DSS MAPOC PRESENTATION

June 12, 2026

Agenda Items

- **Rural Health Transformation Program Update (Dan Sinclair)**
- **Annual Medicaid Financial Review (DC Varrs, Briana Mitchell)**
- **H.R. 1 General Updates (DC Hadler)**

RURAL HEALTH TRANSFORMATION PROGRAM UPDATE

Federally Required Disclaimer

“This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $154,249,105.53 in Budget Period 1 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.”

Overview of Rural Health Transformation Program (RHTP)

- New federal grant to states from Public Law 119-21, also known as H.R. 1 or One Big Beautiful Bill Act
- $50 billion nationally over 5 years—to transform care and improve health outcomes in rural communities
- Grant application was prepared in a short, 7-week deadline, with strict criteria. DSS submitted grant application to CMS on 11/4/2025
- All 50 states applied and were approved. CT received ~$154 million in year 1 of 5 (CMS recalculates each year)

Strategic Goals

Make Rural America Healthy Again

Support health innovations and new access points to promote preventive health and address root causes of diseases

Sustainable Access

Help rural providers become long-term access points for care by improving efficiency and sustainability

Workforce Development

Attract and retain a high-skilled health care workforce by strengthening recruitment and retention of healthcare providers in rural communities

Innovative Care

Spark the growth of innovative care models to improve health outcomes, coordinate care, and promote flexible care arrangements

Tech Innovation

Foster use of innovative technologies that promote efficient care delivery, data security, and access to digital health tools by rural facilities, providers, and patients

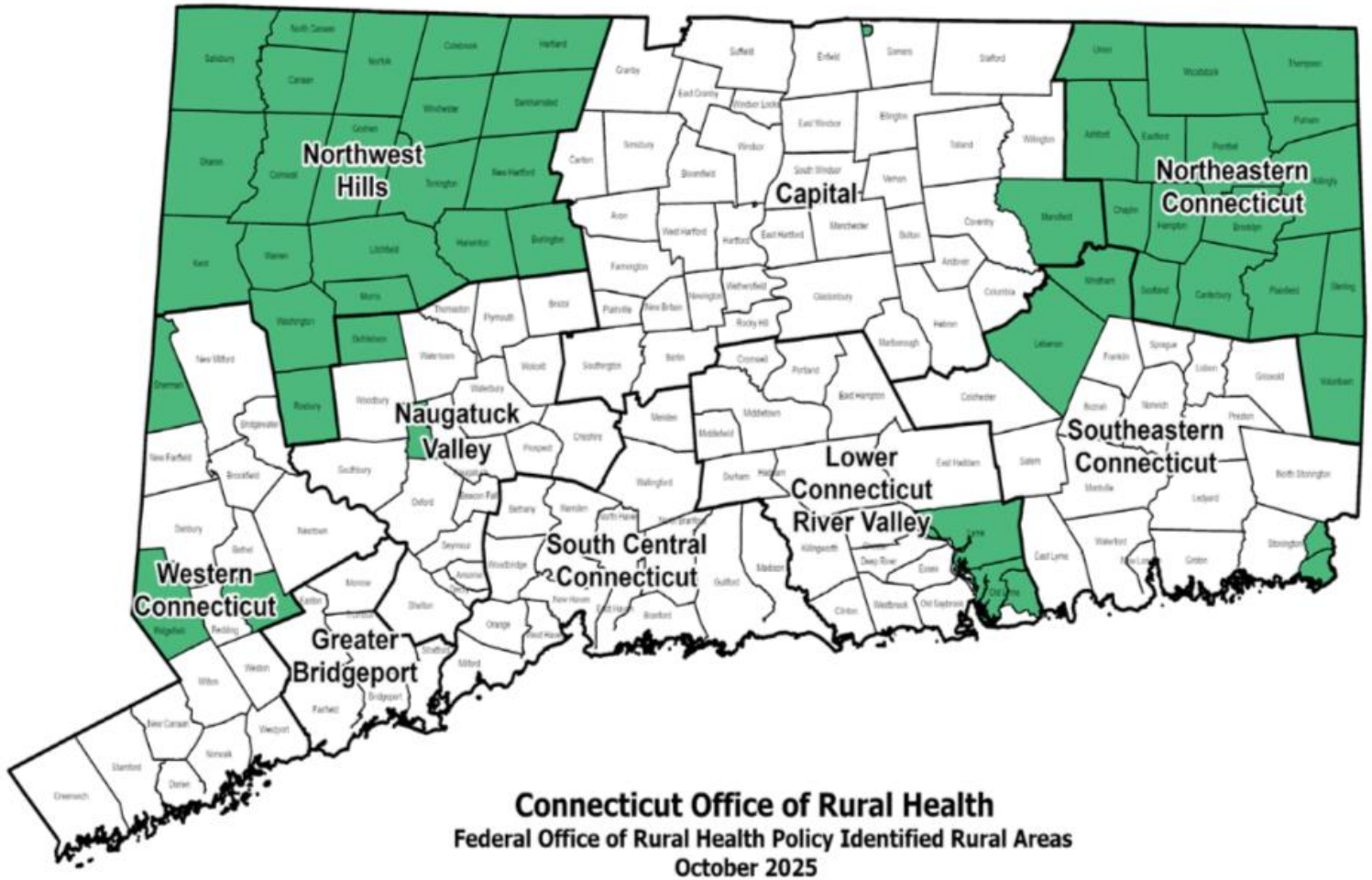
Source: CMS - Rural Health Transformation (RHT) Program Overview

