TEXAS
Health and Human Services

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*Executive Commissioner*

# MEPD and TW Bulletin 23-07

**Date:** March 31, 2023

**To:** Eligibility Services Supervisors and Staff
Program Managers
Regional Directors
Regional Attorneys
Hearings Officers

**From:** Access and Eligibility Services Program Policy
State Office 2115

**Subject:** **End of Continuous Medicaid Coverage**

1. **Maintaining Medicaid Coverage**
2. **Processing Case Actions for Medical Programs**
3. **Reasonable Opportunity Period (ROP)**
4. **Medicaid Buy-In and Medicaid Buy-In for Children Premiums**
5. **Renewals Initiated Prior to April 1, 2023**
6. **SNAP Income to Renew Medicaid**

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The information in this bulletin may be included in a future handbook revision, if required. Until the handbook is updated, staff must use the information in this bulletin. If you have any questions regarding the policy information in this bulletin, follow regional procedures.

Active bulletins are posted on the following websites:

- Medicaid for the Elderly and People with Disabilities Handbook (MEPDH) at https://hhs.texas.gov/laws-regulations/handbooks/mepd/policy-bulletins;
- Texas Works Handbook (TWH) at https://hhs.texas.gov/laws-regulations/handbooks/texas-works-handbook/texas-works-bulletins.

## End of Continuous Medicaid Coverage

### Background

On January 27, 2020, the Secretary of the U.S. Department of Health and Human Services declared that a public health emergency (PHE) exists nationwide due to the novel coronavirus (COVID-19) outbreak. Additionally, on March 13, 2020, Governor Greg Abbott declared a state of disaster for all counties in Texas due to the COVID-19 outbreak.

H.R. 6201 (Families First Coronavirus Response Act (FFCRA)), required Medicaid coverage to be maintained for most people active or certified for Medicaid as of or after March 18, 2020, until the end of the PHE.

Effective **March 31, 2023**, HR 2617 (Consolidated Appropriations Act, 2023), ends the FFCRA requirement to maintain Medicaid coverage.

HHSC provided temporary COVID-19 related policy clarifications and changes to eligibility policies to accommodate processing of case actions during the PHE.

**The information in this bulletin replaces the previous COVID-19 related policy clarifications for maintaining Medicaid coverage and processing Medicaid case actions**.

**Note**: The following COVID-19 related guidance remains in effect until further notice:

- Waiving interviews for Medicaid for Parent and Caretaker Relatives (TP 08);
- Allowing good cause for Texas Health Steps requirements; and
- SNAP and TANF COVID-19 related guidance.

Staff will be notified when the remaining COVID-19 policy modifications are no longer in effect.

## 1. Maintaining Medicaid Coverage

### COVID-19 Policy

Medical Programs

After an initial determination of eligibility, Medicaid must be maintained for the duration of the COVID-19 PHE, unless the person:

- voluntarily withdraws;
- dies;
- moves out of state; or
- is considered invalidly enrolled due to being certified in error at application or HHSC's Office of Inspector General (OIG) determined the person fraudulently received Medicaid and coverage should be denied.

### New Policy

Medical Programs

HR 2617 (Consolidated Appropriations Act, 2023) ends the FFCRA requirement to maintain Medicaid coverage as of **March 31, 2023**.

Effective **April 1, 2023**, Medicaid recipients who are no longer eligible for Medicaid can be denied. However, HHSC must complete a full redetermination of eligibility for all Medicaid recipients before terminating Medicaid coverage.

Medicaid coverage must be maintained even after April 1, 2023, until a full redetermination is completed. A redetermination of eligibility must be initiated for all Medicaid recipients within the 12-month unwinding period, beginning April 1, 2023, through March 31, 2024. All redeterminations must be processed by May 31, 2024.

## 2. Processing Case Actions for Medical Programs

### COVID-19 Policy

Medical Programs

After an initial determination of eligibility, Medicaid must be maintained for the duration of the COVID-19 PHE, unless the person:

- voluntarily withdraws;
- dies;
- moves out of state; or
- is considered invalidly enrolled due to being certified in error at application or HHSC's OIG has determined the person fraudulently received Medicaid and coverage should be denied.

