End of Continuous Medicaid Coverage

Dashboard

March 2024

TEXAS
Health and Human Services

Snapshot

During the public health emergency (PHE), the number of Texans on Medicaid grew from 3.9 million to approximately 6 million. In December 2022, federal legislation ended a requirement to continue Medicaid coverage through the PHE, and now Texas is conducting redeterminations for all Medicaid clients as required by the federal government.

In anticipation of the increase in workload, HHSC improved staff recruitment and retention. Frontline eligibility advisors received up to a 25% salary increase, improving retention among current staff and strengthening recruitment efforts to further boost eligibility operations capacity. Those strategies have reduced the vacancy rate for eligibility advisors from 21.2% in March 2022 to 3% in March 2024.

HHSC has employed a proactive, multi-pronged communications campaign to inform recipients, health care providers, advocates and other stakeholders about its plan to unwind continuous Medicaid coverage.

HHSC developed quality assurance plans to identify and address issues that may arise during the unwinding period. HHSC continues to implement federally approved waiver flexibilities to assist in the unwinding effort, including electronically updating Medicaid recipient addresses and using recent SNAP income data to confirm Medicaid eligibility.

In September 2023, HHSC implemented a new federally approved waiver allowing managed care organizations (MCOs) to help recipients with their renewal applications. HHSC has made multiple technological initiatives to help Medicaid clients access their online applications and more easily update their information.

Timeline

January 2020

The U.S. Department of Health and Human Services declared a PHE in response to the COVID-19 pandemic.

March 2020

Federal legislation requires states to maintain Medicaid coverage for recipients, regardless of eligibility.

December 2022

Federal legislation ends continuous Medicaid coverage and requires states to begin a 12-month unwinding on April 1, 2023.

Medicaid clients are now able to monitor the status of their application online or by updating their Your Texas Benefits mobile app.

Additional information and resources on the HHSC Medicaid redetermination effort, including monthly renewal data, can be found at **hhs.texas.gov/update**.

HHSC Outreach

HHSC developed an **Ambassador Program** to engage Medicaid health plans, health care providers and other stakeholders to help prepare Medicaid recipients for the renewal process. Additionally, the Ambassador Program and its 556 members are amplifying the message by using the ambassador toolkit that includes FAQs, talking points, flyers and social media graphics and messages.

In addition to normal renewal communications, HHSC implemented a robust public education outreach effort across social media platforms and a digital advertising campaign reaching 2.4 million users from Oct. 13, 2022, to Feb. 29, 2024.

The digital advertising campaign ended in November and outreach efforts have continued organically on HHSC social media accounts. HHSC also has hosted in-person renewal events around the state.

HHSC notified Medicaid recipients of the unwinding period by mailing renewal packets in distinct yellow envelopes, instituting robocalls, and disseminating emails and text messages.

HHSC received federal approval to implement a temporary process to update addresses of Medicaid recipients who didn't report a change of address. More than 368,077 addresses have been updated from the recipient's MCO or the United States Postal Service (USPS) National Change of Address (NCOA) database.

Medicaid recipients were notified about their renewal application via direct mail or electronically through their **YourTexasBenefits.com** account. The numbers below reflect additional outreach between April 1, 2023, and March 11, 2024, to Medicaid recipients affected by the renewal process. Recipients who chose to share their phone number and email address receive information about renewing their Medicaid through robocalls, text messages or emails, based on their preferences. Not all recipients opted to receive electronic communications.

Outreach by the Numbers

Robocalls

3,348,382

Text Messages

2,577,281

Emails

723,278

Medicaid by the Numbers

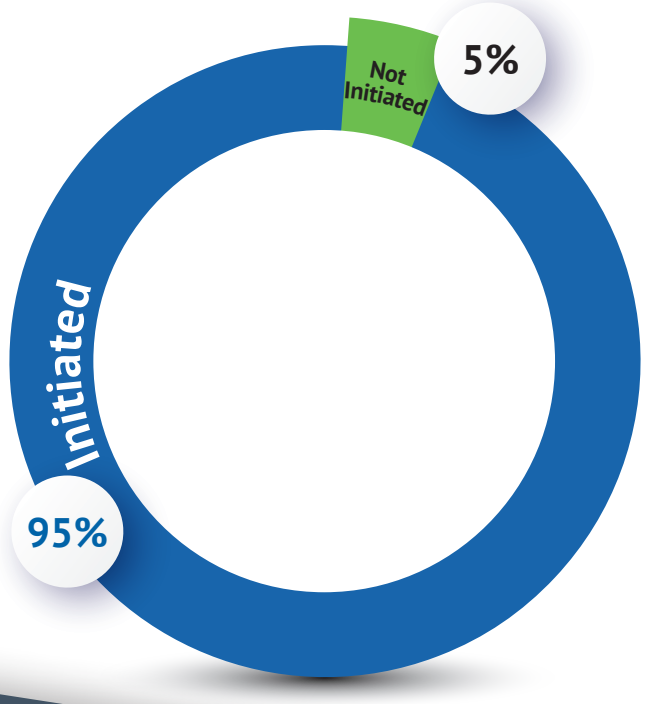
Renewal Months Initiated

HHSC initiated the unwinding period in April 2023 by beginning a phased eligibility review of Texans receiving Medicaid, focusing first on people least likely to still be eligible for Medicaid. HHSC has completed 11 months of its 12-month unwinding effort.

