DSS MAPOC PRESENTATION

July 10, 2026

Agenda

- H.R. 1 Update (Suzette, Christine)
- Pharmacy Benefit Administrator (Bill)
- Pharmacy Pilot Update (Dr. Terranova)
- Dually Eligible Member Update (Bill)
- Fee Schedule Updates (Fatmata)
- DSS Call Center (Deputy Commissioner Canada)

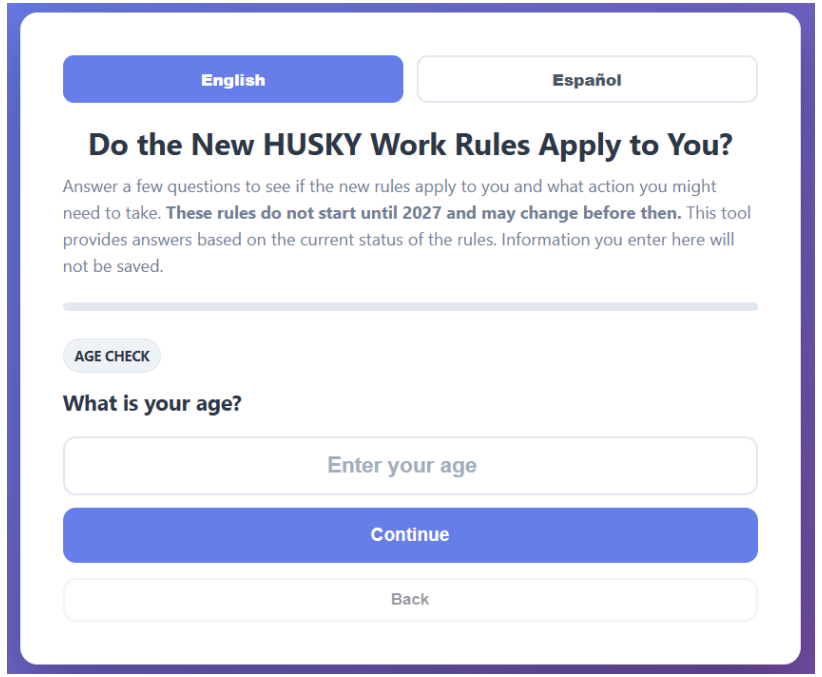
H.R. 1 UPDATE

COMMUNITY OUTREACH

Connecticut Association of Community Action (CAFCA) has hired 41 staff to message the work rule changes

- Between April and June, they held 169 events across the state
- They plan to hold 143 events through now and September

HUSKY PRESCREENER



ONLINE TOOLKIT

H.R.1 work rules toolkit

Will these changes affect your SNAP or HUSKY coverage?

Changes to SNAP and HUSKY Health work rules can be hard to understand. But many people will not lose their benefits.

On this page you will:

1. Find out if these changes affect your coverage.
2. Find out what you can do to stay eligible.
3. Find out how to report your hours.
4. Get help staying connected to your benefits.

If anything changes for your household, DSS will tell you directly.

What groups are affected?

SNAP groups affected

As of 11/2025, anyone getting SNAP who:

- Is 18-64 years old
- Does not live with a child under 14
- Can work (physically and mentally)

must meet the new work rules.

Use this SNAP Work Rules Pre-screener to see if these new rules apply to you >

HUSKY Health groups affected

As of 1/1/2027, any adult on HUSKY D who:

- Is 19-64 years old
- Does not live with a child 13 and under
- Can work (physically and mentally)

must meet the new work rules.

Use this HUSKY D Work Rules Pre-screener to see if these new rules apply to you > >

H.R.1 changes for HUSKY Health

What is changing for HUSKY Health?

H.R.1 introduced many updates that may affect Medicaid coverage (HUSKY Health). These updates change:

- who can qualify
- how certain benefits are provided

Many people who rely on HUSKY for doctor visits, prescriptions, and other care may see changes to their coverage starting in late 2026.

Review the Medicaid H.R.1 frequently asked questions > >

HUSKY Health work rule changes >

Some adults ages 19 to 64 with HUSKY D will have new rules to follow to keep their coverage. They will need to earn a certain amount of money each month or involved in at least 80 hours of approved activities and may need to take new steps to keep coverage.

Retroactive coverage changes >

HUSKY Health programs have changes to how far back coverage can be granted. Review these changes in the Medicaid FAQ section.

Non-citizen eligibility changes >

H.R.1 has placed new restrictions on who can qualify for HUSKY Health coverage. See if you or your household may be affected by these changes.

Changes for Husky D recipients >

Some H.R.1 changes are specific to HUSKY D members. Review those changes here.

