DSS MAPOC PRESENTATION

September 11, 2026

DSS Agenda

1. HR1 Update
   A. Non-citizen eligibility changes
   B. Work rules - Medical frailty policy
   C. Work rules - Communications and outreach
2. DSS-AHCT Shared Operations Update
3. DSS Benefit Center Service Levels
4. Quality Assurance - Provider Audits

H.R. 1 UPDATE

ELIGIBILITY AND MEDICAL FRAILTY

HR1 Effective Date Summary

Policy Change	Effective Date
SNAP work requirements	Upon Passage
SNAP eligibility changes for non-citizens	Upon Passage
SNAP-Ed new funding ends	September 30, 2025
Medicaid changes for non-citizens	**October 1, 2026**
Medicaid work requirements	**January 1, 2027**
Medicaid eligibility verification frequency	January 1, 2027
Medicaid changes to retroactive eligibility	January 1, 2027
Medicaid cost-sharing	October 1, 2028

Medicaid Eligibility for Non-Citizens

Still eligible for Medicaid:

- Lawful permanent residents
- Cuban/Haitian entrants
- COFA citizens*

No longer eligible as of 10/1/26:

- Refugees / asylees / parolees
- Victims of trafficking
- Victims of domestic violence
- Afghan or Iraqi Special Immigrants Visa holders (SIV)**

* COFA (Compacts of Free Association) citizens are those individuals from Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau who lawfully reside in the U.S.

** Afghan or Iraqi SIVs are individuals admitted under Section 101(a)(27) of the Immigration and Nationality Act which grants special immigrant status to individuals who worked with the U.S. government for a period of at least 1 year.

Impact:

- Approximately 4,000 non-pregnant adults expected to lose Medicaid coverage
  - Not eligible for subsidized plans on the exchange (AHCT) starting 1/1/27
  - Can get emergency services through Emergency Medicaid
- No impact on lawfully present children (HUSKY A and B)
- No impact on state-funded programs (State HUSKY A for kids and State Postpartum coverage)

Medicaid Work Requirements

Preliminary estimates subject to change

Updated as of August 2026; based on data currently available in state systems

HUSKY D low-income adults	Feb '26 Members	% Total
At-risk of coverage loss	**108 k**	**34%**
Likely exempt or compliant using available data	**208 k**	**66%**
Medical Frailty *updated after further code review*	133 k ~~130 k~~	42% ~~41%~~
Wage records	94 k	30%
SNAP beneficiary	45 k	14%
Other eligibility factor	34 k	11%
Supplemental Security Income (SSI)	24 k	8%
Student	6 k	2%
Total distinct HUSKY D members	**316 k**	**100%**

Categories are **not** mutually exclusive

Members can appear in multiple categories

Medical Frailty

Medical frailty is defined in 42 CFR §440.315(f) as having any of the following:

- Substance-use disorder
- Disabling mental disorder
- Physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living
- Serious or complex medical condition
- Blind or disabled (per SSA §1614)

DSS developed a definition of "medical frailty" using 6,539 medical diagnosis codes. The definition was informed by analyses and reviews conducted by numerous other states and organizations, as well as DSS data and medical staff.

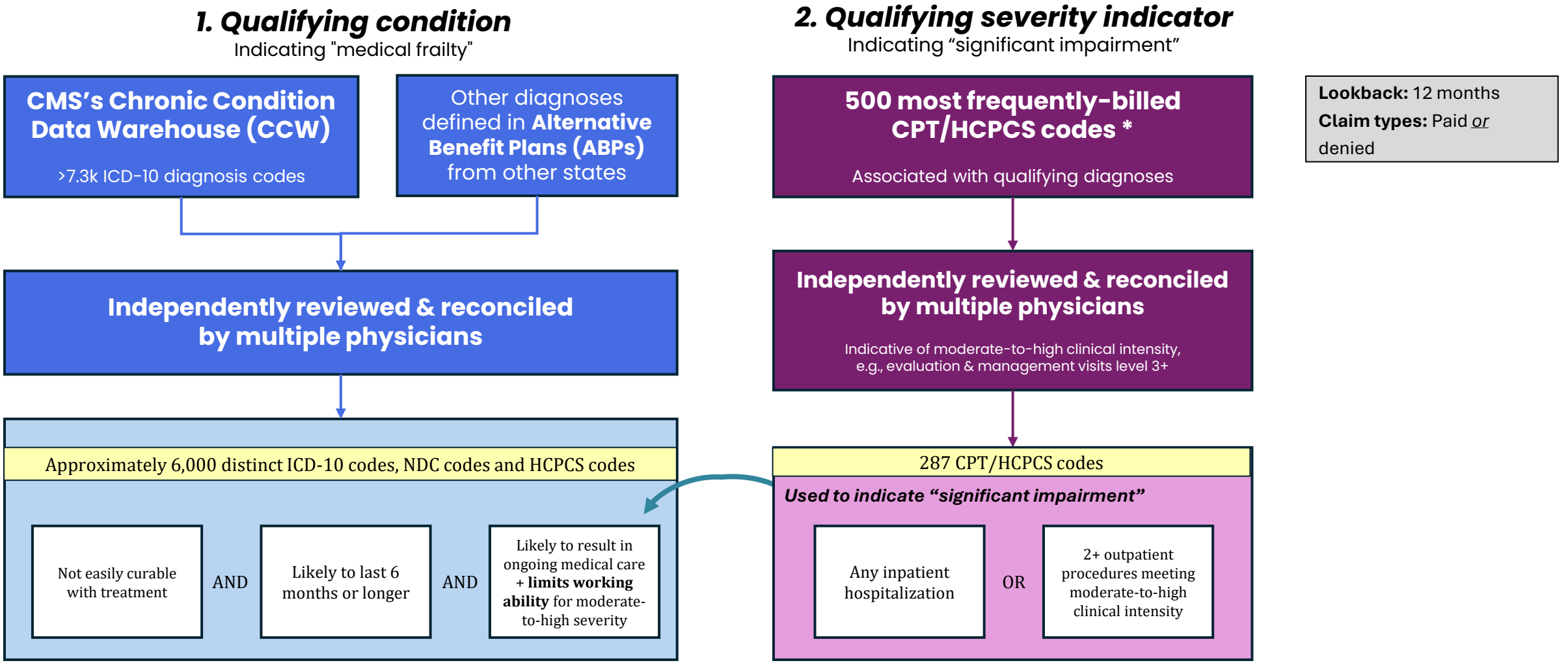
Medical Frailty – Interim Final Rule (IFR) Updates

On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) issued a 387-page IFR interpreting and implementing the H.R. 1 community engagement requirement

- Narrows the medical frailty exclusion by requiring that qualifying conditions **"significantly impair"** an individual's ability to work
- A medical condition or diagnosis alone may not exempt anyone from work requirements. Instead, there is now a two-step analysis of (1) medical frailty and (2) "significant impairment"
- States must use claims data from the prior 12-month period in determining eligibility (aligns to DSS analytical framework)
- Self-attestation is allowed during CY 2027

Medical Frailty – Planned Algorithm

Preliminary estimates subject to change



* Code types include International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes; Current Procedural Terminology (CPT) procedure codes; Healthcare Common Procedure Coding System (HCPCS) procedure codes; and National Drug Codes (NDC) drug codes.

