End of Continuous Medicaid Coverage

Dashboard

September 2023

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 3.8% in August 2023.

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 to allow managed care organizations (MCOs) to help recipients with their renewal applications. HHSC has made multiple technology 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 beginning April 1, 2023.

Beginning in September 2023, Medicaid clients are now able to monitor the status of their application online or through their Your Texas Benefits mobile application. (Mobile users will need to update their Your Texas Benefits app to access this upgrade.)

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 346 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 over 1.9 million users from Oct. 13, 2022, to Aug. 31, 2023. HHSC also has hosted in-person renewal events around the state.

HHSC notified Medicaid recipients of the Medicaid unwinding 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 167,000 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 Sept. 10, 2023, to Medicaid recipients affected by the renewal process. Recipients who choose 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
1,344,028

Text Messages
1,250,623

Emails
394,682

Medicaid by the Numbers

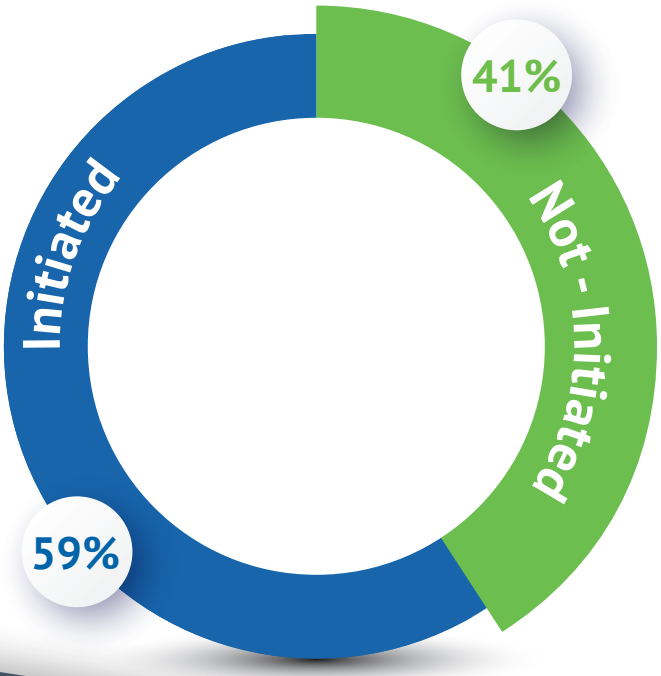
Renewal Months Initiated

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 five months of its 12-month unwinding effort. (HHSC will reach the midway point of its unwinding effort at the end of September.)

HHSC is federally required to conduct a renewal for all Medicaid recipients over a 12-month period from when the state began its unwinding period.

Initiated Renewals

Between April 1, 2023, and Aug. 31, 2023, HHSC initiated renewals for approximately 3.5 million Texans, or 59% of the Medicaid population. The remaining 41% will go through the renewal process before June 2024.



Renewal Status

2,489,101
Not Initiated

3,541,884
Initiated

Total = 6,030,985

Eligibility Determination Outcomes

During the eligibility determination process, HHSC reviews Medicaid recipients' information to determine if they are eligible for continued Medicaid 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 for a recipient who is still eligible for Medicaid is recertified if the requested information is provided within 90 days of termination after the last day of the last benefit month. 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. These denials are categorized as ineligible.