MEDIA MIX

CONNECTICUT Social Services

MEDICAID WORK RULES

media mix

Meta: FB & IG

Promoted posts, awareness & traffic ads & traffic ads served statewide

Google: Search & Video

Ads served to select priority audiences & those searching related keywords

Mobile Geofencing

Digital ads served at select priority locations

Broadcast Radio & Streaming Audio

Audio ads served to priority audiences by interest and location

Note: *Tactics include English & Spanish versions*

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CONNECTICUT Social Services

MEDICAID WORK RULES

media mix

Broadcast TV

Video ads served to priority audiences, based on interest and locations

Out-of-Home: Bus Tails

Ads reaching individuals where they live, work and commute

Out-of-Home: Community Posters

Large community posters placed throughout priority locations statewide.

Streaming TV

Video ads served to audiences with related interests

Note: *Tactics include English & Spanish versions*

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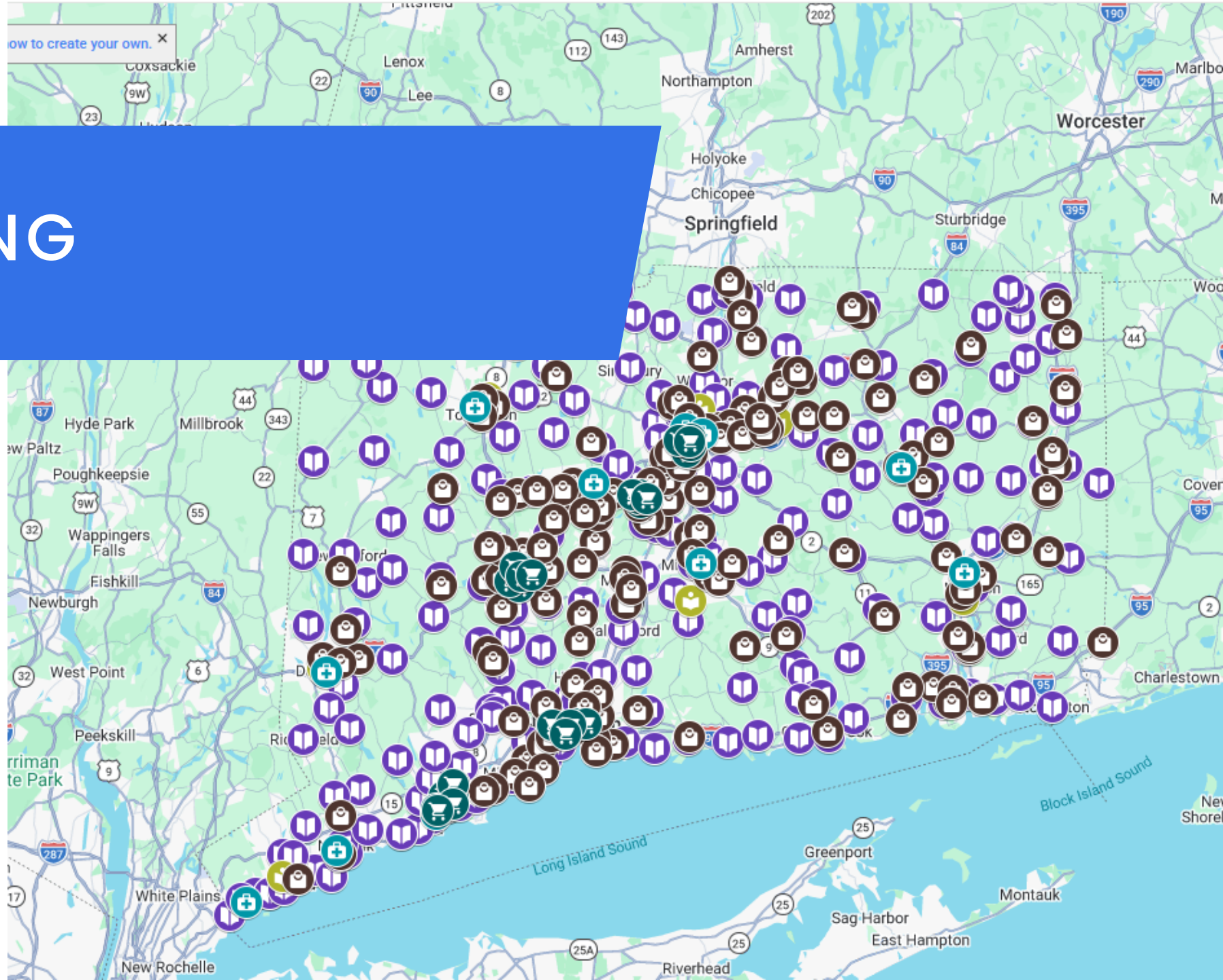
GEOFENCING

- Libraries
- Food Pantries
- Discount Retail
- FQHCs
- Government Buildings



7/10/26

PHARMACY UPDATE

Pharmacy Benefit Administrator (PBA)

Modernization of Connecticut's Medicaid Pharmacy System

Connecticut Department of Social Services | July 2026

What Is a Pharmacy Benefit Administrator?

A PBA focuses on the administrative, transactional, and technology services of the pharmacy benefit program — allowing DSS to remain in control.