HHSC is federally required to conduct renewals for all Medicaid recipients within 12 months of when the state began its unwinding period.

Initiated Renewals

Between April 1, 2023, and March 11, 2024, HHSC initiated renewals for approximately 5.6 million Texans, or 95% of the Medicaid population. The remaining 5% will go through the renewal process by March 2024. The total Texas Medicaid caseload figure will fluctuate based on several factors, including but not limited to Medicaid clients who voluntarily withdrew, moved out of the state, or died.



Renewal Status

300,764
Not Initiated

5,622,823
Initiated

Total = 5,923,587

Eligibility Determination Outcomes

During the eligibility determination process, HHSC reviews Medicaid recipients' information to determine if they are eligible for continued coverage.

Federal law requires states to attempt to verify eligibility of Medicaid recipients using verifiable electronic data sources. This process is often referred to as an ex parte determination.

If HHSC is unable to determine a Medicaid recipient's eligibility through the ex parte determination process, HHSC notifies the Medicaid recipient through a renewal form. The recipient is required to complete and return the form to HHSC within 30 days.

Procedural denials occur when HHSC doesn't have enough information to determine if the recipient is eligible for Medicaid coverage. In most cases, the recipient failed to return a renewal packet or provide requested information.

Coverage is recertified for eligible Medicaid recipients if they provide the requested information within 90 days of the last day of the last benefit month their coverage was terminated. A renewal form returned within the reconsideration period serves as an application, and application timeliness standards apply.

Applicants and previous recipients of Medicaid may also be denied Medicaid coverage if they don't meet eligibility criteria. For example, an applicant or a previous Medicaid recipient's income could be over the Medicaid income limit and be categorized as ineligible.

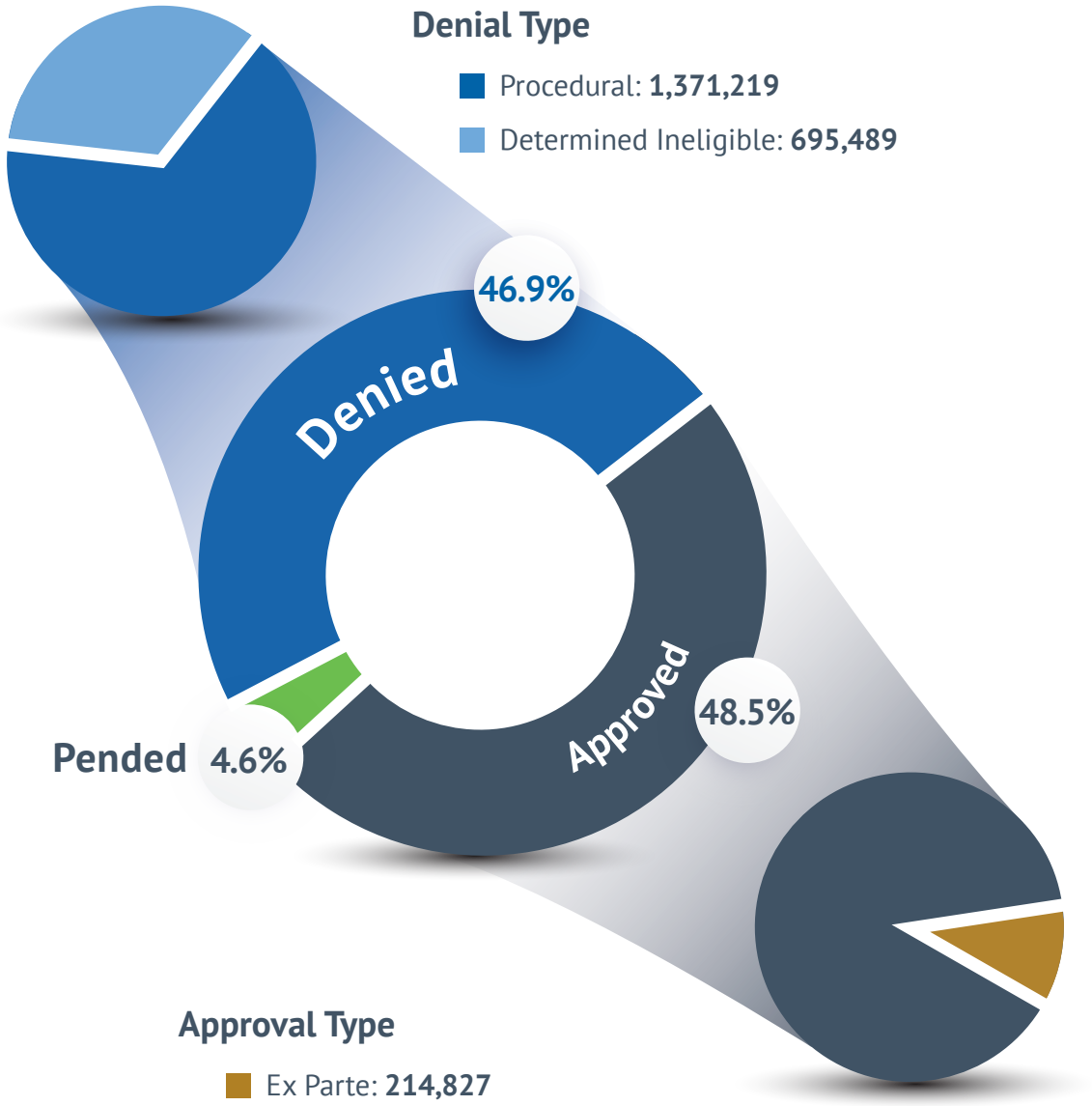
The numbers below reflect the status of renewal outcomes for Medicaid recipients from April 1, 2023, to March 11, 2024. The numbers don't reflect determinations for all renewals initiated, since Medicaid recipients are allowed 30 days to complete and return their renewal form. (Additionally, the Centers for Medicare & Medicaid Services (CMS) modified the definition of "pended." The count below aligns with the modified definition, and as such includes renewals initiated that may have a renewal due date in a future month. CMS previously defined "pended" as a non-determined case that passed the renewal date.)