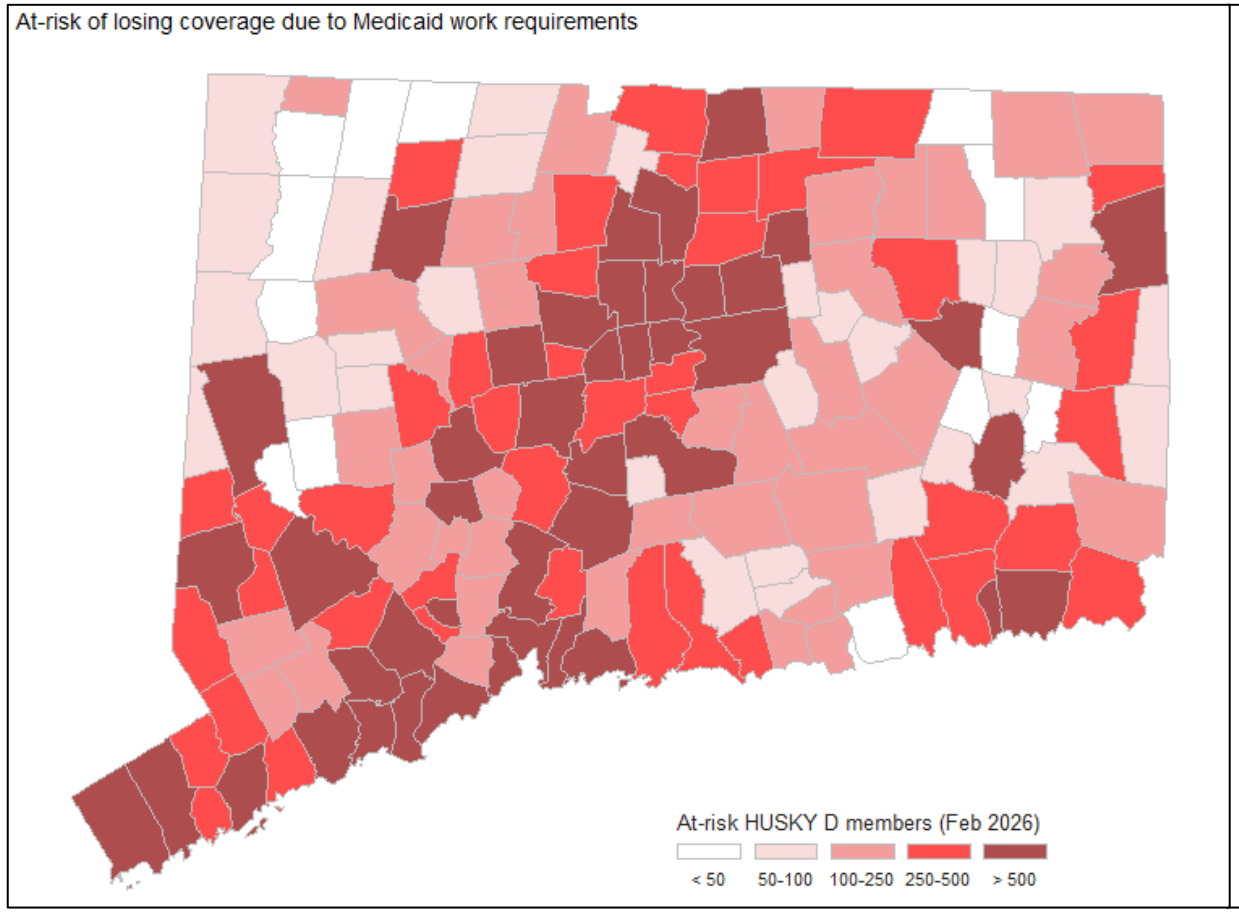
Exemptions for Substance Use Disorder

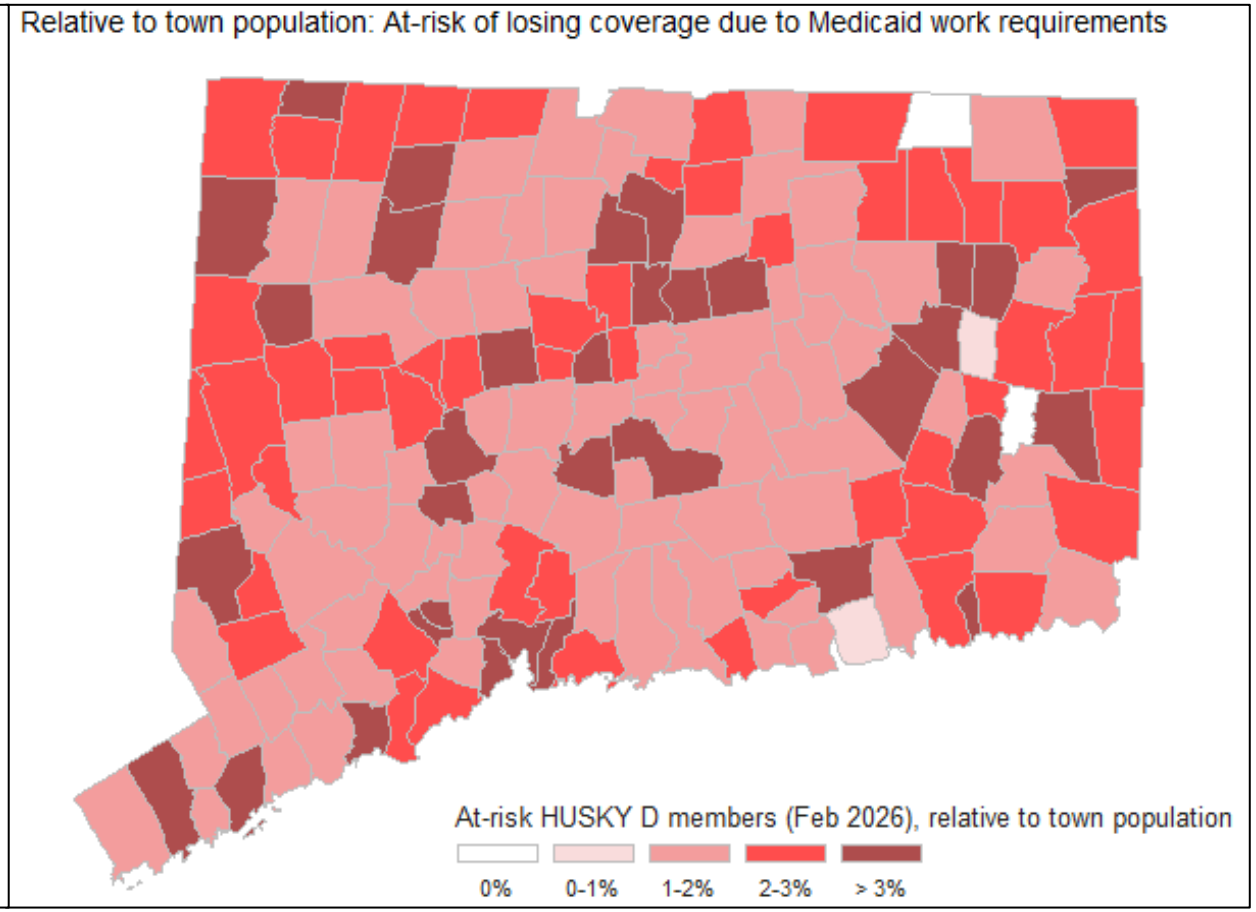
- Medical Frailty: SUD is a qualifying condition under the "medically frail" exemption category – but must meet the "significant impairment" analysis as well pursuant to the IFR.

- Active Treatment: Individuals currently participating in a recognized drug or alcohol treatment program—such as outpatient counseling or medication-assisted treatment—qualify for an exemption.
  - AA and NA are not considered recognized treatment programs.

- Recovery Timeline Limits: The IFR limits certain recovery-based exemptions, so that people who are in "stable recovery" for 5 years or more are not exempt.

