



POLICY & CLINICAL OPERATIONS GUIDANCE

Training on Medicaid & Medical Frailty

Navigating H.R. 1 requirements, documentation standards, FQHC impacts, and patient support strategies.

Clinical Documentation

 Patient Advocacy & Compliance

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Medicaid Policy Shifts Under H.R. 1

Three critical regulatory changes impacting Connecticut adult Medicaid coverage



Work Reporting Standard

Adults ages 19–64 on HUSKY D must report 80 hours per month of work, job training, education, or volunteering.



Non–Citizen Eligibility Cuts

Effective October 2026, non-citizens, refugees, asylees, and lawful permanent residents lose HUSKY coverage access.



Administrative Burden Risk

Two-thirds of HUSKY D adults work, but complex reporting paperwork threatens accidental coverage loss.

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Scope of Impact on HUSKY D Population

Understanding beneficiary risk and income qualification parameters

316,000

Total HUSKY D Enrollees in CT



110,000

At Risk of Coverage Loss (~33%)



57,000

Estimated Medically Frail Beneficiaries



Income Threshold Guidelines

HUSKY D serves low-income adults ages 19–64 without dependents up to **138 % FPL**.

- **Individual:** ~\$22,025 / year
- **Household of Two:** ~\$29,863 / year

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Work Rules & Key Exempt Groups

Evaluating patient pathways to maintain Medicaid eligibility

Work Rule Standards

Effective Date: Jan 1, 2027 start for non-exempt recipients.

Monthly Target: 80 hours/month of work, training, education, or volunteering (or earn $\geq$ \$580/mo).

Volunteer Proof: Requires official charity address and written supervisor confirmation.

Renewal Frequency: Cycles shorten to as often as every 6 months.

Exempt Statuses (Check First)



Medical Frailty

Disabling physical or mental conditions



Caregivers

Unpaid care for elderly parent/dependent



Veterans

Qualifying disability rating holders



Recently Released

Individuals returning from incarceration

Additional Exemptions: Pregnant & postpartum individuals, Native American / Alaska Native status, and former foster youth ages 19–25.

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Medical Frailty: The Dual-Criteria Requirement

Both components must be documented to secure exempt status

⚠ Critical Standard Update:

Prior medical diagnosis or claims records alone are **no longer sufficient**. Documentation must explicitly prove the condition significantly impairs work compliance.

1 Qualifying Diagnosis

A verified serious, disabling, or chronic physical or mental health condition established by clinical assessment.

2 Significant Impairment

Demonstrated functional limitation directly impacting the patient's capacity to maintain 80 hours/month of work activity.

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How DSS Verifies Medical Frailty

The four-step verification sequence applied by state agencies

Step 01

Check Records

DSS reviews Medicaid claims & encounter data from last 12 months. Older data excluded.

Step 02

Reach Out

If records fall short, patient gets ≥ 30 days to submit provider form or medical records.

Step 03

Self-Attest

Allowed through 2027. From Jan 1, 2028, counts only once per person per lifetime.

Step 04

Recheck

Frailty rechecked at least every 12 months. Some state cycles check every 6 months.



Beneficiary Protection Clause

A diagnosis code alone cannot verify frailty. If a patient genuinely cannot obtain paperwork, DSS **cannot cut coverage** for that reason alone.

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Documenting So It Holds Up

Connect clinical diagnosis directly to concrete, work-related functional limits

✖ WEAK DOCUMENTATION

“Patient has chronic pain.”

Lacks concrete functional limitation or work impact details.

✔ STRONGER DOCUMENTATION

“Pain prevents standing for more than an hour.”

Links medical condition to a measurable capacity restriction.

4 Key Elements to Include

- ✔ **Timeframe:** State whether limit is temporary (with rough duration) or permanent.
- ✔ **Evidence Base:** Note whether limit rests on clinical exam, patient report, or both.
- ✔ **Restriction Level:** Separate full restriction (cannot do) from partial (slower capacity).
- ✔ **Treatment Dependence:** For stable conditions, note stability requires continued care access.

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If Denied, & Where to Get Help

Appeals protocols and essential support portals for patients and staff



Frailty Status Denied?

Patients can formalize a challenge through the DSS notice and fair-hearing appeal process.

Advising Patients: Read formal DSS notice closely and adhere strictly to appeal instructions and deadlines.

Free Help for Patients & Staff

DSS Benefits & H.R. 1 Hub

portal.ct.gov/dss/all-programs/dss-benefits-and-hr1

HUSKY DPreScreenerTool

portal.ct.gov/husky/huskydprescreener

Community Action Agencies (CAFCA)

cafca.org | (860) 832-9438

CHA Provider Toolkit

cthosp.org/h-r-1-and-husky-d-changes-resources

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What Clinics & Health Centers Can Do Now

Coverage rules change Jan 1, 2027 — proactive readiness timeline



With Patients

- › Direct patients to HUSKY D PreScreeners to verify exemptions early.
- › Educate that past medical diagnosis alone will not satisfy DSS.
- › Prepare for frequent renewal cycles (as often as every 6 months).



For Health Centers

- › Identify HUSKY D panel members likely affected; run targeted outreach.
- › Deploy rapid re-enrollment protocols to close temporary coverage gaps.
- › Model bad debt & cash flow under varied enrollment loss scenarios.
- › Ensure cost reports remain complete, precise, and up-to-date.

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SUMMARY & OPERATIONAL TAKEAWAY

Protecting Patient Coverage

Early screening, precise clinical documentation, and rapid re-enrollment are key to ensuring continuity of care under H.R. 1.

01. EARLY ACTION

Screen all HUSKY D patients well before the Jan 1, 2027 deadline.

02. CLINICAL ACCURACY

Tie diagnoses explicitly to work-related functional limitations.

03. FQHC READINESS

Prepare clinic operations and financial modeling for renewal shifts.

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