Medicaid coverage that is terminated for any other reason must be maintained until the end of PHE.

Medicaid recipients can be transferred to another Medicaid type of assistance (TOA), except for Healthy Texas Women (HTW) and Community Attendant Services (CAS), when processing a change in circumstances or a redetermination if the recipient meets the eligibility criteria for the new Medicaid TOA. If the recipient does not meet the eligibility criteria for another type of Medicaid or does not provide enough information to make an eligibility determination, coverage must be maintained on the existing Medicaid TOA.

To ensure Medicaid is maintained during the COVID-19 PHE, TIERS automatically reinstates terminated Medicaid eligibility determination groups (EDGs) after disposal and adds the following case comment: *"Medicaid eligibility is being sustained due to COVID-19."*

### New Policy

Medical Programs

A redetermination of eligibility must be initiated for all Medicaid recipients within the 12-month unwinding period beginning April 1, 2023, through March 31, 2024. All redeterminations initiated during this 12-month period must be processed by May 31, 2024.

Medicaid coverage must be maintained even after April 1, 2023, until a redetermination is completed.

The renewal process initiated in April 2023 will be for renewals due in July 2023. Staff must process renewals that are due in July 2023 and for ongoing months and

received after April 1, 2023, according to regular policies and procedures. (TWH B-122.4.1, Automated Renewal Process; MEPDH B-8400, Procedures for Redetermining Eligibility).

If the recipient is:

- No longer eligible for their current Medicaid TOA, explore eligibility for all other Medicaid TOAs.
- Eligible for a different TOA based on the reported information, process the transfer to the new Medicaid TOA.
- No longer eligible for their current Medicaid TOA and is only eligible for HTW or CAS, the system will automatically generate a renewal packet.
    - If a signed renewal/application form is not returned by the 30th day, eligibility is auto-disposed and benefits are terminated for failure to provide the requested information following Advance Notice of Adverse Action. No staff action is needed.
    - If the renewal/application form is returned by the 30th day, staff must process the redetermination following regular policy and procedures (TWH B–122.4.2, Processing a Manual Renewal and MEPDH B–8400, Procedures for Redetermining Eligibility).
- If the recipient is no longer eligible for any Medicaid TOA, process the redetermination and terminate the Medicaid EDG.
- Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made.

Cases processed in Change Action or during a Mass Update that result in termination, must be maintained until a complete redetermination is processed.

TIERS automation changes will update the EDG from denied to an approved status until a redetermination is completed.

Staff must continue to terminate Medicaid coverage for the following reasons:

- Death;
- Moves out of state;
- Voluntary withdrawal; or
- is considered invalidly enrolled due to being certified in error at application or HHSC's OIG has determined the person fraudulently received Medicaid and coverage should be denied.

### Renewal Due Dates

Medical Programs

Households must be provided at least 30 days to return a complete renewal form. The 30-day timeframe is calculated from when the household has access to their renewal form.

Under current administrative renewal processes, some households will only receive a cover letter, Form H1211, It's Time to Renew Your Health-Care Benefits Cover Letter, informing them of how to access their renewal form. (MEPDH B-8400, Procedures for Redetermining Eligibility and TWH B-122.4.1.3 Renewal Correspondence)

If the household only receives a Form H1211 and does not receive their correspondence electronically, the 30-day timeframe will start when the household accesses a copy of their renewal form. Staff can view TIERS Correspondence to determine if the household was mailed a copy of their renewal form or just the Form H1211.

If the household contacts the agency in person or by phone to request a copy of their renewal form, staff must document the date the renewal form was provided, recalculate the 30-day due date, and document in TIERS case comments. Staff must reopen the Medicaid EDG if it was terminated before the recalculated 30-day timeframe.

### Special Populations

TW Modified Adjusted Gross Income (MAGI) Alerts

Prior to terminating Medicaid benefits, eligibility must be explored for all other medical programs. (TWH A-2342, Denial at Redetermination)

### Current Policy

TP 07, TP 20, TP 40, TP 44, TP70 and TA 82

Retest the recipient's potential eligibility for other Medical Programs by manually running the Texas Works Medical Program Hierarchy explained in A-132.1, Medical Programs Hierarchy. (TWH A-2342.1, Retesting Eligibility)

### New Policy

TP 07, TP 20, TP 40, TP 44, TP70 and TA82

TIERS will automatically retest eligibility for the following MAGI alert populations.