HUSKY D “At-risk” Population Profile





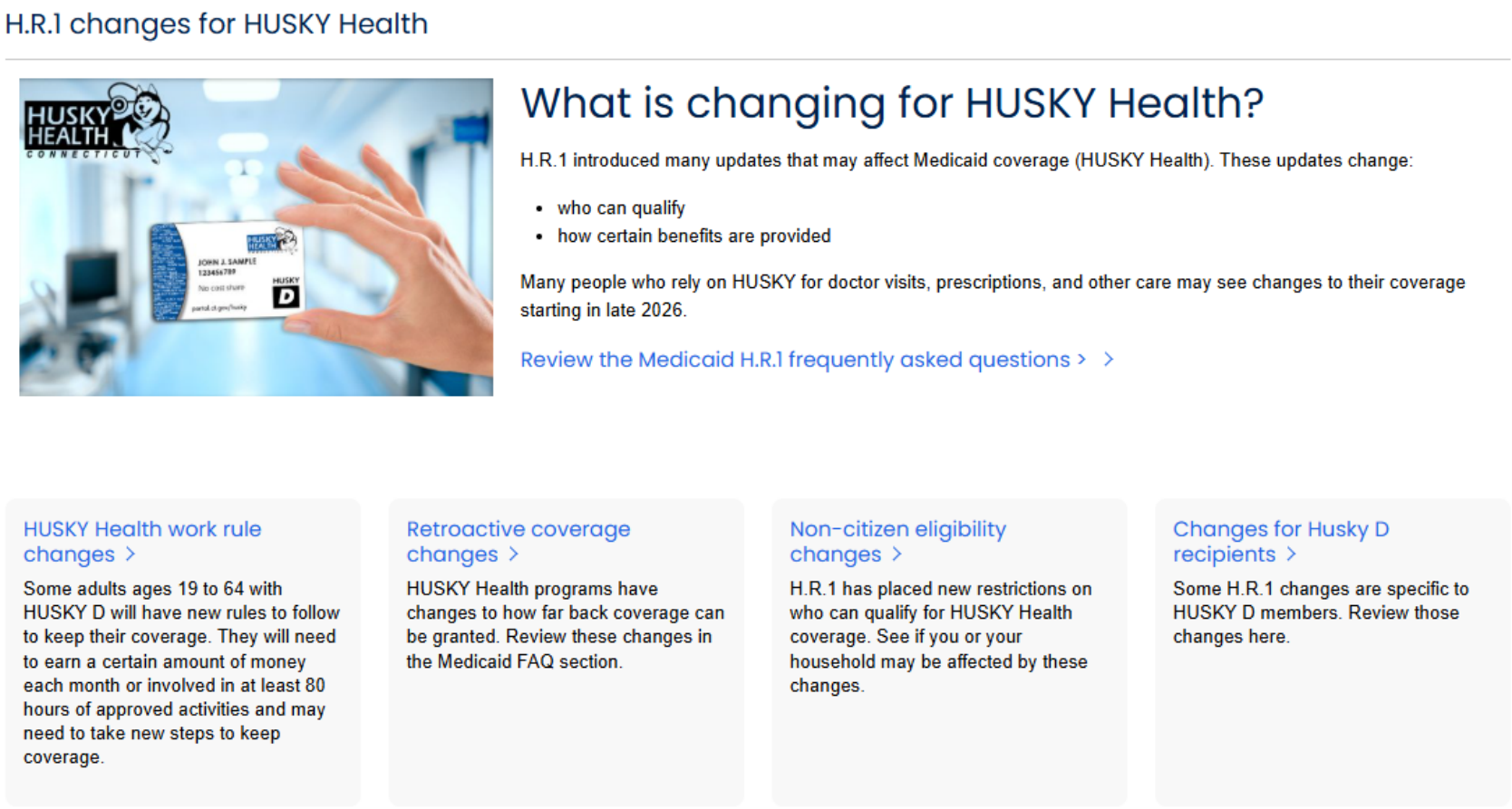
Data analysis does not include potential impact of medical frailty “significant impairment” rule, which could increase the “at-risk” population.

H.R. 1 UPDATE

COMMUNICATIONS AND OUTREACH

H.R.1 Toolkit

https://portal.ct.gov/dss-hr1



- Explanation of changes for clients and partners.
- Outlines steps someone will need to take to maintain their coverage.
- Updates will continue to be made as operational implementation steps are finalized.

H.R. 1 & Connecticut Partners

Stakeholder information on changes due to H.R.1

HR1 Partner Toolkit

This toolkit contains resources to help community partners educate and assist HUSKY Health members and SNAP recipients as changes are implemented due to H.R.1. The materials below include educational resources, outreach materials, and FAQs that can be used help you and the individuals you serve understand these upcoming changes.

We will continue expanding this toolkit as additional resources become available, so please check back regularly for updates.

HR1 Partner Resources

Resources for community partners and providers, such as flyers, social media posts, and talking points.

HR1 Partner Virtual Classroom

A repository of webinars and informational videos to support our community partners in learning about H.R.1 changes to DSS programs.

HR1 Partner FAQs

A list of frequently asked questions from community partners. Check back often as this list will be updated as we collect partner inquiries.

SNAP work rules prescreener

Answer a few questions to see if the SNAP work rules apply

Able-Bodied Adults Without Dependents or ABAWDs >

HUSKY D work rules prescreener

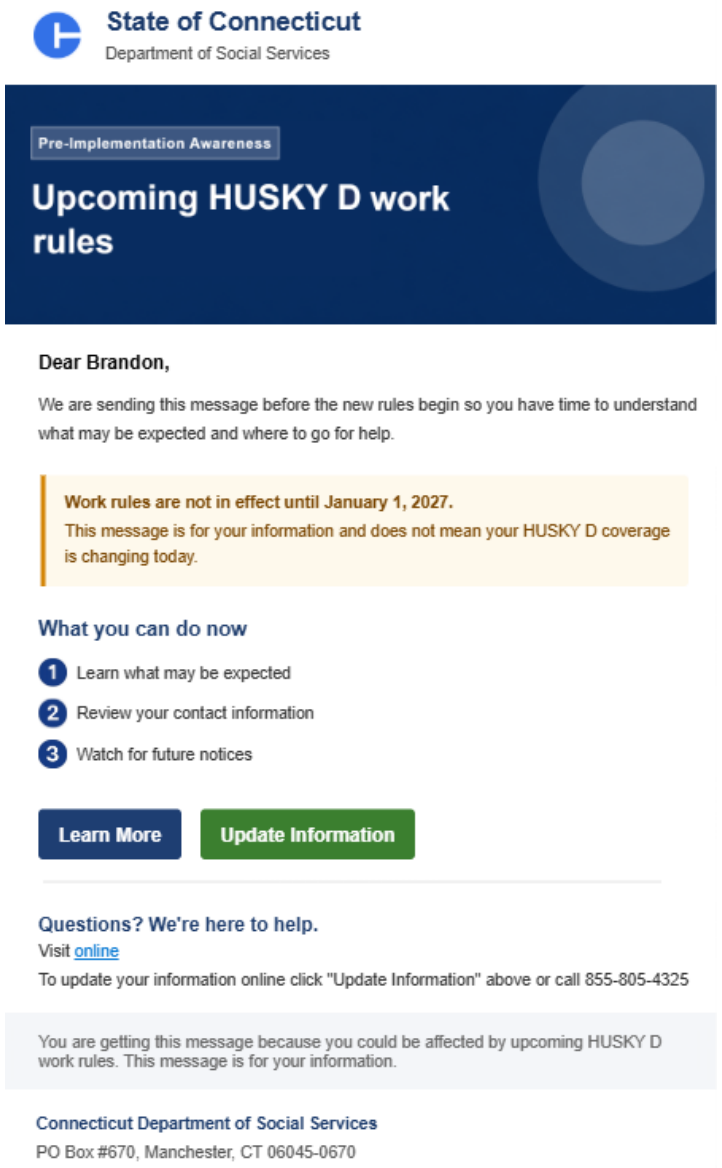
Answer a few questions to see if the new HUSKY D work rules apply

HUSKYDPrescreener >

H.R.1 Partner Toolkit Preview

- Updated Partner Toolkit https://portal.ct.gov/dss-hr1
- Resources for partners that assist clients.
- Updates will continue to be made as operational implementation steps are finalized.

Medicaid Work Requirement Notices



State of Connecticut
Department of Social Services

Pre-Implementation Awareness

Upcoming HUSKY D work rules

Dear Brandon,

We are sending this message before the new rules begin so you have time to understand what may be expected and where to go for help.

Work rules are not in effect until January 1, 2027.
This message is for your information and does not mean your HUSKY D coverage is changing today.

