **Does** return a renewal form, the advisor manually processes the renewal.
"Review Required: Additional Information Needed"	*Additional Information Needed* (TIERS did not have sufficient information to determine the client potentially eligible.)	• Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, is sent to the client, informing them that they must return a signed renewal form and additional verification to renew their Medicaid Benefits. • If the client: ○ **Does not** return a renewal form, the system auto-denies the EDG. ○ **Does** return a renewal form, the advisor manually processes the renewal.

The following screenshots show how the renewal status will be displayed in TIERS.

Review Required: Eligibility Approved



Review Required: Additional Information Needed



Effective Date

Changes to policy are effective September 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled “Course AG10: ACA - Administrative Renewals” and “Course AG7: ACA - First Steps of Periodic Income Checks and Administrative Renewals for Advisors.” Additional training will be delivered in the web-based courses titled “Course AG11: ACA - Administrative Renewals for MTFCY and FFCC” and “Course AG1: ACA - Overview of Administrative Renewals.”

Administrative Renewal Correspondence for FFCC

Added September 1, 2014

Current Policy

Effective January 1, 2014, the ACA requires HHSC to determine eligibility for TA 82, Former Foster Care Children (FFCC). The first renewals for FFCC are due in December 2014.

HHSC does not currently have renewal correspondence for FFCC.

New Policy

The following administrative renewal client correspondence is generated during the automated renewal process.

Form H1211, It’s Time to Renew Your Health-Care Benefits Cover Letter

Form H1211, It’s Time to Renew Your Health-Care Benefits Cover Letter, notifies the client of:

- The eligibility outcome from the automated renewal process,
- The action needed to take to complete the renewal, and
- The types of changes that clients are required to report (for more information, see the section for Changes).

This form is dynamic based on the eligibility outcome and type program. TIERS generates and mails this form to the client with no advisor action in the 9th month of the certification period.

The following chart shows the correspondence generated for each eligibility outcome and the response that is required from the client.

Eligibility Outcome	Correspondence and Required Client Response

Eligibility Potentially Approved	• The Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must review the information used to determine their eligibility. They are only required to return a signed renewal form, Form H1206, if the information used to renew their Medicaid benefits was incorrect or there has been a change to their case. Form M5017, Documents to Send with your Renewal Application, is included with Form H1206. • No additional forms are sent with Form H1211.
Additional Information Needed	• The Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, notifies the client that they must return a signed renewal form, Form H1206, and additional verification. Form M5017, Documents to Send with your Renewal Application, is included with Form H1206. • The Form H1020, Request for Missing Information or Action, is included with Form H1211 when "Additional Information Needed" is determined as the eligibility outcome. The Form H1020 includes all the required verifications to complete the renewal and a statement that the signed renewal form is required.

Form H1206, Health-Care Benefits Renewal - FFCC

Form H1206, Health-Care Benefits Renewal - FFCC, is pre-populated with information from the client's case and, in some scenarios, information from electronic data sources. HHSC generates this form but does not automatically mail it to the client. A client can print the Form H1206 by logging into YourTexasBenefits.com using a case access account and selecting the "Letters and Notices" tab.

Form H1206 is pre-populated with the following information for a client who needs to renew benefits:

- Contact, demographic, and case information,
- Residency status and intent to reside in Texas,
- Citizenship or immigration status; and
- Third party insurance information.

Note: Form H1206 cannot be used to renew SNAP or TANF benefits. Clients must still use the Form H1010R, Your Texas Works Benefits: Renewal Form, to renew SNAP and TANF benefits.

Form M5017, Documents to Send with your Renewal Application

TIERS generates Form M5017, Documents to Send with your Renewal Application, and includes it with the Form H1206 in the renewal packet.

Form TF0001, Notice of Case Action

Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made. The form states the dates of the new certification period for Medicaid benefits or the denial reason for not recertifying Medicaid benefits.

Form H1010-R, Your Texas Benefits: Renewal Form

The Form H1010-R, Your Texas Benefits: Renewal Form, must be accepted as a valid renewal form for FFCC if it contains FFCC client information and a valid signature. The signature provided on the Form H1010-R is considered valid as long as it is provided by the certified FFCC client or an individual that is allowed to sign for the FFCC client. The advisor should enter the information provided on the Form H1010-R and pend for any information that cannot be verified through electronic data sources.

Automation

An advisor can access a client's Form H1211 and the renewal packet that includes Forms H1206 and M5017 by selecting the "History Correspondence" from the Left Navigation (left nav.) and selecting the form. This can only be done once the administrative renewal correspondence has been generated for the specific client. The Forms H1211 and H1206 are not available to be printed without client information because they are dynamic based on eligibility outcome and type program.

Effective Date

Changes to policy are effective September 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled "Course AG10: ACA - Administrative Renewals." Additional training will be delivered in the web-based courses titled "Course AG11: ACA - Administrative Renewals for MTFCY and FFCC," "Course AG2: ACA - Changes to Correspondence," and "Course AG3: ACA - Changes to YourTexasBenefits.com."

Administrative Renewal Processing for FFCC

Added September 1, 2014

Current Policy

Effective January 1, 2014, the ACA requires HHSC to determine eligibility for Former Foster Care Children (FFCC). The first renewals for FFCC are due in December 2014.

HHSC does not currently process renewals for FFCC.

New Policy

<u>Renewals that Require Advisor Action</u>

If an individual returns a paper Form H1206, Health-Care Benefits Renewal - FFCC, the form will be routed to CBS for processing.

Note: A Form H1010-R, Your Texas Benefits: Renewal Form, must be accepted as a valid renewal form for FFCC if it contains FFCC client information and a valid signature.

