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Medicaid Update

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INTRODUCTION

I. DEFENDING CLIENTS' MEDICAID ELIGIBILITY DURING THE "UNWINDING" OF THE PANDEMIC PROTECTIONS

A. THE TEXAS HHSC PLAN FOR "THE UNWINDING"

The Centers for Medicare and Medicaid Services (CMS) required each state to develop a plan for "unwinding" the federal statutory requirement that Medicaid eligibility be continued in most cases. That requirement ended effective March 31, 2023, and a Texas HHSC plan for "unwinding" from that requirement was published in early April 2023 then revised and republished in June 2023.[1] The following provisions of the Texas plan may be the most useful for Elder Law attorneys:

- Those who did not renew successfully, or who HHSC believes for any reason are not now eligible, will receive renewal notices in the six months after March 31, 2023.[2]
- All renewal notices that are sent by postal mail will arrive in a yellow envelope with "Action Required" in red.[3] (The most significant meaning of this statement may be that the special envelope apparently does *not* indicate that the recipient is in the "first cohort" of individuals "most likely to lose eligibility.")
- Clients will have 30 days to respond, as with annual reviews.[4] Also as with annual reviews, the notices are sent by postal mail and tend to arrive about 10 days after the date on the form, leaving only about 20 days to respond unless you get an extension.
- Most importantly: "Clients will not lose coverage until their redetermination is complete, provided they respond by the due date to redetermination packets or requests for information."[5]

Some other resources are on the HHSC web page cited in footnote 1.

The first version of the state plan submitted to CMS said all renewals will be on Form H1206-ME. However, that form is not mentioned in the June version of the plan, and as of

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[1]The version online as of this writing is titled *Continuous Medicaid Coverage Unwinding Operational Plan* (June 2023). It is found through the following link under the name *State Report on Plans for Prioritizing and Distributing Renewals Following the End of the Medicaid Continuous Enrollment Provisions* at https://www.HHSC.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-information-people-receiving-services/end-continuous-medicaid-coverage .

[2]*Id.* on page 6.

[3] *Id.* on page 17.

[4] *Id.* on page 6.

[5] Id. on page 19.

this writing none of our clients have received a Form H1206-ME. Therefore, that part of the HHSC plan may have changed. Form H1206-ME is not in any handbook, but a sample is available at https://www.HHSC.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information/end-continuous-medicaid-coverage-ambassador-toolkit .

B. WHAT IS THE REAL REVIEW RESPONSE DEADLINE?

At this writing in June 2023, we are still experiencing the following issue, noted in last year's Medicaid Update: the deadline contained in the notice requiring the application is often not the "real" deadline. If you file the application within the deadline in the notice, you may have to file it twice, because the real deadline may be later and the client will get another notice within a short time. In the past we asked the Office of Eligibility Services for that information, but OES response time at this writing is several weeks. Also, now that we are in the "Unwinding" period, we expect the agency to begin putting correct deadlines in the notices. Therefore, we are assuming in each case that has happened, at the risk of having to file a second application in a few months.

Sometimes the date on the notice is weeks earlier than the date it arrived by postal mail. In such cases, if there is not time to collect and file the required documents, the proper response is to send a request for extension of the deadline, explaining the late receipt and/or other circumstances leading to need for the extension.

C. WHAT IS THE REAL PROBLEM TO BE SOLVED?

In summary, the requirements for responding to the HHSC notices requiring a "review" application during the "unwinding" period are essentially the same as for annual reviews, as required by CMS directives.[6] The big difference during the "unwinding" is that there are some cases in which the agency has already determined that eligibility requirements have not been met. Since the agency gives no notice as to which redeterminations are in that category, nor as to why eligibility will be terminated, we need to try to figure it out ourselves so as to get ahead of any planned termination. For that purpose, we have identified the following possible reasons for loss of eligibility so are asking all clients filing review applications to let us know if any of the following have occurred since March of 2020:[7]

- You received a notice that you were required to file an annual review application and either did not respond or responded after the deadline (If this is the only known

[6] See, e.g., CMS Letter SHO #22-001 (March 3, 2022) page 12 at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf .

[7] No doubt there are other possible events that may trigger termination, so look closely at the facts of each case and add to this list if you can.

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