- Alert 823: MA Child Aging Out Test MAGI
- Alert 824: Pregnancy Ending Test MAGI

- Alert 825: Transitional MA Ending Test MAGI
- Alert 903: Test MAGI Individual Aging Out of TP70 or TA82

During the unwinding period, a modified retest eligibility process will be initiated for the alert populations. During the modified retest eligibility process, available information from the existing case record and information obtained from electronic data sources is used to determine eligibility for other medical programs.

If the available information is sufficient to make an eligibility determination for another medical program, the case is auto-disposed and approved for the new medical program. No staff action is required.

If additional information is needed, the system automatically generates the following correspondence:

- Form H1830R, Texas Works Renewal Notice
- Form H1010R, Your Texas Benefits; Renewal Form
- Form H1020, Request for Information or Action

If a signed renewal/application form is not returned by the 30th day, eligibility is auto-disposed and benefits are terminated for failure to provide the requested information following Advance Notice of Adverse Action. No staff action is needed.

If the case exceptions out of the modified retest process, a MAGI alert will generate for staff to manually process. Staff should follow current policy and procedures when receiving an alert.

If the renewal/application form is returned by the 30th day, staff must process the redetermination following regular policy and procedures (TWH B–122.4.2, Processing a Manual Renewal and MEPDH B–8400, Procedures for Redetermining Eligibility).

Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made.

Medicaid for Newborn Children (TP 45), Medicaid for Breast and Cervical Cancer (MBCC) (TA 67), and Pre-MAGI Healthy Texas Women (HTW) (TA 41)

Medicaid recipients who no longer meet the eligibility requirements for Medicaid for Newborn Children, MBCC, or pre-MAGI HTW benefits may still be eligible for Medicaid under another eligibility group. Currently, these eligibility groups do not go through an administrative renewal process. Prior to terminating Medicaid, eligibility for all other medical programs must be explored.

**Current Process**

TP 45

Medicaid coverage for Newborn children is provided through end of the child's first birthday and cannot be renewed. A Form TF0001, Notice of Case Action, is sent once benefits are terminated. In addition, an application packet is sent to allow the household an opportunity to apply for another Medicaid program.

TA 67

The Texas Integrated Eligibility Redesign System (TIERS) generates a renewal packet for MBCC EDGs two months before the periodic review due date.

If a renewal packet is received, staff must process information following regular policy and procedures.

If a renewal packet is not received by the requested due date, benefits are automatically terminated at the end of the certification period. No staff action is required.

TA 41 (pre-MAGI)

This is the population of HTW recipients that were determined ineligible based on MAGI rules when a renewal was processed; therefore, their coverage is being maintained. Due to TIERS limitations, a renewal could not be conducted on this eligibility group.

**New Process**

TP 45, TA 67, TA 41 (pre-MAGI)

During the unwinding period, a modified administrative renewal process will be initiated for Medicaid for Newborn Children, MBCC, and pre-MAGI HTW recipients. During the modified administrative renewal process, available information from the existing case record and information obtained from electronic data sources is used to determine eligibility for other medical programs.

If the available information is sufficient to make an eligibility determination for another medical program, the case is auto-disposed and approved for the new medical program. No staff action is required.

If additional information is needed, the system automatically generates the following correspondence for Medicaid for Newborn Children or pre-MAGI HTW:

- Form H1830R, Texas Works Renewal Notice
- Form H1010R, Your Texas Benefits; Renewal Form
- Form H1020, Request for Information or Action

If additional information is needed for MBCC recipients **under 65 years old**, the system automatically generates the following correspondence:

- Form H1830P, It's Time to Review Your Health-Care Benefits, to notify the recipient they must complete and return the application form within 30 days
- Form H1010R, Your Texas Benefits; Renewal Form
- Form H1020, Request for Information or Action

If additional information is needed for MBCC recipients **over 65 years old**, the system automatically generates the following correspondence:

- Form H1233P, It's Time to Review Your Health-Care Benefits, to notify the recipient they must complete and return the application form within 30 days
- Form H1200, Application for Assistance – Your Texas Benefits
- Form H1020, Request for Information or Action

If a signed renewal/application form is not returned by the 30th day, eligibility is auto-disposed and benefits are terminated for failure to provide the requested information following Advance Notice of Adverse Action. No staff action is needed.

