

Connecticut
Medicaid Managed Care Council
Consumer Access Subcommittee
Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-0023
www.cga.ct.gov/ph/medicaid

Meeting Summary: May 24, 2006

Chair: Christine Bianchi

*Next meeting dates: **June 21 and July 19 @ 10:30 AM at the LOB RM 3800***

Attendees: Christine Bianchi (Chair), Sen. Edith Prague, Kevin Loveland, Glendine Henry, Theresa Rugens, Hilary Silver & Tricia McCooey (DSS), Steve MacKinnon & Kevin Colvin (CHNCT), Linda Bradanini, Mary Beth Barnum & Gail DiGioia (Anthem),, Christoher Savold (WellCare/PONE), Valerie Lane (Health Net), Sue Greeno & Amy Gagliardi (CHC, Inc, Tanya Barrett (United Way HUSKY Infoline), William Diamond (ACS), Sharon Langer (CTVoices), Judith Calechman (Yale CSHCN Regional Medical Center), Linda Moriber (CT United Way), M.McCourt (Council staff).

The meeting focused on the federal mandate for Medicaid clients' proof of citizenship /identity commencing July 1, 2006 and the June 30, 2006 Transitional Medical Assistance (TMA) coverage issues. The other agenda items, updates on Expedited Eligibility (EE) for pregnant women and children's Presumptive Eligibility (PE) and review of the DSS/MCO Prior Authorization report template were deferred to the June 21 meeting.

Proof of Citizenship/Identity

Beginning **July 1, 2006** the federal Deficit Reduction Act (DRA) requires states to implement procedures to fulfill the federal law that all U.S. citizens applying for or renewing Medicaid coverage must provide the state with documentation of their citizenship & identity in order to receive or continue to receive Medicaid services. Of note, the provisions in DRA relate to federal matching funds; does not amend eligibility requirements for Medicaid. Documentation of citizenship is not a federal Medicaid condition for eligibility.

In Connecticut, approximately 420,000 Medicaid clients, adults and children, will be subject to this law. Proof of citizenship need be provided only one time beginning July 1, at the time of new application or renewal of coverage in Medicaid. While the DRA defines acceptable documents that meet the provisions, the U.S. Department of Health & Human Services can identify "other acceptable" documents that states can accept as proof of citizenship/identity. The Centers for Medicare & Medicaid Services (CMS) has not (*as of June 6*) released guidelines to states on the implementation of the law. Without CMS guidelines, states will have to interpret the law as they develop their procedures and could risk loss of federal match dollars for Medicaid eligible enrollees if states misinterpret the mandate parameters. Clients that have difficulty obtaining "appropriate" documents in a "timely manner" could lose eligibility or the state could continue to provide Medicaid coverage with state-only dollars. States' overriding concerns associated with the mandate are 1) ensuring people eligible for Medicaid

continue to have access to Medicaid coverage and 2) the risk states may encounter in using state-only funds to provide Medicaid coverage for some clients who are unable to produce the documentation within "specified" time frames. The 'standard of promptness' (45 days/90 days) time frame is too short for some applicants to produce the required documentation. CMS has indicated state audits will be undertaken.

Of course Connecticut is committed to following the law but lacking clear guidelines, DSS will do the best they can in interpreting the statutory provisions, in planning for implementation July 1, 2006. Plan components include, but are not limited to:

- In order to reduce client burden and obtain timely evidence of citizenship, DSS will identify other databases that would show evidence of US birth and/or citizenship, doing a data cross walk with Medicaid.
 - Talking with DPH about birth registry matches with Medicaid.
 - Explore possible current SSI data interface with DSS.
 - Access federal Medicare databases that would have social security number; SSN requires evidence of US birth/citizenship. NOT AVAILABLE TO STATES UNTIL FEBRUARY 2007.
- Enlist help from community-based organizations that can in turn help their clients secure the required documentation, including allowable notarized affidavits.
- Work to determine application/renewals eligibility for those that have been submitted prior to July 1, 2006. If these applications/renewals eligibility determinations have not been completed by June 30th, the applicant will be subject to the proof of citizenship rules. Of note, this federal law comes at a time when approximately 8,600 families are coming to the end of their 12-month TMA June 30, 2006. CGA repeal of a significant coverage barrier, elimination of self-declaration of income (SB 703) impact may be seriously offset with the added documentation required in DRA, continuing or worsening Medicaid pending/discontinuances for incomplete documentation.

The elderly Medicaid clients may be most vulnerable to losing eligibility as they may encounter the most difficulty in providing proof of citizenship absent the Medicare data match until 2/07. Georgia, the state of the two congressional members that authored the legislation, actually exempted Medicare & SSI Medicaid members from the proof of citizenship state policy, enacted prior to the DRA.

The Department will provide updates to the Medicaid Council if or when CMS issues guidance and the agency's steps to implement the federal mandate. Please refer to a review of the issues provided by CT Voices at www.ctkidslink.org.

Addendum: CMS released proof citizenship/identity guidelines Friday afternoon June 9, 2006. See site below for more information:

http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp

Outreach to Transitional Medical Assistance (TMA) Clients (click on icon 1 for DSS client notification and icons 2/3 for MCO letter to their members impacted by the end of TMA June 30th.)

TMA, shortened from 24 months to 12 months effective July 1, 2005, will end for about 8,600 families (12, 000 individuals) June 30, 2006. Additional families that were

covered under TMA as the result of the 2003 lawsuit are also reaching the end of their TMA period. Given the state's experience in July 2005 when about 10,000 HUSKY enrollees lost coverage, some of which was attributed to non-receipt of notification letters, as well as confusion about various policy changes during a short time-period, it is imperative that a collaborative outreach effort, both at the state and community level be used to alert community members to the coming coverage changes. To date:

- DSS letters have gone out to these Medicaid enrollees 60 days prior to the end of coverage; clients are urged to complete HUSKY applications, as family coverage (parent/caregivers) income limits were increased to 150% FPL (or they may be eligible for other Medicaid programs). Families eligible for HUSKY can also have private insurance, with Medicaid as the payer of last resort. Notices sent out in June will include information that *applicants/renewals can once again 'self-declare' income on the application/renewal.*
- The HUSKY MCOs will receive files identifying their members that will lose TMA; the MCOs will send reminder notices to their clients as well.

Unfortunately the specter of outdated addresses (those not in the system) overshadows the success of reaching some/many of these enrollees to inform them of coverage termination under TMA. Hence community organizations may be successful in informal out-reach within their area, to inform their residents of the TMA notices and importance of applying for HUSKY.

Christine Bianchi noted that HUSKY applicants' "authorized representatives" such as Healthy Start do not receive follow up information on the application/renewal status of clients that may benefit from further assistance to complete the process. DSS responded that this is being looked at to ensure compliance with HIPAA Privacy rules and possible concerns about behavioral health partnership issues. Also, it was noted that the representative is not listed on the application, although there is an existing field that could be used for "authorized representative". Resolution of this is important in light of the recent increasing monthly losses of children in the HUSKY program (about 800/month).

Based on HUSKY A & B enrollment reports **children's (A & B) enrollment decreased by 6039** enrollees during July 2005 – May 2006. **Adult enrollment increased by 3079** during that same period.

Action: DSS HIPAA staff, DSS staff and Christine Bianchi will explore this with resolution hopefully by the June meeting.