- Process prescription claims & prior authorizations in real time
- Collect data and improve transparency through analytics
- Ensure compliance with state and federal regulations
- Provide online access for providers and members
- Manage call centers to support members and providers
- Identify and investigate fraud, waste, and abuse

Why are we procuring a new PBA?

Our current pharmacy technology system was last procured in 2008 — the landscape has changed dramatically since that time.

Centers for Medicare & Medicaid Services (CMS) requires a new procurement prior to current contract expiring at the end of November 2027.

The pharmacy module is part of an overall upgrade to our Medicaid management information system.

Outdated technology

No electronic prior authorizations, no real-time portals, limited data analytics

Increasing pharmacy costs

Drug costs rising while rebates are declining

Lack of transparency

Limited data reporting and fraud detection

PBA vs. PBM: What's the Difference?

PBA

Pharmacy Benefit Administrator

- DSS controls the pharmacy benefit program
- Fee-for-service basis — no spread pricing
- No retained profits by the PBA
- Full transparency on claims and rebates
- Administers DSS's plan
- Maximizes available drug rebates

PBM

Pharmacy Benefit Manager

- Manages their own plan
- Spread-pricing model — incentivizes markup
- Retains profits, which creates conflict of interest
- Limited transparency on drug costs
- Can inflate drug costs
- *Not what DSS is seeking*

DSS is procuring a PBA — not a PBM.

How a PBA Helps Providers & Members

Electronic Prior Authorizations

Streamlined ability to electronically submit prior authorizations, replacing outdated manual processes

Enhanced Staff Access

A pharmacy system allowing DSS staff to access and review information to assist providers as needed

Improved Communication

Enhanced provider notification and communication tools built into the platform

Call Center Support

Real-time information and dedicated call center access for urgent concerns

Member Outcome:

Improved same-day refill rate

Member Protections Remain in Place

Our primary goal: members have access to the high-quality medications they need, when they need them.

Connecticut law (Conn. Gen. Stat. § 17b-491a) guarantees:

- Emergency 14-day drug supply if any issues arise
- Written instructions from pharmacist to contact prescribing doctor
- Prior authorization permitted for one full year for most prescriptions
- Review for approval or denial within 24 hours
- Legislative approval required for dispensing limits on certain drugs

Procurement Timeline

Procuring a PBA is a competitive, multi-step process overseen by DSS and subject to CMS approval.

1

Phase 1: Research

Information gathering, market research, identifying challenges and opportunities

2

Phase 2: Planning

Drafting business outcomes, identifying procurement vehicles and funding sources

3

Phase 3: Procurement

Notifying vendors, issuing statement of work, evaluating applications and demos

4

Phase 4: Award

Procurement report, awarding vendor, formal notice, applying for CMS approval

5

Phase 5: Implementation

Design, development, implementation, CMS certification, and ongoing maintenance

How We're Funding This

Enhanced Federal Funding

Available from CMS specifically to support technology upgrades for state Medicaid systems.

Part of a Broader Modernization Effort

Completed:

✓ Enterprise data warehouse & analytics
✓ Provider enrollment & enterprise care system
✓ Case management system

Upcoming:

→ Pharmacy system (current initiative)
→ Claims system
→ Financial systems

Key Takeaways

- This is a technology upgrade — not a shift to managed care
- DSS remains in full control of the pharmacy benefit program
- The PBA will serve members and providers with modern tools
- No capitated payments, no retained profits — only more transparency
- Funded through available federal CMS enhancement dollars
- Member protections are guaranteed by Connecticut state law

Pharmacy Prior Authorization Pilot

Data from January-May 2026

Pharmacy Pilot Data

- Beginning January 1, 2026, new prescriptions for non-preferred drugs in 11 classes required submission of clinical information along with the prior authorization (PA) form
- Members currently on these medications as of December 31, 2025, were grandfathered during the 1st quarter of 2026 even if their prior PA would have expired during the 1st quarter
- As of April 1, 2026, grandfathering ended for non-preferred prescriptions for Antipsoriatic topicals, Antimigraine: Other, and Hypoglycemics, Incretin Mimetics/Enhancers (GLP-1s for diabetes)
- Coverage for prescriptions in the remaining 8 classes continues until the active prior authorization expires

Pilot Program at a Glance

From implementation in January 2026, through May 2026, 18,332 initial pharmacy requests were tracked from same-day fill through prior authorization, appeal (letter of medical necessity (LMN)/DSS), and — where denied — alternative same-class fill.