Rural Health Transformation Program Funding Scope – Key Federal Rules

Use funding to pay for ….	Cannot use funding to pay for …
✓ Transformation of care delivery	× New construction (minor alterations only)
✓ Improved access to, quality of, and cost of healthcare in rural America	× Clinical services that duplicate billable services and/or attempt to change payment amounts of existing fee schedules
✓ Technological & infrastructure investments and startup costs that will have sustainable impact beyond the end of the program	× Ongoing expenses, such as student loan repayment and food
✓ Expanded or enhanced services but not duplicate programs	× Transportation
	× Broadband expansion
	× Other specified limitations outlined in the notice of funding opportunity, including no supplantation

All of State Government Approach & Transparent Stakeholder Process

- Broad vision to improve health for residents of rural areas
- DSS as lead agency collaborates with 11 other state agencies
- CT's Rural Health Transformation Program (RHTP) includes 30 projects
- Grant application was informed by significant stakeholder input
- DSS will provide other public and stakeholder engagement opportunities as the RHTP implementation continues
- **Please visit our webpage for ongoing updates on RHTP: https://portal.ct.gov/dss/rural-health-transformation-program**



Connecticut Office of Rural Health

Federal Office of Rural Health Policy Identified Rural Areas

October 2025

Planning Region

Rural - Federal Office of Rural Health Policy

Spending Deadlines

- RHTP funds will be distributed over 5 budget periods. **States have until the end of the federal fiscal year to spend allocated funds for each budget period**.
- After that, CMS will redistribute unexpended or unobligated funds in the nearest following federal fiscal year.

Budget Period	Begins	Ends	Spend Deadlines
1	December 29, 2025	October 30, 2026	September 30, 2027
2	October 31, 2026	October 30, 2027	September 30, 2028
3	October 31, 2027	October 30, 2028	September 30, 2029
4	October 31, 2028	October 30, 2029	September 30, 2030
5	October 31, 2029	October 30, 2030	September 30, 2031

Key Details for Implementation

- DSS is the lead administering agency
- The implementing agency will design and implement their assigned RHTP project
- RHTP subawards will be for specific deliverables to help implement RHTP and its federally approved projects
- State procurement and other rules apply to RHTP subawards as relevant to each project
- The state will share subaward opportunities through standard channels as relevant. As feasible, the state will cross-reference opportunities on DSS' RHTP webpage

CT's Four Transformation Initiatives

Initiative Alignment Within 30 Projects Across 11 Sister Agencies

POPULATION HEALTH OUTCOMES

Outdoor recreation, ACCESS Mental Health expansion, nurse home visiting, mobile clinic pilot, exercise for older adults, non-traditional farming.

WORKFORCE

Rural residency expansion, interstate licensure compact, certified nurse aide training, rural provider incentives, AHEC workforce pipeline.

DATA & TECHNOLOGY

Bridging the digital divide, integrated care network, Connie HIE enhancements, predictive analytics, consumer AI-powered care management.