Cumulative Redetermination Outcomes

Determination Type	TOTAL
Total Approved	**2,139,324**
Ex Parte	214,827
Determined Eligible	1,924,497
Total Denied	**2,066,708**
Procedural	1,371,219
Determined Ineligible	695,489
Pended	**202,467**
Total	**4,408,499**

Eligibility Determination Outcomes

Cumulative Eligibility Determination Outcomes



Cumulative Renewal Status

2,066,708	2,139,324	202,467
Denied	Approved	Pended

Total = 4,408,499

Program Transitions for Completed Renewals

Because HHSC operates multiple health care programs, recipients who no longer qualify for a Medicaid program may transition to different health coverage for which they are eligible, such as CHIP or another Medicaid program. If they are determined ineligible for Medicaid, HHSC may refer individuals to the Federal Marketplace.

Between April 1, 2023, and March 11, 2024, HHSC referred 695,489 recipients to the Federal Marketplace. Some procedural denials may have been referred to the Federal Marketplace, however the current data do not reflect those referrals.

Federal Marketplace data can be found at **cms.gov/newsroom/data**.

The numbers below represent 2,834,184 Medicaid recipients who completed renewals between April 1, 2023, and March 11, 2024. These recipients either remained in their program or were transitioned to another program.

Due to data limitations, approximately 2,403 Medicaid recipients are not included in the table below.

Program Transitions for Completed Renewals

Program Type (Prior to Renewal)	Program Type (After Renewal)				
	CHIP	Medicaid	HTW	Federal Marketplace	Total
CHIP	9,803	3,600	92	5,841	**19,336**
Medicaid	117,463	1,738,618	48,487	470,394	**2,374,962**
Medicaid for pregnant women	30	80,480	44,735	110,442	**235,687**
HTW	24	15,480	79,883	108,812	**204,199**
Total	**127,320**	**1,838,178**	**173,197**	**695,489**	2,834,184

Eligibility Determination Outcomes for Non-disabled Children and Pregnant Women

The largest Medicaid programs HHSC administers serve non-disabled children and pregnant women.

The numbers below represent the renewal outcomes between April 1, 2023, and March 11, 2024, for children and pregnant women based on their initial eligibility group. Based on the federal continuous coverage requirement, their eligibility groups stayed the same throughout the PHE.

The figures only reflect two Medicaid eligibility groups and are not comprehensive of all Medicaid groups.

Due to data limitations, approximately 2,403 Medicaid recipients are not included in the table below.

Determination Outcomes by Medicaid Program Coverage During PHE

Medicaid Renewal Outcomes	Newborn	Under 1	Ages 1–5	Ages 6–18	Children Total	Pregnant Women	Children and Pregnant Women Total
Approved – Ex Parte	0	753	48,568	150,251	199,572	0	199,572
Approved – Determined Eligible	220,481	6,025	306,856	841,726	1,375,088	123,833	1,498,921
Denied – Procedural	47,824	6,651	163,665	774,177	992,317	56,966	1,049,283
Denied – Determined Ineligible	47,717	2,347	53,027	250,781	353,872	110,442	464,314
Pended	8,805	421	36,930	149,112	195,268	3,642	198,910
Total	**324,827**	**16,197**	**609,046**	**2,166,047**	**3,116,117**	**294,883**	**3,411,000**

Appealing an Eligibility Determination

Medicaid recipients can object to any determination of coverage by filing an appeal by mail, calling **2-1-1** and selecting Option 2, or visiting a local eligibility office.

Medicaid recipients can also file a complaint with the HHS Office of the Ombudsman if they disagree with the action taken on their case by calling 877-787-8999 from 8 a.m. to 5 p.m. Central time, Monday through Friday, or visiting **hhs.texas.gov/ombudsman** for more information.

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