What you can do now

1. Learn what may be expected
2. Review your contact information
3. Watch for future notices

Learn More | Update Information

Questions? We're here to help.
Visit online
To update your information online click "Update Information" above or call 855-805-4325

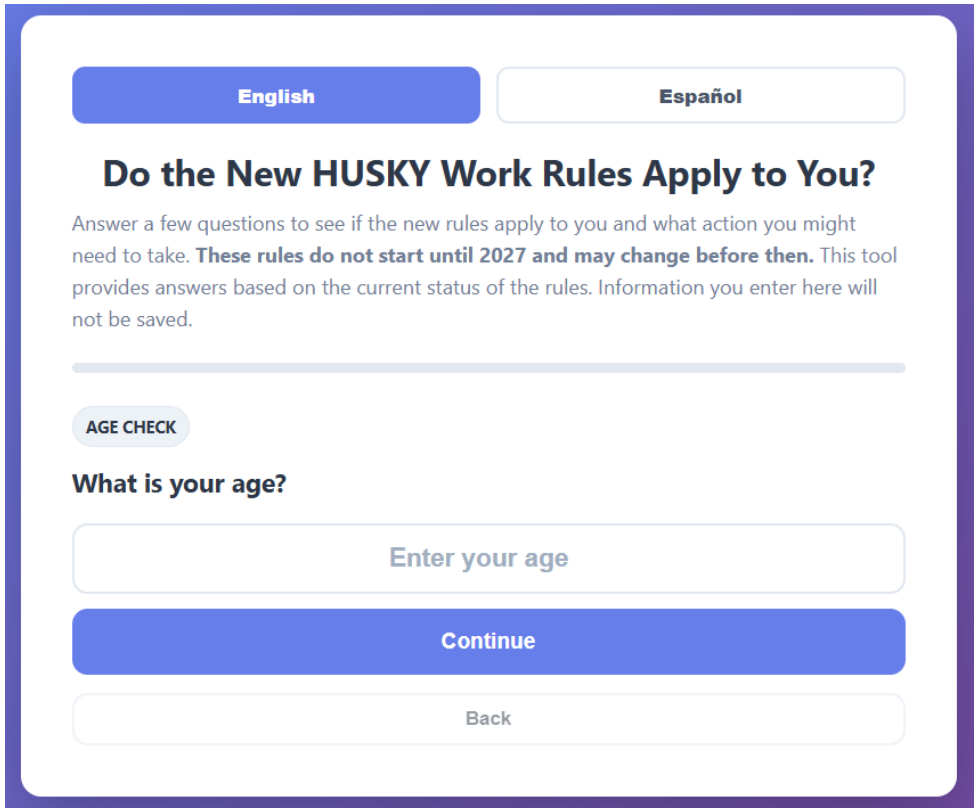
You are getting this message because you could be affected by upcoming HUSKY D work rules. This message is for your information.

Connecticut Department of Social Services
PO Box #670, Manchester, CT 06045-0670

In September, DSS began sending notices to all HUSKY D members about the changes to the work rules via text, emails, and paper notices.

The notice includes links to the HUSKY D pre-screener so members can see if the rules apply to them; to update their information with Access Health CT; or to get support from their local community action agency.

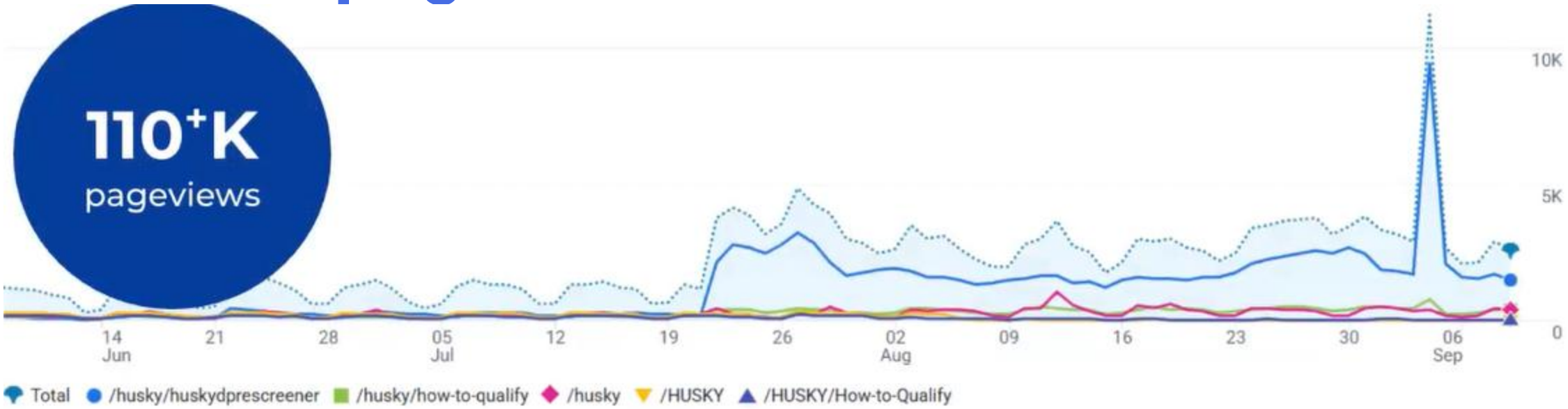
Medicaid Work Requirements Pre-Screener



https://portal.ct.gov/HUSKY/HuskyDprescreener

HUSKY Webpage Access Data

110⁺K
pageviews



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	Page path and screen class	Views	Active users	Views per active user	Average engagement time per active user	Event count All events	
	Total	204,050 100% of total	121,017 100% of total	1.69 Avg 0%	27s Avg 0%	1,761,713 100% of total	
1	/husky/huskydprescreener	110,340 (54.07%)	81,093 (67.01%)	1.36	6s	894,877 (50.8%)	

H.R. 1 & Connecticut Partners

How can we help our fellow CT residents?

- Make sure we have current contact information so residents don't miss any important updates!
- If they are unsure where to update their info they can go to: https://portal.ct.gov/UpdateUsDSS

Update Us so we can Update U

- Ensure they save DSS phone numbers in their contacts:
  - Text messages related to general eligibility come from **1-855-626-6632** or **60302.**
  - Text messages about HUSKY D work rules will come from **1-959-246-3060** or **648731**

DSS-AHCT SHARED OPERATIONS UPDATE

Shared Operations Call Center Metrics for July 2026

The DSS-AHCT shared call center is the primary gateway for telephone calls related to eligibility and enrollment for HUSKY A/B/D, State HUSKY, Covered CT, and Qualified Health Plans (QHPs). These programs all use Modified Adjusted Gross Income or "MAGI" as the foundation for income eligibility.

The call center also handles live chat questions, serving 936 requests for assistance during the week displayed in the chart.

The call center is staffed by a contracted vendor partner, TTEC.

ASA	Avg Speed of Answer (in seconds)
AHT	Avg Handle Time
FCR	First Call Resolution
CSAT	Customer Satisfaction

Metric	Goal	Weekly Results	EOM Jul	Q3 2026
Calls Handled	N/A	10,416 (10,449 Offered)	43,622 (43,763 Offered)	43,622 (43,763 Offered)
Service Level	70/100	90.5%	92.2%	92.2%
ASA	N/A	12	11	11
AHT	840 Sec	964	957	957
Abandon Percent	<5% with 100 Sec	0.1%	0.08%	0.08%
Total Abandon	N/A	0.2%	0.2%	0.2%
Abandon Calls >20 Sec	N/A	0.3%	0.3%	0.3%
FCR	85%	92.0%	92.6%	92.6%
Quality	90%	94.1%	94.0%	94.0%
CSAT	90%	95.4%	95.0%	95.0%

DSS BENEFIT CENTER SERVICE LEVELS

Summary of Benefit Center Service Levels

Call Center Performance Update – August

1. Call Volume Trends

- Call volumes decreased in August.
- Anticipated reasons include:
  - Decreased SNAP program enrollment.
  - Reduction in repeat callers.
- Further analysis will be provided once the data team completes their review.