18,332

Initial Requests

Jan–May 2026 total

14.6%

Same-Day Fill Rate (PA on file)

2,669 of 18,332 filled same day

58.3%

PA Submission Rate after provider notified

9,135 of 15,663 denied claims

61.5%

PA Approval Rate

5,622 of 9,135 PAs submitted

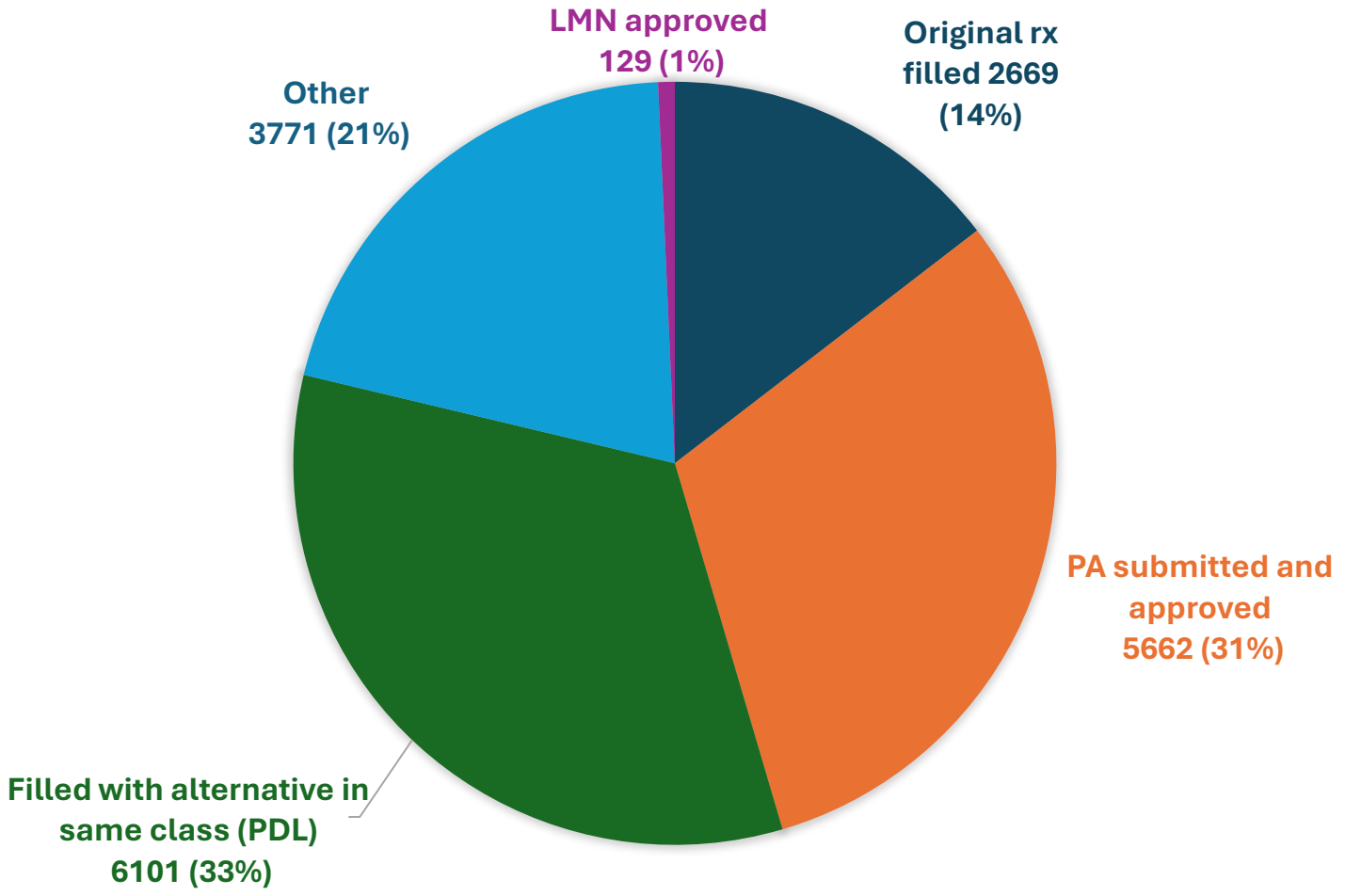
32.7%

Same-Class Alternate Fills (PDL)