If an FFCC renewal is submitted to a local office, it may be processed by the local office advisor but only CBS advisors may dispose the FFCC EDG. If an FFCC renewal needs to be disposed, a TLM task will be generated for CBS instructing them to dispose the renewal.

File Date

The file date is the day any local eligibility determination office receives the Form H1206, Health-Care Benefits Renewal - FFCC.

Interview

An interview is not required for FFCC renewals.

Timeliness

Staff must process renewals, received timely or untimely, by the 30th day from the file date or by cutoff of the 12th month of the certification period, whichever is later.

Verification and Pending Information

Verification previously provided can be used to renew eligibility for FFCC. The CBS advisor must check to see if there is any verification that can be used before requesting verification from the client. The household must be allowed at least 10 days to provide missing information, and the due date must fall on a workday.

Note: Do not use verification more than 90 days old from the FFCC file date.

All missing information must be received before the cutoff date of the 12th month of the certification period.

If the missing information is received:

- Before the date of denial in the 12th month, the EDG must be updated with the new information.
- After the date of denial in the 12th month of coverage, the denied EDG must be reopened, which may result in a break in FFCC coverage.

Renewal Form or Information Returned After Termination

Information or Verification Returned After Termination

When a renewal is denied due to failure to provide information or verification and the information or verification is provided after the date of denial but by the 90th day after the last day of the last

benefit month, staff must reopen the EDG. The date the information or verification is provided is the new file date.

Renewal Form Returned After Termination

If a renewal form is not received by the date of denial in the 12th month of the certification period, the EDG is denied for failure to return a renewal packet. A renewal form received after the last day of the 12-month certification period must be treated as an application using application processing time frames. The file date is the day that any local eligibility determination office receives the FFCC renewal form.

Note: If the renewal form is received after the date of denial but before the last day of the 12th month of the certification period, reopen the EDG and process as a renewal.

Renewal Form Not Returned
Revised September 1, 2015

Administrative Renewal Automatic Eligibility Determination

When a renewal form is not returned, TIERS automatically makes an eligibility determination through mass update based on the eligibility outcome from the automated renewal process. This does not require the CBS advisor to run eligibility or dispose the EDG.

Below are the eligibility outcomes during the automated process:

- "Eligibility Potentially Approved," the system auto-approves the EDG without advisor action. The file date is the date the system auto-approves the EDG, and the client is granted a new 12-month certification period.
- "Additional Information Needed," the system auto-denies the EDG without advisor action.

Mass Update Exceptions

In some cases, an EDG may exception out of the mass update for the administrative renewal auto-disposition. When this occurs, TIERS creates a TLM task based on the eligibility outcome from the automated renewal process.

TLM creates Alert #840, Process Mass Update Exception—Approve, when the eligibility outcome is determined as "Eligibility Potentially Approved." This requires the CBS advisor to process the task and approve the EDG. No additional verification is required because the automated renewal process was able to verify all the required information. The file date is the date the auto-disposition should have occurred.

CBS advisors manually approve EDGs that exception out of the mass update auto-disposition for administrative renewals using these steps:

- Claim the task, Alert #840, Process Mass Update Exception—Approve.
- For approval during an administrative renewal:
  - Select the "Complete Action" mode from the drop down menu for the "Interview Mode" question on the **Initiate Interview** page in Data Collection.
  - Use the disposition date (the date the task is claimed) as the "Packet Received Date."
  - Run EDBC and dispose the EDG.

TLM creates Alert #839, Process Mass Update Exception—Termination, when the eligibility outcome is determined as "Additional Information Needed." This requires the CBS advisor to process the task and deny the EDG. The EDG is denied because the client has not returned the renewal packet by the final due date.

CBS advisors manually terminate EDGs that exception out of the mass update auto-disposition for administrative renewals using these steps:

- Claim the task, Alert #839, Process Mass Update Exception—Termination.
- For a termination during an administrative renewal:
  - Select the "Change Action" mode from the drop down menu for the "Interview Mode" question on the **Initiate Interview** page in Data Collection.
  - Navigate to the **Run Eligibility** page through Left Nav.
  - Select "Manually Select Eligibility Determination Date?"
  - Enter the begin date as the current month.
  - Select "Next" on **Run Eligibility.**
  - Select "Run EDBC."

Client Requesting and Submitting a Renewal Form

Online

Based on the eligibility outcome, if clients are required to update information, provide missing information, and electronically sign the YourTexasBenefits.com renewal form, they can submit a renewal form online by logging into YourTexasBenefits.com using a case access account on any computer with internet access or at a local office

Paper Form

Based on the eligibility outcome, if clients are required to update information, provide missing information, and electronically sign the YourTexasBenefits.com renewal form, they can access the paper form in one of the following ways:

- Print Form H1206 through YourTexasBenefits.com by logging in using a case access account and selecting the "Letters and Notices" tab.
- Dial 2-1-1 to request that the Form H1206 be mailed.
- Go to a local office to:
  - Print the Form H1206 through YourTexasBenefits.com, or
  - Request that the Form H1206 be printed.

Effective Date

Changes to policy are effective September 1, 2014.

Handbook

Staff will be informed when the Texas Works Handbook is updated.

Training

Training will be presented as part of an instructor-led training series titled “Course AG10: ACA - Administrative Renewals.” Additional training will be delivered in the web-based courses titled “Course AG11: ACA - Administrative Renewals for MTFCY and FFCC,” “Course AG3: ACA - Changes to YourTexasBenefits.com,” and “Course AG15: ACA - Changes to Task List Manager (TLM).”