2. Staffing and Operational Improvements

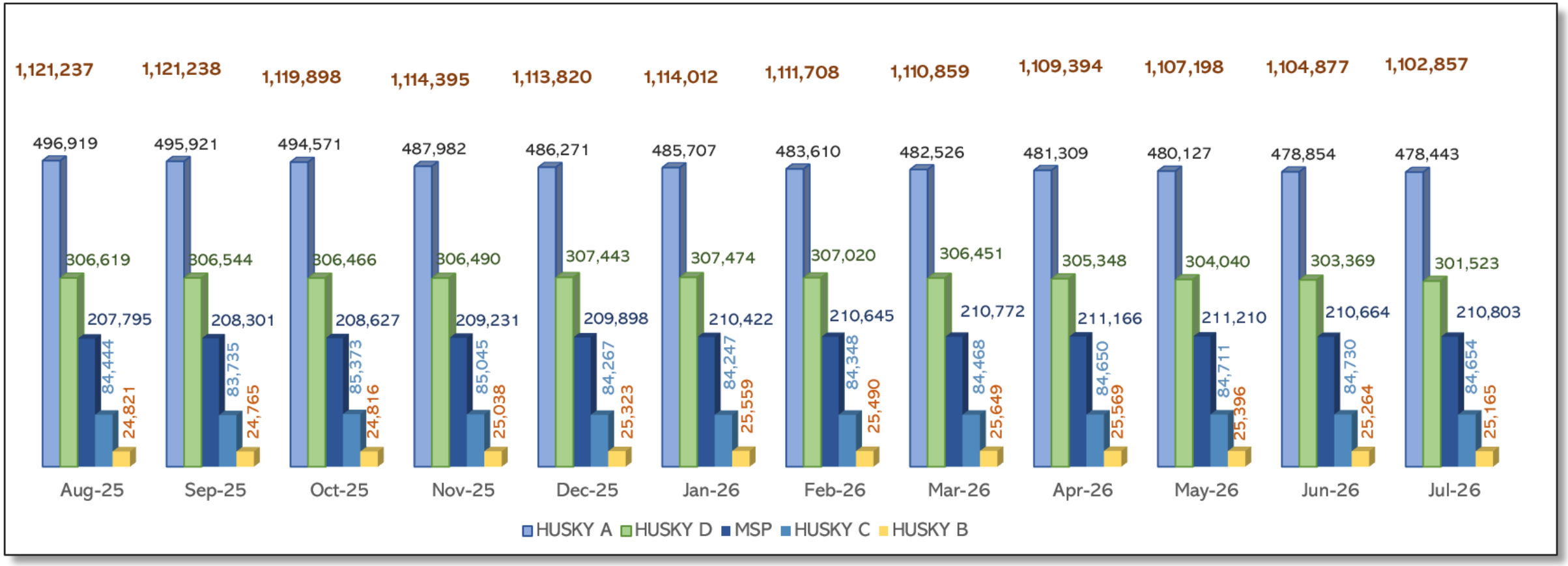
- Tier 1 staffing increased, enabling the team to answer 95% of calls within the same day for late July and all of August.