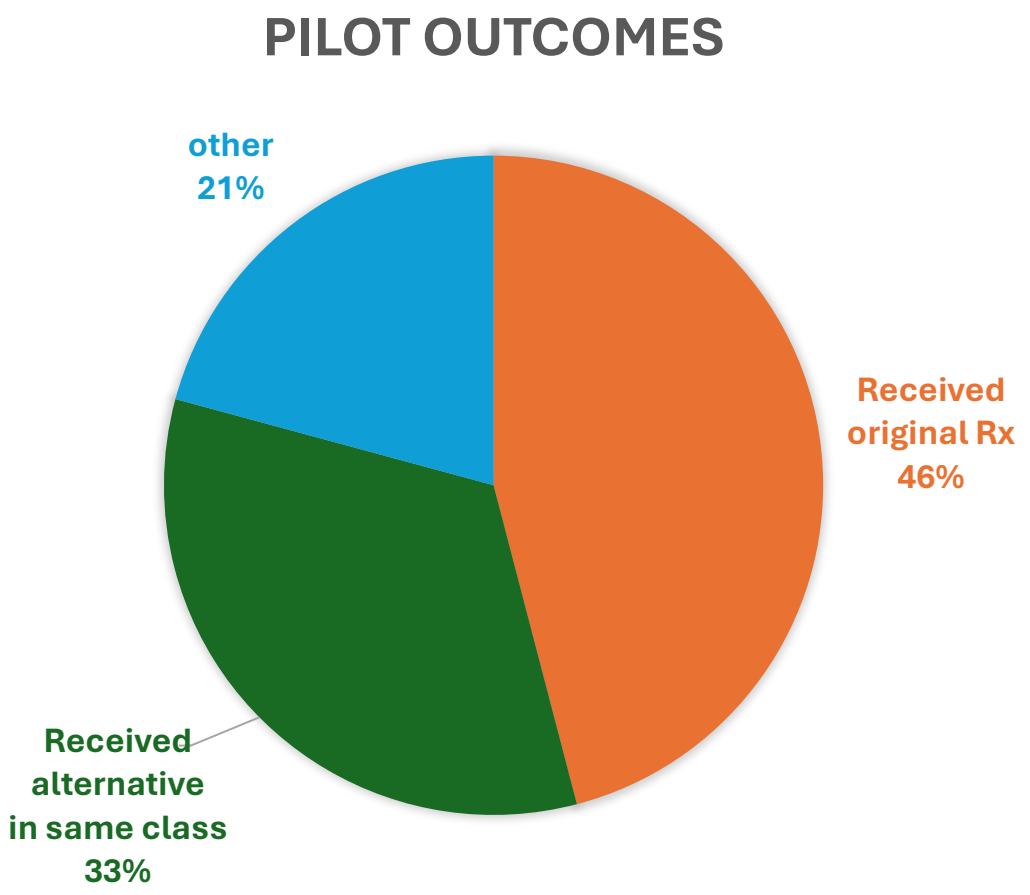
6,101 filled across all denial paths

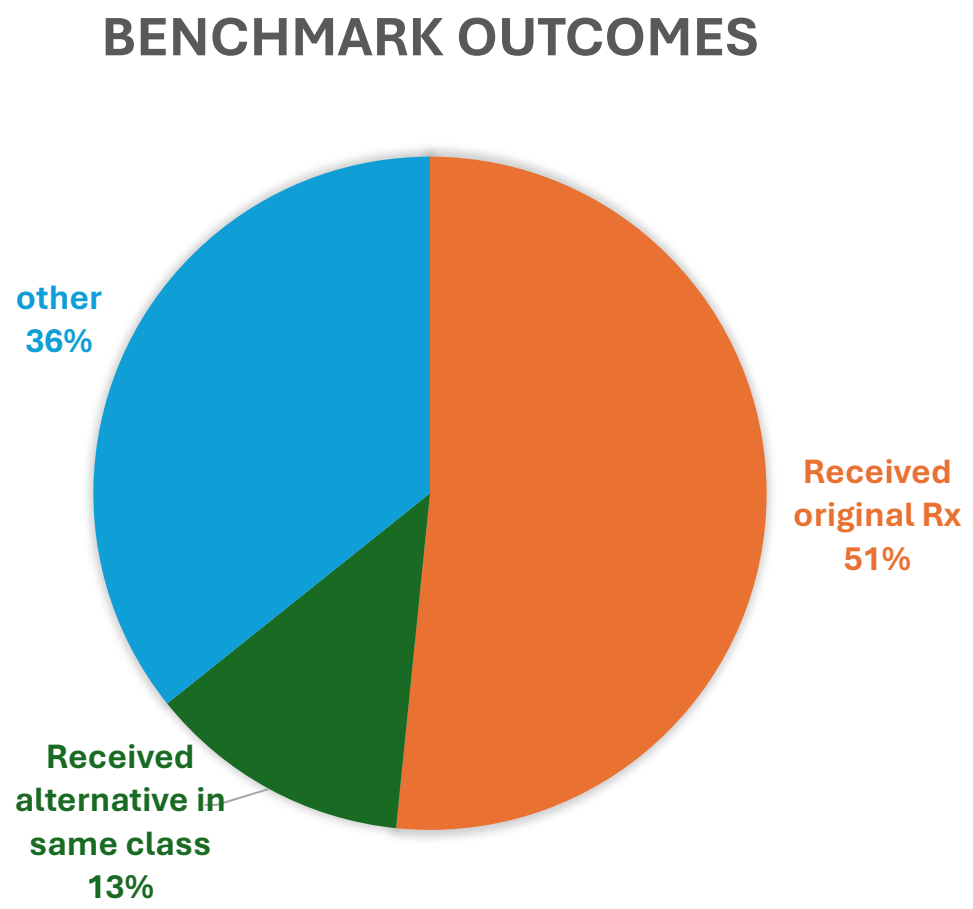
Summary of Prescription Outcomes

(N=18,332)