If the renewal/application form is returned by the 30th day, staff must process the redetermination following regular policy and procedures (TWH B–122.4.2, Processing a Manual Renewal, X-2060, Processing Renewals and MEPDH B–8400, Procedures for Redetermining Eligibility).

Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made.

Department of Family and Protective Services (DFPS) Eligibility Groups

Medicaid recipients who no longer meet the eligibility requirements for Foster Care (FC), Adoption Assistance (AA), or Permanency Care Assistance (PCA) Medicaid benefits may still be eligible for Medicaid under another eligibility group. Prior to terminating FC, AA, and PCA Medicaid coverage, eligibility for all other medical programs must be explored.

**Current Process**

DFPS Eligibility Groups

Medicaid coverage for recipients who no longer meet the eligibility requirements for FC, AA, or PCA Medicaid benefits is terminated. When FC, AA, or PCA benefits are terminated, HHSC is notified through an interface. A Medicaid denial notice is only generated for AA Medicaid to inform the recipient that Medicaid benefits are ending because they are no longer eligible for AA Medicaid coverage, and they must submit

an application if they wish to apply for another Medicaid program. Correspondence is not generated when FC and PCA Medicaid benefits are terminated.

**New Process**

DFPS Eligibility Groups

During the unwinding period, a modified administrative renewal process will be initiated for terminated FC, AA, and PCA recipients.

- During the modified administrative renewal process, available information from the existing case record and information obtained from electronic data sources is used to determine eligibility for other medical programs.
  - If all eligibility criteria can be verified during the automated renewal process, the case is auto-disposed and the individual is approved for the new medical program. No staff action required.
  - If the system cascades to an MA TOA, and the EDG is denied or pending, the system automatically generates the following correspondence:
    - Form H1830P, It's Time to Review Your Health-Care Benefits, to notify the recipient they must complete and return the application form within 30 days;
    - Form H1020, Request for Information or Action, that identifies the required verification(s) needed to complete the eligibility determination (if pending for VCL);
    - Form H1010R, Your Texas Benefits; Renewal Form; and
    - Form M5017, Documents to Send with Your Renewal Application, that explains the verification documents needed to determine eligibility.
  - If the system cascades to an ME/MC TOA, and the EDG is denied or pending, the system automatically generates the following correspondence:
    - Form H1233P, It's Time to Review Your Health Care Benefits, to notify recipient they must complete and return the application form within 30 days;
    - Form H1020, Request for Information or Action, that identifies the required verification(s) needed to complete the eligibility determination (if pending for VCL);
    - Form H1200, Application for Assistance – Your Texas Benefits; and
    - Form M5017, Documents to Send with Your Renewal Application, that explains the verification documents needed to determine eligibility.
  - If a signed renewal/application form is not returned by the 30th day, eligibility is auto-disposed on the 31st day and Medicaid is terminated for

failure to provide the requested information, following Advance Notice of Adverse Action. No staff action is needed.
- If the renewal/application form is returned by the 30th day, staff must process the redetermination and explore potential eligibility for all medical programs following regular policy and procedures (TWH B–122.4.2, Processing a Manual Renewal and MEPDH B–8400, Procedures for Redetermining Eligibility).
- Form TF0001, Notice of Case Action, is sent when a final eligibility determination has been made.

To ensure recipients remain eligible throughout the unwinding period, Medicaid eligibility will be maintained until a redetermination is completed.

Task List Manager (TLM) Alert Tasks, Alert 910 and Alert 911

If the case exceptions out of the modified retest process, an alert will generate for staff to manually process. Staff should follow current policy and procedure when receiving an alert.

Supplemental Security Income (SSI) Eligibility Groups

Medicaid recipients who no longer meet the eligibility requirements for SSI benefits may still be eligible for Medicaid under another eligibility group. Prior to terminating SSI Medicaid, eligibility for all other medical programs must be explored.