3. Enhanced Client Experience

- Majority of client calls are answered and returned within the same day

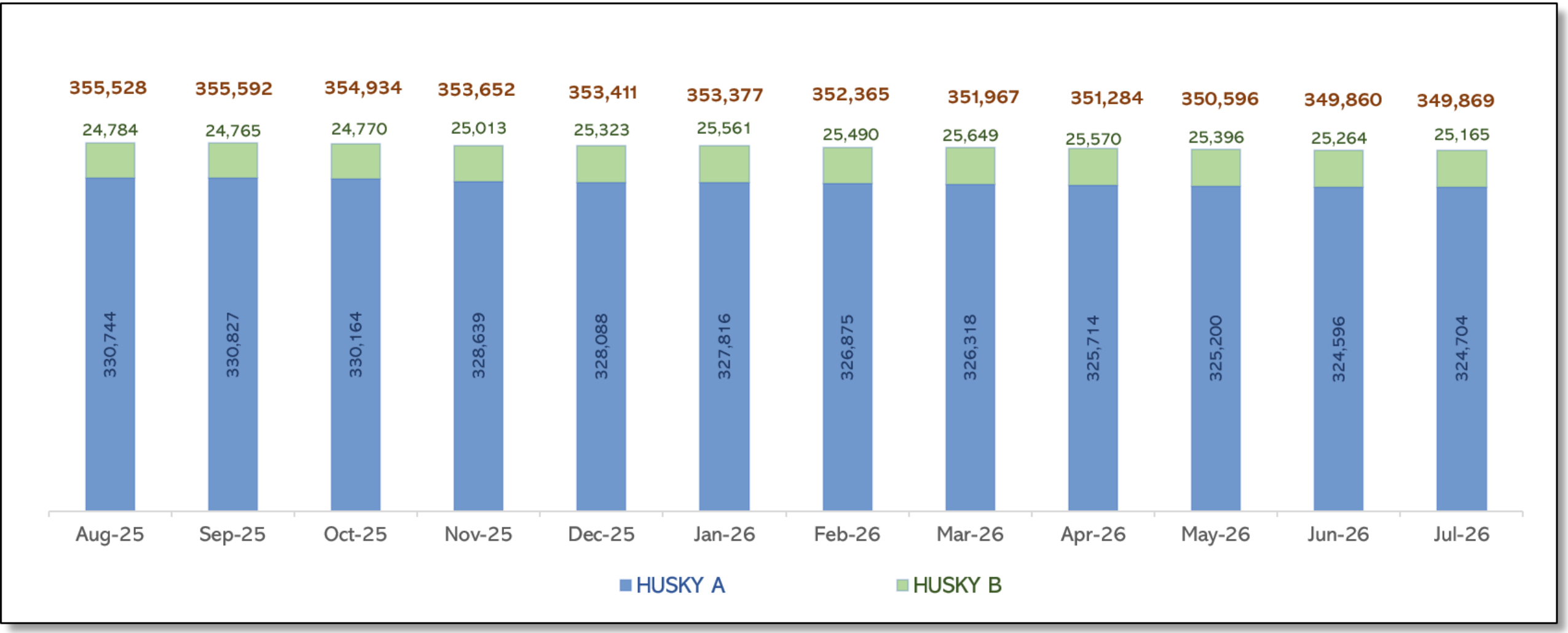
HUSKY ENROLLMENT

HUSKY Enrollment



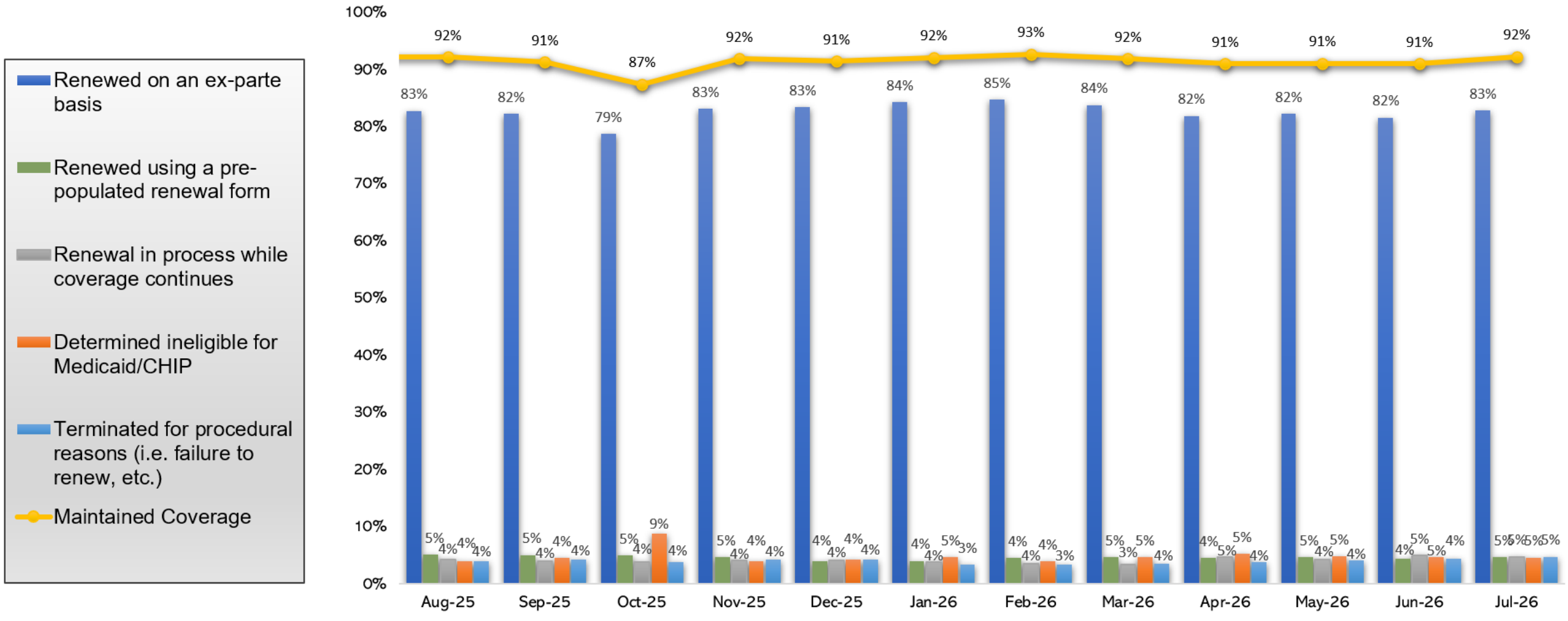
** Excludes limited benefit programs and state-funded programs*

Child Enrollment HUSKY A & B



HUSKY RENEWAL AND APPLICATION ACTIVITY & OUTCOMES

HUSKY Health Renewal Outcomes



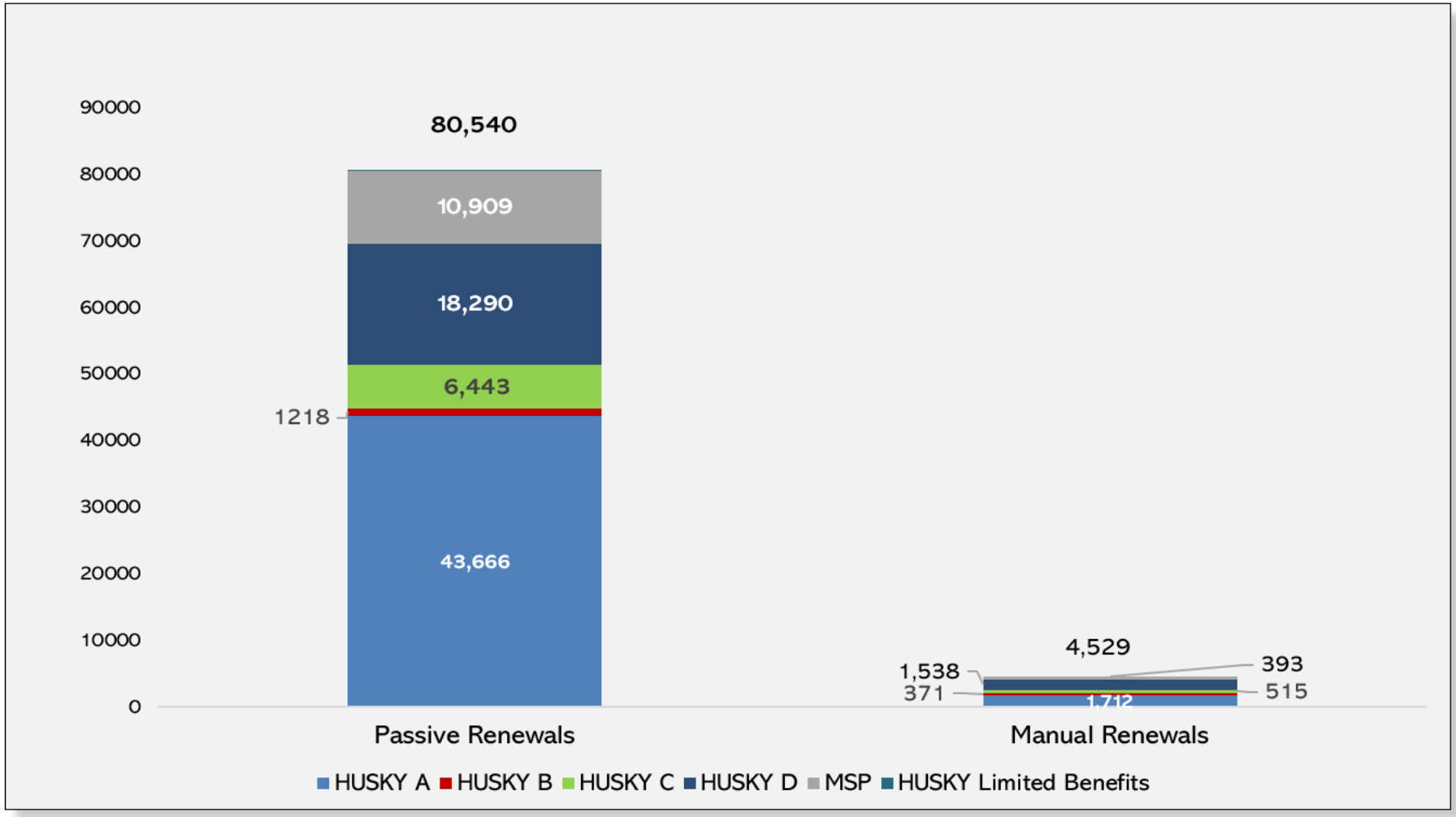
During the last 12 months, an average of 91% of individuals maintained coverage at month end.

HUSKY Health Renewal Outcomes – July 2026

Passive vs. Manual Renewals by Medical Benefit Plan

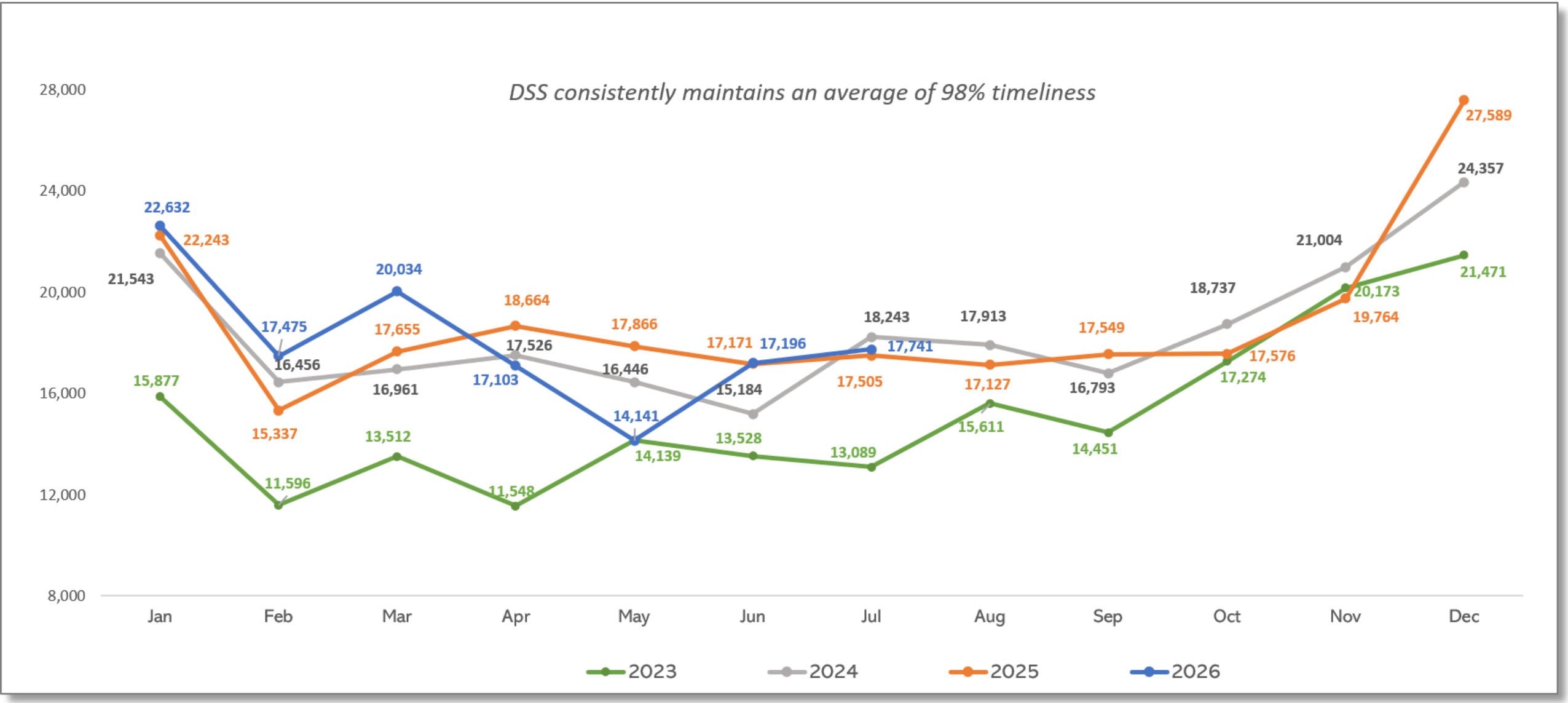
Medical Benefit Plans refer to the HUSKY Programs (A, B, C, and D) and the Medicare Savings Program (MSP)