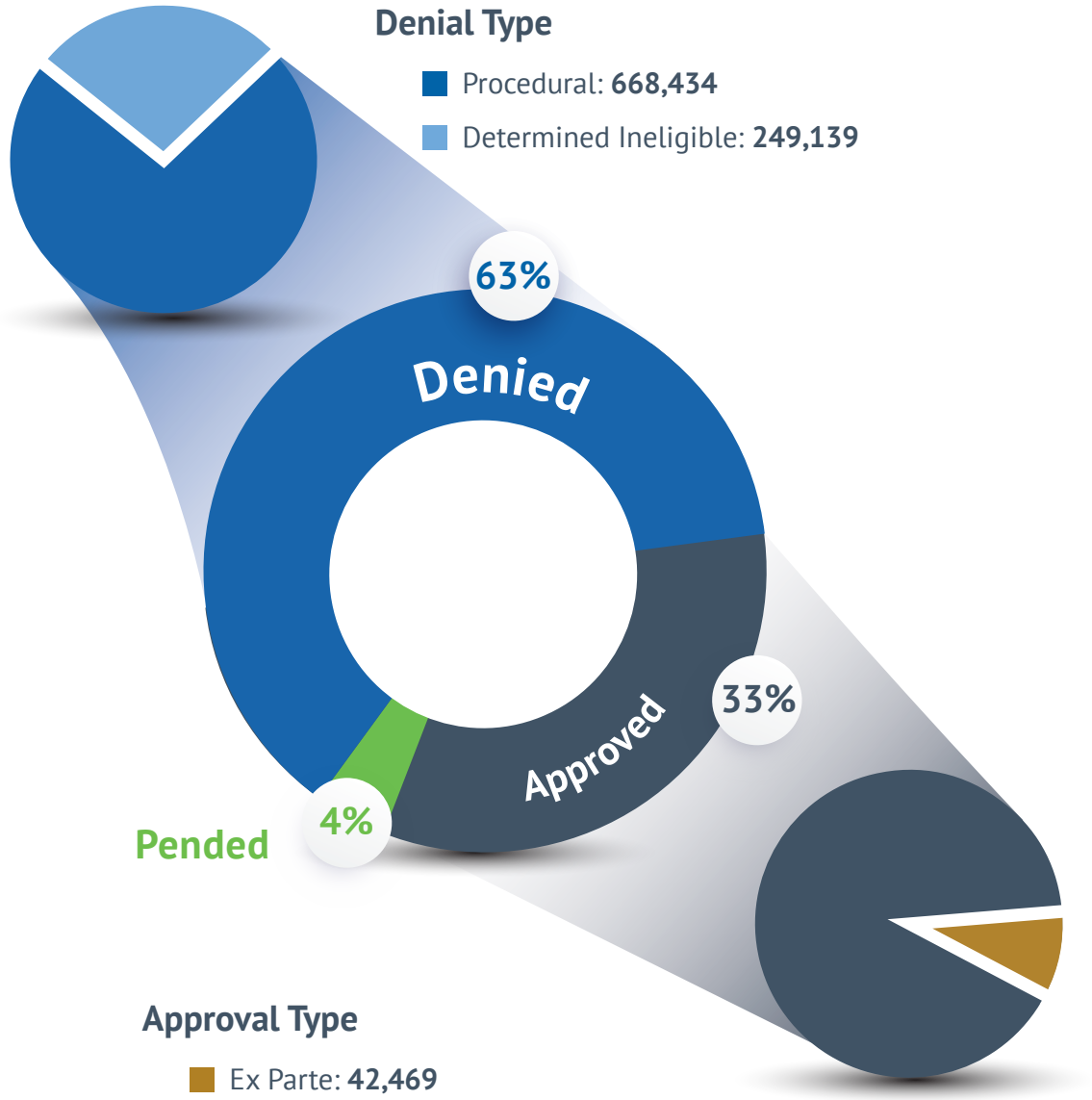
The numbers below reflect the status of renewal outcomes for Medicaid recipients from April 1, 2023, to Aug. 31, 2023. The numbers don't reflect determinations for all renewals initiated, since Medicaid recipients are allowed 30 days to complete and return their renewal form.

Cumulative Redetermination Outcomes

Determination Type	TOTAL
Total Approved	**474,692**
Ex Parte	42,469
Determined Eligible	432,223
Total Denied	**917,573**
Procedural	668,434
Determined Ineligible	249,139
Pended	**63,132**
Total	**1,455,397**

Eligibility Determination Outcomes

Cumulative Eligibility Determination Outcomes



Cumulative Renewal Status

917,573	474,692	63,132
Denied	Approved	Pended

Total = 1,455,397

Program Transitions for Completed Renewals

Because HHSC operates multiple health care programs, recipients who no longer qualify for Medicaid 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 Aug. 31, 2023, HHSC referred 249,139 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 723,565 Medicaid recipients who completed renewals between April 1, 2023, and Aug. 31, 2023. These recipients either remained in their program or were transitioned to another program.

Due to data limitations, approximately 355 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	1,930	508	22	1,150	**3,610**
Medicaid	41,763	364,936	6,504	143,612	**556,815**
Medicaid for pregnant women	8	12,134	31,430	96,372	**139,944**
HTW	5	2,203	12,983	8,005	**23,196**
Total	**43,706**	**379,781**	**50,939**	**249,139**	**723,565**

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 Aug. 31, 2023, 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 355 Medicaid recipients are not included in the table below.

Determination Outcomes for Non-disabled Children and Pregnant Women

Medicaid Renewal Outcomes	Newborn	Under 1	Ages 1–5	Ages 6–18	Children Total	Pregnant Women	Children and Pregnant Women Total
Approved – Ex Parte	-	232	9,511	27,742	37,485	-	37,485
Approved – Determined Eligible	18,548	2,128	77,561	201,395	299,632	43,550	343,182
Denied – Procedural	5,582	5,639	101,017	395,269	507,507	55,187	562,694
Denied – Determined Ineligible	3,354	1,189	20,115	91,108	115,766	96,372	212,138
Pended	701	273	7,565	24,712	33,251	10,076	43,327
Total	**28,185**	**9,461**	**215,769**	**740,226**	**993,641**	**205,185**	**1,198,826**

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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