**Current Process**

SSI Eligibility Groups

When a recipient's SSI benefits are terminated, HHSC receives the termination notice through the state data exchange (SDX) file and sends Form H1296, SSI Denial Letter to the client. The notice informs the recipient that Medicaid benefits are ending because they are no longer eligible for SSI and they must submit an application to apply for another Medicaid program.

Prior to termination, certain SSI recipients are screened for temporary extended Medicaid eligibility (MEPDH B-7110, Continuous Medicaid Coverage After SSI Denial for Income).

**New Process**

SSI Eligibility Groups

During the unwinding period, for terminated SSI recipients a modified administrative renewal process will be initiated after the temporary extended Medicaid process, to explore eligibility for all other medical programs.

- During the modified administrative renewal process, available information from the existing case record and information obtained from electronic data sources is used to determine eligibility for other medical programs.
  - If all eligibility criteria can be verified during the automated renewal process, the case is auto-disposed and the individual is approved for the new medical program. No staff action is required.
  - If the system cascades to an ME/MC TOA, and the EDG is denied or pending, the system automatically generates the following correspondence:
    - Form H1233P, It's Time to Review Your Health-Care Benefits, to notify the recipient they must complete and return the application form within 30 days;
    - Form H1020, Request for Information or Action, that identifies any required verification(s) needed to complete the eligibility determination (if pending for VCL);
    - Form H1200, Application for Assistance – Your Texas Benefits;
    - Form M5017, Documents to Send with Your Renewal Application, that explains the verification documents needed to determine eligibility; and
    - Form H1296, Notice of SSI Medicaid Ending, explains SSI Medicaid ending due to the loss of SSI benefits.
  - If the system cascades to an MA TOA, and the EDG is denied or pending, the system automatically generates the following correspondence:
    - Form H1830P, It's Time to Review Your Health-Care Benefits, to notify the recipient they must complete and return the application form within 30 days;
    - Form H1020, Request for Information or Action, that identifies the required verification(s) needed to complete the eligibility determination (if pending for VCL);
    - Form H1010R, Your Texas Benefits; Renewal Form;
    - Form M5017, Documents to Send with Your Renewal Application, explains the verification documents needed to determine eligibility; and
    - Form H1296, Notice of SSI Medicaid Ending, explains SSI Medicaid is ending due to the loss of SSI benefits.
  - If a signed renewal/application form is not returned by the 30th day, eligibility is auto-disposed on the 31st day and Medicaid is terminated for failure to provide the requested information, following Advance Notice of Adverse Action. No staff action is needed.

- If the application is returned by the 30th day, staff must process the application and explore potential eligibility for all medical programs following regular policy and procedures. (TWH B–122.4.2, Processing a Manual Renewal and MEPDH B–8400, Procedures for Redetermining Eligibility).
- Form TF0001, Notice of Case Action, is sent when the final Medicaid eligibility determination is made.

To ensure recipients remain eligible throughout the unwinding period, Medicaid eligibility will be maintained until the redetermination is completed.

**Automation**
Changes to TIERS are currently scheduled to be implemented with TIERS Release R114.2 on April 22, 2023, and R114.3 on May 27, 2023.

Automation changes for the following programs will be implemented on April 22, 2023:

- Medicaid for Newborn Children, MBCC and Pre-MAGI HTW; and
- SSI and DFPS eligibility groups.

Automation changes to the MAGI alerts will be implemented on May 27, 2023.

**Correspondence**
Beginning the weekend of January 28, 2023, Form H1809, Special Emergency Notification, was sent to notify Medicaid recipients that the federal requirement to maintain Medicaid coverage is ending on March 31, 2023. The notice included steps on how Medicaid recipients can update their case information, submit a renewal packet, and respond to any requests for information.

New cover letters will be generated for renewal packets sent to the special populations to include language that applies to these groups:

- Form H1830P, It’s Time to Review Your Health-Care Benefits; and
- Form H1233P, It’s Time to Review Your Health-Care Benefits.

**Handbook**
Handbook updates are not required.

**Training**

- The *End of Continuous Medicaid Coverage* training was available in PALMS on March 23, 2023. A training broadcast will be sent on March 31, 2023.

- Training for DFPS/SSI Eligibility groups will be available in a Release 114.3 WBT on May 18, 2023.