- HUSKY A – Medicaid for children, parents, relative caregivers, and pregnant individuals, etc.
- HUSKY B – Children's Health Insurance Program (CHIP)
- HUSKY C – Medicaid for older adults and individuals with disabilities
- HUSKY D – Medicaid for adults without dependent children
- MSP – provides premium and/or copayment assistance to Medicare beneficiaries



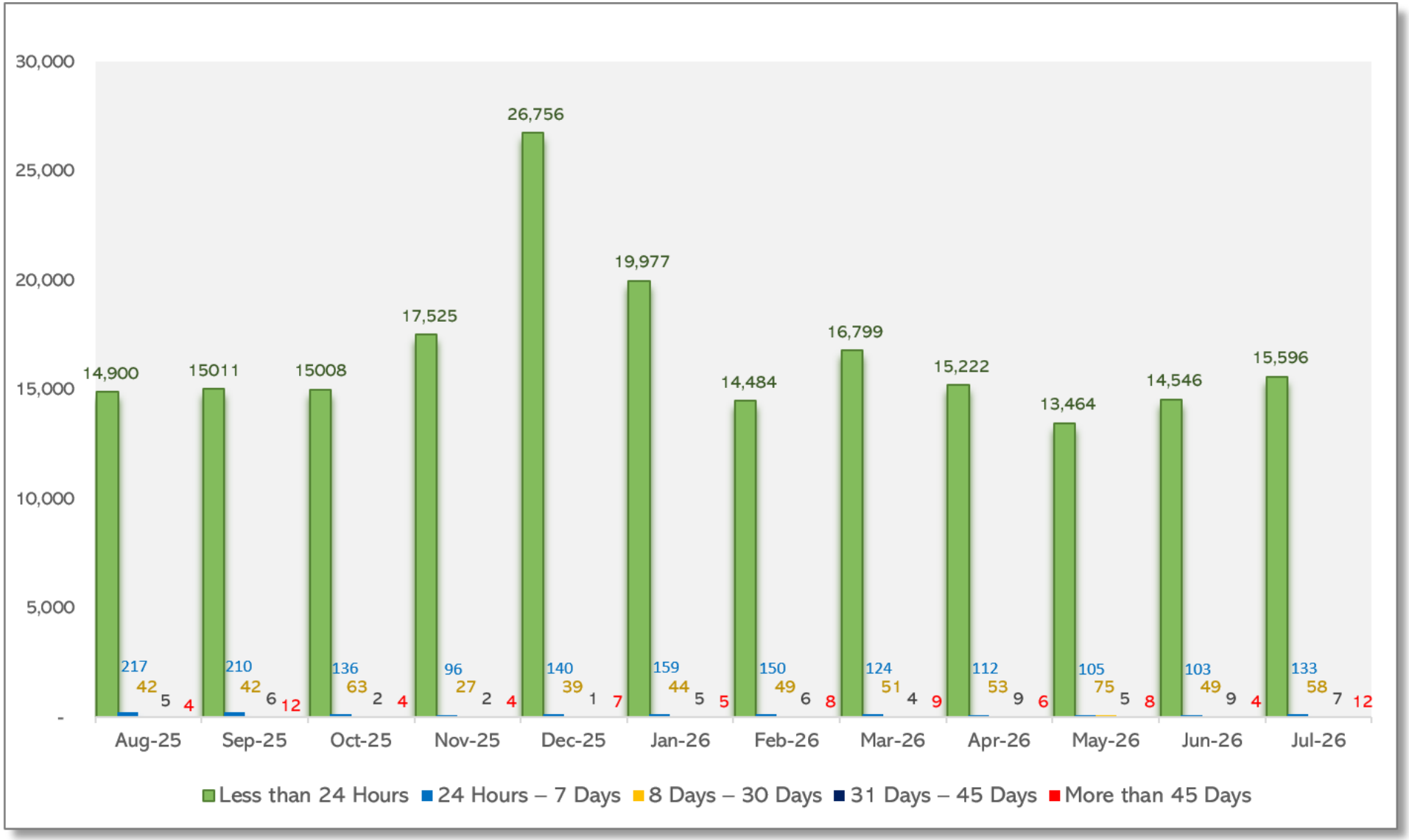
During July 2026, 80,540 individuals renewed "passively" while 4,529 renewed using a pre-filled form.