Pilot vs Benchmark





Summary

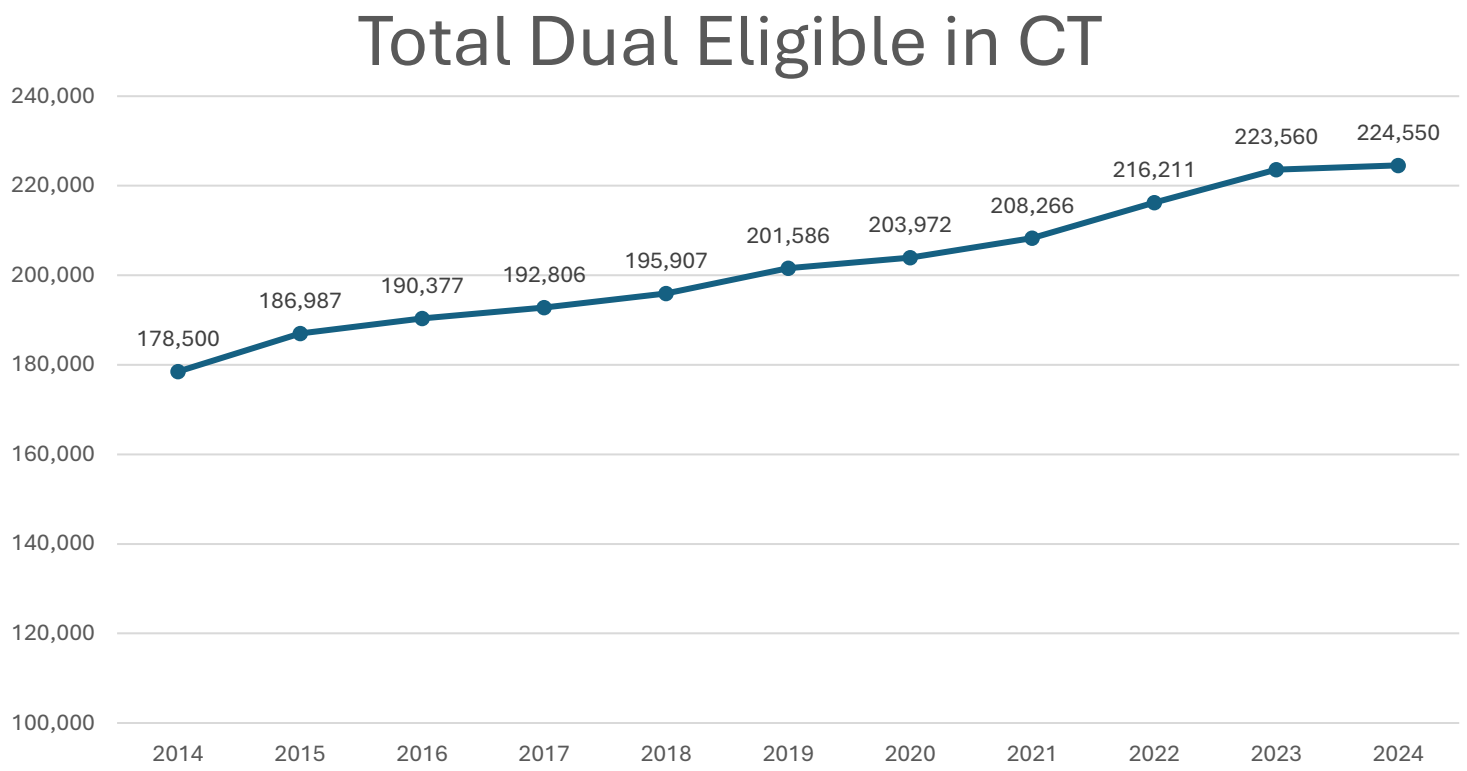
- The pilot is shifting some members to preferred drugs and other alternatives while not limiting access
- GLP1s (Hypoglycemics, Incretin Mimetics/Enhancers) are the highest volume of prescriptions and have the highest denial/no fill rates
- Areas for improvement include increasing same-day fill rate by having PA on file prior to or at time of submission of prescription

DUALLY-ELIGIBLE POPULATION

Dually-Eligible Population: Quick Context

- **Dually-eligible members are individuals who are eligible for both Medicare and Medicaid**
- Medicare covers acute medical care, while Medicaid helps cover premiums, out-of-pocket costs, and long-term care services for low-income individuals and those with disabilities.
- One of the most clinically and financially complex groups in the U.S. healthcare system, they face significant health and socioeconomic challenges with a higher prevalence of multiple chronic conditions, cognitive impairments, and behavioral health needs compared to other beneficiaries.
- Federal Fiscal Year 2024 Data
  - Medicare Advantage
    - Full Dual: 47,773 members
    - Partial Dual: 109,558 members
  - Traditional Fee-for-Service (FFS)
    - Full Dual: 37,808 members
    - Partial Dual: 29,460 members

