End of PHE: FAQs and Staff Talking Points

Overview

The COVID-19 Public Health Emergency (PHE) ends on May 11, 2023. With this announcement also comes the end of continuous Medicaid coverage, which has been in place since April 20, 2020. Your patients' Medicaid coverage may be impacted by the end of continuous Medicaid coverage.

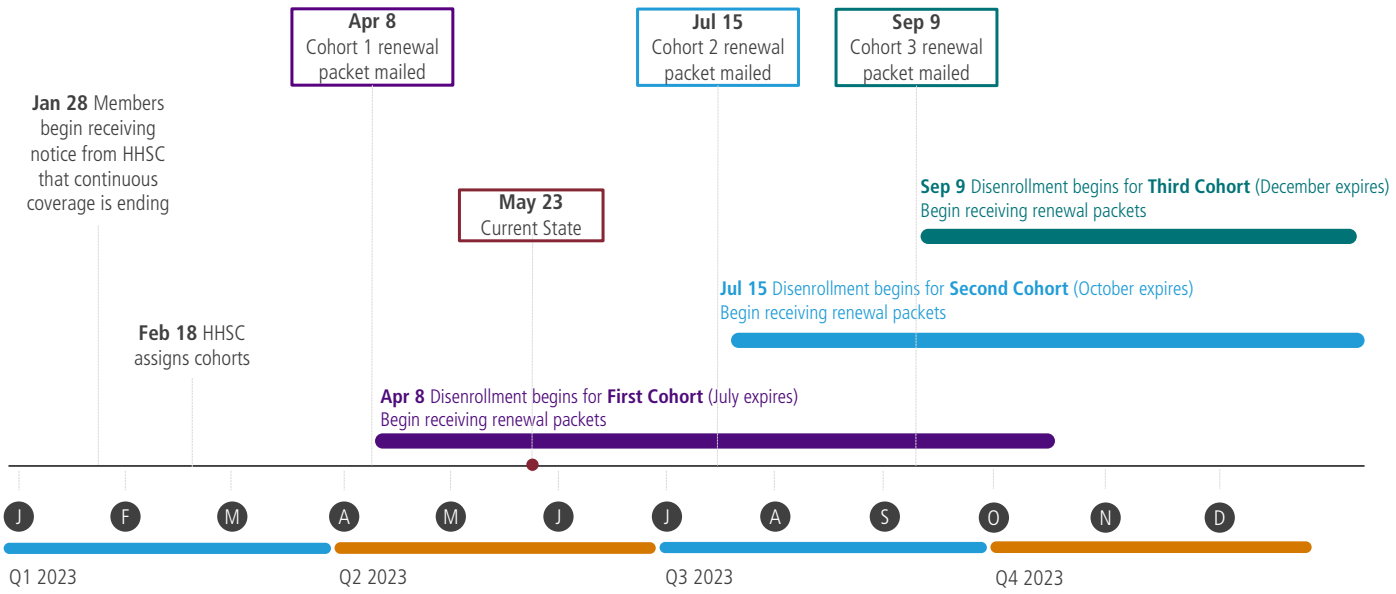
Communicating with patients and educating them on next steps can help avoid a gap in their coverage and care.

Frequently Asked Questions (FAQs)

What is the timeline for enrollment/disenrollment?

The disenrollment process will occur in three different waves (cohorts). The graphics below explain who is included in each cohort, along with their corresponding disenrollment periods.

First Cohort	Second Cohort	Third Cohort
Includes individuals most likely to be ineligible or transitioned to CHIP	Includes individuals likely to transition to a different Medicaid eligibility group	Includes everyone remaining from the previous groups, including those most likely to remain eligible
• Women who were pregnant who may transition to HTW; • Members who aged out of Medicaid; • Adults who no longer have an eligible dependent child in their household.	• Medicaid children, parent/caretaker and waiver groups pending information, • Certain MAGI population groups (e.g., women aging out of Children's Medicaid, people under Transitional Medical Assistance).	• Older adults and people with disabilities.



How do I verify my patient's Medicaid coverage?

- You can verify patient eligibility for Medicaid through the Texas Medicaid & Healthcare Partnership's (TMHP) TexMedConnect portal.
- You can also call 2-1-1. Press option 2 after the language prompt, and then option 2 again. Be prepared to provide your National Provider Identifier (NPI).

If my patient is uninsured, where can they go for coverage?

- If your patient was found ineligible for Medicaid, their case has been automatically sent to the federal Marketplace to be considered for coverage options. For more information, visit Healthcare.gov.
- If they were disenrolled because they never responded to Texas Health and Human Services (HHSC) or didn't complete their renewal application, they will not be transferred to the Marketplace. This is because HHSC was not able to confirm their eligibility for Medicaid. In this case, they should submit their renewal application for benefits.

What is Prior Medicaid Coverage, and how does someone apply?

- When a person applies for Medicaid coverage through HHSC, they can apply for Medicaid benefits for up to three months prior to the month of application if they have unpaid medical bills in those three months.
- People can apply for prior Medicaid coverage by submitting Form H1113, Application for Prior Medicaid Coverage. Please refer patients to the Texas Works Handbook for more information.

Next Steps for Your Patients

It's important for patients to feel prepared and ready for their next steps. So long as patients are within the 90-day window of their coverage expiration, they are eligible to apply. You can help your patients by telling them to:

Create an Account.

If they don't have an account, they can create one at YourTexasBenefits.com or through the Your Texas Benefits mobile application.

Why? Having an updated YTB account is the best way to receive timely updates about their coverage. They can use this account to renew online, which is the easiest and most efficient way to go through the process.

Verify and/or Update their Contact Information.

They should do this as soon as possible, especially if their information has changed (i.e., they have moved, had a baby, changed jobs, etc.). This can be done at YourTexasBenefits.com, through the Your Texas Benefits mobile application, or by calling 2-1-1 (and selecting option 2).

Why? If HHSC does not have accurate information, they may not be able to determine eligibility or communicate important updates to the individual about their coverage. These complications may result in an individual losing their coverage.

Look for a Notice in the Mail.

If they did not choose to receive paperless notifications (or don't have a YTB account), they will receive a notice in the mail from HHSC. This notice will come in a yellow envelope labeled "Action Required." If they receive this notice they should respond quickly.

Why? Receiving this notice means the individual has approximately 30 days left before their coverage expires (it could be slightly more or less). To avoid any issues with their coverage, it's recommended that they immediately review the contents of the notice and follow the instructions to complete and return the information as soon as possible.

Complete and Submit the Renewal Form before their coverage expiration date.

The best way to do this is online at YourTexasBenefits.com. They can also submit renewal forms by mail or fax.

Why? If they're unable to submit the renewal on time, their coverage will automatically expire. In this case, they'll experience a gap in their coverage and will have to submit a new application for benefits.