**Effective Date**
This policy is effective April 1, 2023.

## 3. Reasonable Opportunity Period (ROP)

### Background

Medicaid applicants who attest to being a U.S. citizen or claim a qualifying immigration status, but who are unable to provide verification of their status at initial application are allowed a ROP and appropriate notice is provided. (TWH A-351.1, Reasonable Opportunity, and MEPDH D-5500, Reasonable Opportunity to Provide).

### COVID-19 Policy

Medical Programs

Failure to provide verification of citizenship or immigration status before the end of the ROP is not a valid reason to terminate Medicaid during the COVID-19 PHE. Recipients who do not provide verification of citizenship or qualifying immigration status before the end of the ROP, continue to receive Medicaid until the end of the COVID-19 PHE.

### New Policy

Medical Programs

Medicaid eligibility can be terminated without a full redetermination for recipients who were provided a ROP but did not provide verification of citizenship or qualifying immigration status and the state is unable to verify their citizenship or immigration status.

Staff must use electronic data sources to explore current citizenship and immigration status and terminate Medicaid eligibility if the ROP has expired and verification of their citizenship or qualifying immigration status is not available.

Advance Notice of Adverse Action must be provided prior to termination.

**Note:** Staff must continue to follow normal policy and procedures when providing a ROP. (TWH A-351.1, Reasonable Opportunity and MEPDH D-5500, Reasonable Opportunity to Provide).

### Automation

During a one-time mass update, TIERS will identify and automatically terminate Medicaid eligibility for people who:

- were provided a fully compliant ROP and the ROP has expired;
- their Medicaid coverage has been maintained; and
- their citizenship or qualifying immigration status remains unverified.

A TF0001, Notice of Case Action, will generate to inform these households of the reason for termination of coverage. Households who are terminated coverage for these reasons are provided 30 days of Advance Notice of Adverse Action. (TWH A-351.1 Reasonable Opportunity).

Exception cases will generate a report sent to designated eligibility staff to process.

For ongoing cases, if a person does not provide verification of their U.S. citizenship or qualifying immigration status by their ROP due date, TIERS will consider it a valid denial and will allow the termination.

Changes to TIERS were implemented with TIERS Release 114 Cycle 1 Deployment 113.2 on December 10, 2022.

**Correspondence**
Correspondence changes are not required.

**Handbook**
Handbook updates are not required.

**Training**
Training is not required.

**Effective Date**
This policy is effective April 1, 2023.

## 4. Medicaid Buy-In (MBI) and Medicaid Buy-In for Children (MBIC) Premiums

### Background

MBI and MBIC recipients may have to pay a monthly premium as a condition of eligibility. Recipients residing in a federally declared disaster area are exempt from paying monthly premiums for up to three months beginning with the month a disaster is declared.

Based on the COVID-19 Presidential Disaster Declaration, an emergency hardship exemption to waive monthly premiums for MBI and MBIC recipients was approved for March, April, and May 2020.

MBI recipients terminated for failure to submit premium payments who reapply and are determined eligible for MBI, must pay all past due premium payments incurred within 12 months of reapplying prior to recertification.

MBIC recipients who are terminated and later reapply are not required to pay missed premiums from a previous eligibility period prior to recertification.

### COVID Policy

MBI and MBIC

Due to the FFCRA maintenance of coverage requirement, Medicaid eligibility has been maintained for MBI and MBIC recipients who have past due monthly premiums.

### New Policy

MBI and MBIC

Effective April 1, 2023, a full redetermination of eligibility must be completed for all Medicaid recipients following regular renewal policies (MEPDH B-8400, Procedures for Redetermining Eligibility).

To avoid termination for missed premium payments, all past due premiums incurred after March 1, 2020, must be removed.

Designated staff will manually override any past due monthly premiums and zero out the premium amounts for those months.

## Staff Procedures

*MBI and MBIC*

When processing a redetermination, staff must review the case to identify any past due monthly premiums.

If there are no unpaid premiums, staff must process the case following current policies and procedures. No additional action is needed (MEPDH Chapter M, Medicaid Buy-In Program and Chapter N, Medicaid Buy-In for Children).

If there are unpaid premiums, staff must send an email to designated staff. The designated staff will review the case record and zero out any past due premiums.