Connecticut – Dual Eligible
Medicare Advantage/Traditional Medicare FFS



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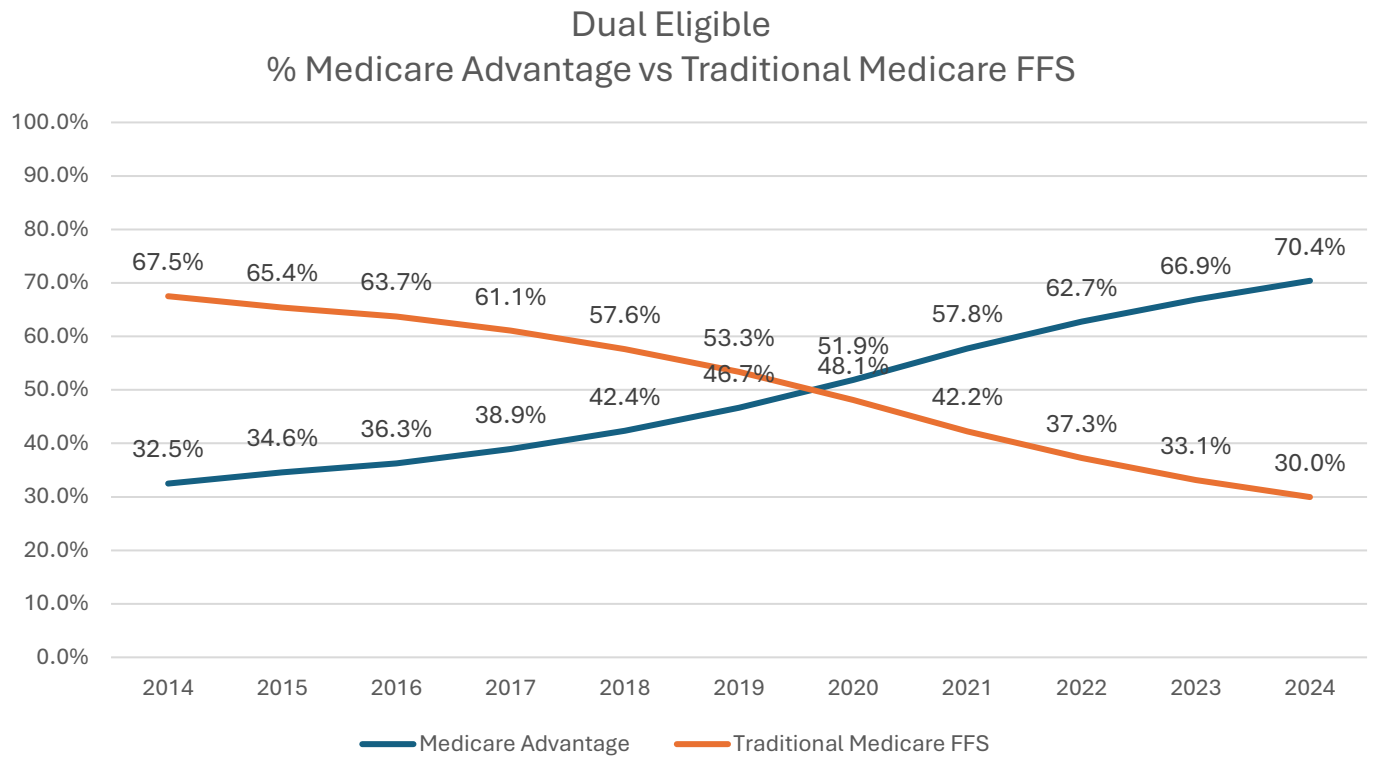
Connecticut – Dual Eligible
Medicare Advantage/Traditional Medicare FFS



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Dual Eligible Work Streams

Dual eligible special needs plans (D-SNPs)

- D-SNPs are required to contract with Medicaid agency
- DSS is reviewing how to enhance these contracts to receive additional information

Data Analysis Deep Dive

- Utilization by level of care
- Claims by level of care
- Demographic/ geographic
- Medicaid and available Medicare data integration

Program of All-Inclusive Care for the Elderly (PACE)

- Collaborating with the Rural Health Transformation team on implementation of PACE program
- Evaluating other geographic areas for a PACE program

Stakeholder Engagement / Listening Sessions

- Speaking to individuals, stakeholders, and providers on how to improve services for the dually-eligible population
- Other state Medicaid agencies
- CMS Technical Assistance

FEE SCHEDULE UPDATES

JULY 1, 2026 EFFECTIVE DATE

Fee Schedule Changes Effective 7/1/26

Policy	Short Description
Quarterly HIPAA Compliant Update - Physician Office and Outpatient Fee Schedule	DSS is incorporating the July 2026 Healthcare Common Procedure Coding System (HCPCS) changes to the physician office and outpatient fee schedule.
Rate Updates to Select Procedure Codes for Optometry Services	Pursuant to Sec. 40 of Public Act 26-76, reimbursement for select procedure codes for optometry services will be adjusted to the same rate that is reimbursed to a physician under the Connecticut Medical Assistance Program (CMAP).
Updates to the Chiropractor Fee Schedule	DSS is end-dating procedure code 98943, effective July 1, 2026, to ensure compliance with federal and state law, including Sections 17b-262-535 - 17b-262-545 of the Regulations of Connecticut State Agencies and 42 CFR 440.60, which specify Medicaid coverage for chiropractor services as manual manipulation of the spine.