Year-Over-Year New Medical Applications



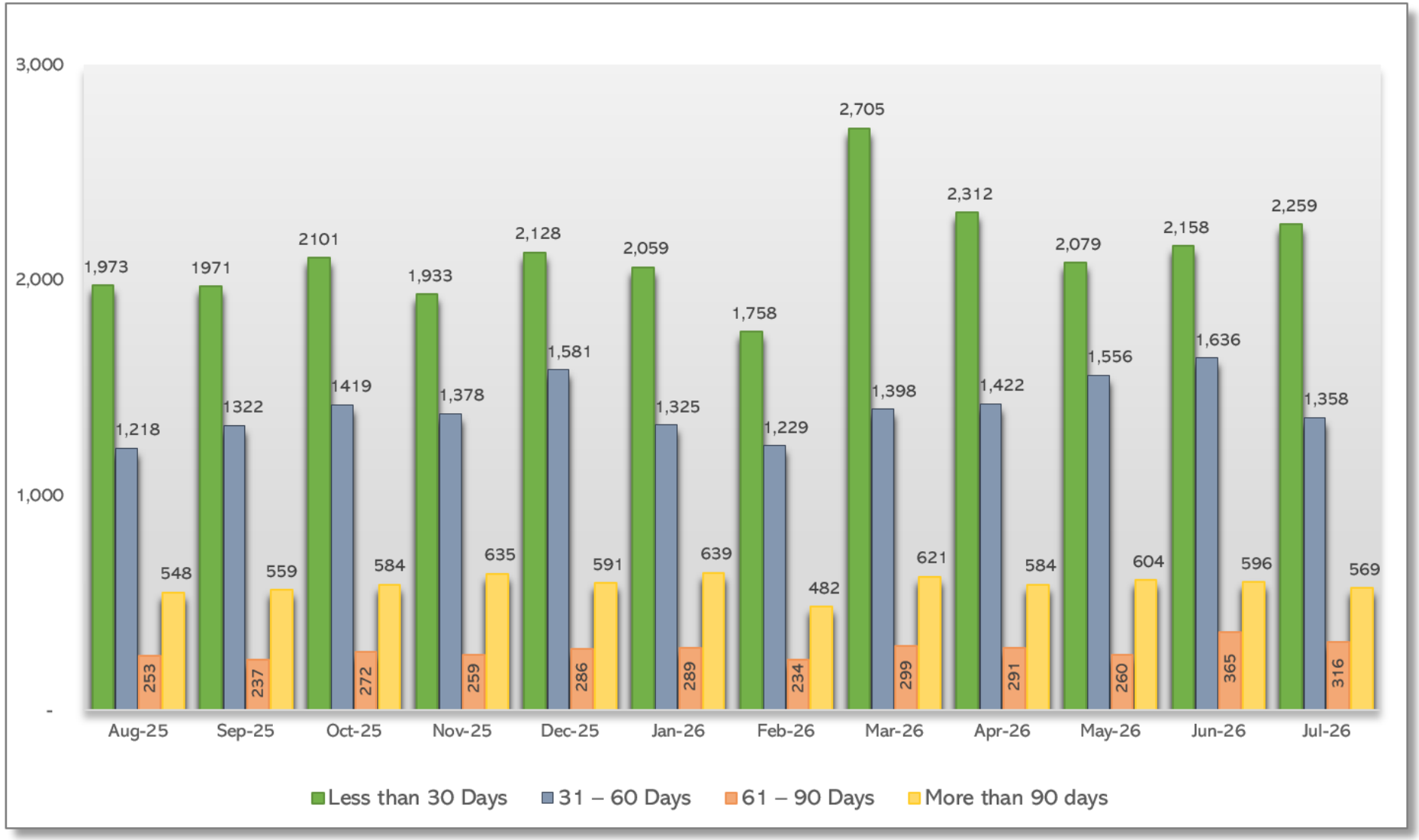
MAGI Medicaid New Applications by Processing Time

- The standard of promptness for MAGI-based Medicaid applications is 45 days from receipt.
- Current median processing time in CT is less than 24 hours.



Non-MAGI Medicaid New Applications by Processing Time

- The standard of promptness for most Medicaid applications is 45 days from receipt.
- A longer period of up to 90 days is allowed for people with disabilities and applications for long-term services and supports.
- Current median processing time is 30 days.



QUALITY ASSURANCE – PROVIDER AUDITS

DSS Quality Assurance Audit Division

- The audit division currently has 29 staff auditors, including accounts examiners, nurses, and pharmacists.
- The audit division performs two types of reviews: statistically valid full audits (extrapolated results) and integrity reviews (dollar-for-dollar recoupments).
- Typical audits from start to finish take approximately 6 months. Individual timelines may vary depending on multiple factors.
- The Department's audit process is governed by subsection (d) of section 17b-99 of the Connecticut General Statutes.

Audit Selection Process

- Audits are selected in a few ways:
- Our analytical platform has an audit selector tool that tallies a composite risk score for providers.
- The Audit Division will receive referrals from the QA Special Investigations Division in situations where there is not enough evidence to prove fraud but there are billing abnormalities related to internal investigations.
- We do follow up audits on providers to ensure that they have implemented corrective actions to address prior audit findings.

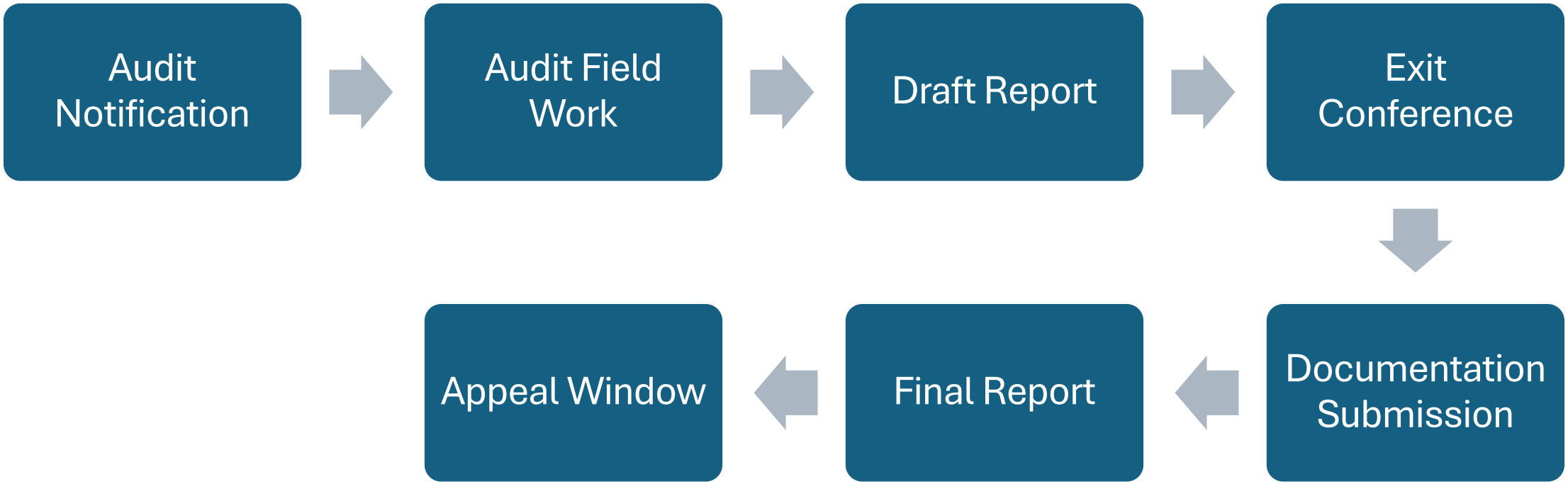
Audit Process

- The Department will give the provider written notification of not less than 30 days prior to the commencement of an audit.
- The audit sample is selected by a contracted statistician (not a DSS employee)
- Audit work is completed. Supporting documentation is gathered and reviewed related to the sample claims contained in the audit.
- The Department will provide a preliminary/draft written report of the audit to the provider that was the subject of the audit not later than 60 days after the Department determines that the preliminary fieldwork, review, and analysis of the audit has concluded

Audit Process (Continued)

- Following the issuance of the preliminary written report, the Department will hold an exit conference with the provider to discuss the preliminary report.
- A two-week period is offered to the provider to supply any additional documentation related to open findings.
- The Department will produce a final written report concerning the audit. The final written report will be provided to the provider not later than 60 days after the date of the exit conference, unless the Department agrees to a later date or there are other referrals or investigations pending concerning the provider.
- A provider aggrieved by a decision contained in the final written report may, not later than 30 days after receipt of the final report, request, in writing, a contested case hearing

Audit Process Flow



Extrapolation

- Extrapolation is a method to predict an outcome outside the range of the available data set.
- For each audit, a sample of claim lines is randomly selected (by outside statistician) for review.
- The results of the sample are then extrapolated over the entire universe of paid claims to the provider during the audit period (typically two-year audit period). The extrapolated figure is the final amount of calculated overpayments for the audit.
- Audits are only extrapolated if the extrapolated amount meets a certain percentage of total paid claims (currently 1.75%, but increasing to 2.75% effective October 1, 2026).

Simplified Extrapolation Example

- Provider was paid for 1,000 claims.
- Audit sample contained 100 claims
- Total audit error in the 100 claims was $500
- $500/100 claims = $5 → Average overpayment per claim sampled
- $5 x 1,000 claims = $5,000 → Extrapolated amount

Audit Protocols

- The Department has posted its audit protocols on the quality assurance webpage. portal.ct.gov/dss/quality-assurance/audit-protocols
- The purpose of the protocols is to assist the medical provider community in developing programs to improve compliance with Medicaid requirements under state and federal law.
- The audit protocols are broken down by provider type. They give examples of certain common audit findings, the Department's criteria for the finding, and the regulatory reference.