Staff must **NOT** zero out monthly premium amounts that have already been paid.

## Automation

Automation changes are not required.

## Correspondence

A special insert will be added to the premium payment coupon notices. The insert informs recipients that they are required to pay monthly premiums by the due date to remain eligible for Medicaid.

## Handbook

Handbook updates are not required.

## Training

Training is not required.

## Effective Date

This policy is effective with the release of this bulletin.

## 5. Renewals Initiated Prior to April 1, 2023

### Background

The Medicaid administrative renewal process is initiated when information from electronic data sources is compared to the case information. This occurs before cut-off in the ninth month of the 12-month certification period.

Due to the continuous Medicaid requirement, recipients cannot be terminated if the administrative renewal process was initiated before April 1, 2023 (start of the 12-month unwinding period).

### COVID-19 Policy

Medical Programs

The administrative renewal process for Medicaid EDGs with renewal due dates in April, May, and June 2023 is initiated between January and March 2023, which is prior to the unwinding period.

When processing these renewals, if the final eligibility determination results in termination, including termination for failure to provide information, the existing Medicaid coverage will be maintained for an additional six months. Additional language will be added to the Form TF0001, Notice of Case Action, to notify recipients that Medicaid coverage will continue until a full redetermination is completed. Another redetermination for these recipients must be initiated during the unwinding period.

If the redetermination results in approval for the same TOA or higher coverage, a new 12-month certification period is approved and Form TF0001, Notice of Case Action, is sent to the recipient.

### Automation

Changes to TIERS were implemented with TIERS Release R114.1 on March 18, 2023.

### Correspondence

Changes to Form TF0001, Notice of Case Action, were implemented on March 18, 2023.

### Handbook

Handbook updates are not required.

### Training

Training is not required.

**Effective Date**

This policy was effective with the implementation of TIERS Release 114.1 on March 18, 2023.

## 6. SNAP Income to Renew Medicaid

### Background

For the 12-month unwinding period following the end of continuous Medicaid, HHSC received federal approval to implement a temporary process to use verified SNAP income to redetermine eligibility for Medicaid recipients.

### Current Policy

MAGI Medical Programs

During the administrative renewal process, the automated renewal process checks for required verifications and attempts to verify income by determining if the person's income information is reasonably compatible with income information available through electronic data sources.

SNAP income verified within the previous 60 days is considered an acceptable verification source.

### New Policy

MAGI Medical Programs

Through the unwinding period, TIERS will compare SNAP gross countable income to the applicable MAGI income limit for the program during the initial automated portion of the administrative renewal process for MAGI Medicaid recipients with an active SNAP EDG.

If the SNAP income was verified within the previous six months and is below the applicable Medicaid income limit, TIERS will complete the Medicaid redetermination without conducting a separate MAGI-based income redetermination.

If SNAP income is not available or has not been verified within the previous six months, TIERS will follow the regular administrative process and use income information available through electronic data sources to complete the administrative renewal process.

### Automation

TIERS will compare the SNAP gross countable income to the applicable Medicaid income limit:

- If SNAP gross countable income is above the applicable Medicaid income limit, TIERS will follow the regular administrative renewal process.
- If the SNAP gross countable income is below the applicable Medicaid income limit, TIERS will follow the temporary administrative renewal processes outlined below.

For the temporary administrative renewal process, if the SNAP income is below the applicable Medicaid income limit, TIERS will:

1. Disable the Reasonable Compatibility screen in the Eligibility Summary LUW.
2. Mark the "Reasonable Compatibility Result" in EDG summary as "Not Applicable."
3. Complete the Required Verification (RV) process to identify any non-financial information needed and pend if applicable.
4. Add the following information in case comments:
   "MAGI EDG number(s) <#> - SNAP countable income is used for MAGI/FPIL limit in Total Income and Net Income."

Changes to TIERS were implemented with TIERS Release 114.1 on March 18, 2023. The temporary administrative renewal functionality will be effective in TIERS on April 1, 2023.

**Correspondence**
Correspondence changes are not required.

**Handbook**
Handbook updates are not required.

**Training**
Training is not required.

**Effective Date**
This policy is effective April 1, 2023.