Fee Schedule Changes Effective 7/1/26

Policy	Short Description
Updates to the Independent Radiology and Physician-Radiology Fee Schedules	The Centers for Medicare & Medicaid Services (CMS) consolidated and revalued select radiation treatment services. Consequently, DSS is updating the reimbursement rates for procedure codes for radiation treatment services listed on the physician radiology and independent radiology fee schedules, effective July 1, 2026, and forward.
Updates to the Reimbursement Rates of Select Services on Family Planning Fee Schedule, Including Reimbursement Rates for Select Long-Acting Reversible Contraceptive (LARC) Devices	Pursuant to Sec. 448 of Public Act 26-68, DSS is updating select rates on the Family Planning Clinic fee schedule. DSS is also updating the reimbursement rates for select LARC devices on the Family Planning Clinic fee schedule.

Fee Schedule Changes Effective 7/1/26

Policy	Short Description
Reimbursement Update for Early Intervention Services under the Special Services - Birth to Three Years Fee Schedule	Pursuant to-Public Act 26-68, DSS is updating the reimbursement rates for select services on the Special Services - Birth to Three Years fee schedule. The following procedure codes will be updated: H2014, T1023, T1027, T1028, and T2024.
Coverage for the Collaborative Care Model (CoCM)	Pursuant to Sec. 59 of Public Act 22-47, which requires DSS to implement a reimbursement model that incentivizes collaboration between primary care and behavioral health providers, DSS will cover CoCM, a nationally recognized, evidenced-based behavioral health integration model, in (1) physician offices, (2) medical clinics, including school-based health centers, (3) outpatient hospital settings ***as a professional service***, and (4) FQHC settings (reimbursement separate from the encounter rate since the service does not meet the definition of an encounter).

CALL CENTER UPDATE

Contact Center Performance Metrics for June 2026

High engagement with Connecticut residents: Across Tier 1, Tier 2, and Long-Term Services and Supports (LTSS)/Community Options, the Contact Center supported **over 92,000 inbound contacts**, demonstrating strong public reliance on DSS services.

Efficient callback system delivering thousands of successful connections:

- **Tier 1**: Completed 35,961 callbacks, helping clients resolve SNAP, Medicare/Medicaid, and general status questions quickly.
- **Tier 2 (Generalist)**: Completed 6,926 callbacks, ensuring residents with more complex needs receive specialized support.
- **LTSS/Community Options**: Delivered 4,174 callbacks, providing timely assistance to vulnerable populations.

Service levels reflect dedicated staff performance:
Tier 2 maintains a **low 9.43% abandon rate**, showing strong efficiency in handling complex inquiries. LTSS/Community Options achieves a **2.5-day** average callback response, reflecting responsive service for high-need clients.

Overall system demonstrates capacity and commitment: Despite high demand, teams continue to deliver meaningful, person-centered assistance while working to look for improvements to shorten wait times and expand access.

Social Service Assistants (SSA) – Tier 1

Social Service Assistants are in a working test period for 6 months. During this time, they begin a two-phase approach in which they are trained and evaluated in DSS' various programs, policies and procedures. Upon completion, the trainees then begin taking supervised phone calls.

Phase 1: Orientation, Mandatory Web-based Trainings and Team Building

(First Two Weeks)

- Attend orientation
- Complete mandatory online trainings
- Two weeks of team building with supervisors to understand expectations and how to assist clients
- Job shadowing with current SSAs to understand impact they have on meeting the clients' needs

Phase 2: Core Tier 1 Training

(Weeks 3-5 (9 Days))

- During the instructor-led training, the SSAs learn ImpaCT navigation, including:
  - Basic case information and questions (non-eligibility processing)
  - Case noting
  - General understanding of DSS notices/ policy and procedures
  - Customer service review – positive customer interactions, de-escalation of calls, empathy
  - VoiceCT training – the Department's new phone system

Connecticut Career Trainee Training Plan

CT Career Trainees typically are in a working test period for a year. During this time, they begin a four-phase approach in which they are trained and evaluated in DSS' various programs, policies and procedures. Upon completion, the trainees then become Eligibility Services Workers.

Phase 1: Orientation and Core Training

(Months 1-3)

- Attend orientation
- Complete mandatory online trainings
- Attend 3 months of core training within 2-3 weeks of hire
- Learn all agency's programs, policies, systems, etc.
- Participate in Practical Application Learning days – in-office training to coincide with core training lessons

Phase 2: Case Processing Experience

(Months 4-6)

- Develop case processing accuracy
- Initial focus is on SNAP processing, additional programs added as proficiency increases
- Apply program knowledge independently while receiving ongoing coaching

Phase 3: Service Center Experience

(Months 7-9)

- Continue building efficiency and accuracy in case processing
- Develop customer service skills and enhance interview skills through in-person interactions with clients

Phase 4: Benefit Center Experience

(Months 10-12)

- Continue building efficiency and accuracy in case processing
- Continue to develop customer service and interview skills via our Benefit Center