CARE TRANSFORMATION & STABILITY

Behavioral health crisis stabilization, mobile integrated health, rural hospital right-sizing, PACE, school-based behavioral health, community navigators.

Connecticut Rural Health Transformation Project Summaries

Agency	Project Title	Summary
ADS	Promoting Healthy Aging in Rural Connecticut Through Engaging Exercise	Implement a 10-week exercise program in rural Connecticut senior centers to improve strength, balance, and fall prevention in older adults.
	Bridging the Digital Divide	Expand digital access and literacy for rural older adults and people with disabilities through devices, internet access, tech training, and virtual support for telehealth, social connection, and engagement.
DEEP	Outdoor Recreation Program	Improve access to a 50-mile multi-use state park trail in rural northeastern Connecticut with resurfacing, drainage, Americans with Disability Act (ADA) upgrades, and signage to boost use and community connectivity.
DMHAS	Expand ACCESS Mental Health Model to Adults	Expand ACCESS Mental Health Connecticut to provide timely psychiatric consultation and training for adult Primary Care Providers (PCPs) in rural/underserved areas, building on youth/prenatal models to strengthen statewide behavioral health support.
	Adult 23-Hour Crisis Stabilization Units	Establish four rural adult 23-hour Crisis Stabilization Units with respite beds as home-like Emergency Department (ED) alternatives, offering multidisciplinary assessment, treatment, peer support, and 988 network integration to reduce hospitalizations.
DoAg	Seed Funding for Non-Traditional Farming Infrastructure	Support innovative agricultural ventures like container/vertical/aquaponic farms to boost fresh produce access, local food systems, and rural economic opportunities.
DPH	Mobile Clinic Pilot	Deploy 4 primary care and 4 dental mobile vans—including 1 each for CT Tribal Nations—for post-discharge follow-up, chronic care, meds support, and community/behavioral health links, targeting women/children outcomes.
	Rural Provider Incentives	Administer annual incentives to retain rural CT healthcare providers, including $1M for Tribal Nations, offsetting housing/childcare costs for a 5-year service commitment.
	Formalize Certified Nurse Aide (CNA) Training	Expand and standardize CT CNA training across healthcare settings with increased rural practicums to boost workforce participation in underserved areas.
	Rural Residency Development Grant	Expand primary care/behavioral health residencies in rural shortage areas, enabling accredited programs to strengthen workforce capacity and recruitment.
	Formalize Medication Administration Training	Centralize and standardize medication administration training through CT community colleges to strengthen workforce preparedness across healthcare settings.

	Interstate Licensure Compact Support	Implement and manage interstate licensure compacts to streamline cross-state licensing and expand rural healthcare workforce, with DPH staff overseeing enrollment, processing, and rural facility outreach.
	Mobile Integrated Health Pilot	Pilot Mobile Integrated Health program for in-home preventive/chronic/post-acute care, including follow-up, disease/medication management, behavioral health support, and community links to reduce hospitalizations and improve health outcomes for women/children.
DSS	ACCESS Mental Health ASD Service Access	Expand specialized ASD (autism spectrum disorder) consultation/support to build competencies in pediatrics, family medicine, behavioral health, and crisis care for timely, community-based expert guidance.
	ACCESS Mental Health Enhanced School-Based Mental Health Care	Strengthen school-based health centers' capacity for complex student behavioral health needs through ACCESS Mental Health for Youth – School Expansion, providing staff psychiatric consultation, guidance, and referrals to expand access and competency.
	Integrated Care Network	Establish Integrated Care Networks linking rural hospitals, Federally Qualified Health Centers (FQHCs), long-term care, Emergency Medical Services (EMS), and community organizations to improve prevention, chronic care, and access, with a TA vendor guiding feasibility/recruitment and organizations implementing state-approved plans.
	Improving Primary, Maternal, Behavioral, and Dental Health through Direct Investment and Value-Based Payments (VBP)	Support rural primary care, maternal, behavioral health, and dental providers' practice transformation via National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH) certification, Electronic Health Records (EHR)/telehealth adoption, and Administrative Services Organizations (ASO) technical assistance for value-based care readiness, with consultant/advisory council advancing sustainable payment models.
	Program of All-Inclusive Care for the Elderly (PACE)	Establish regional PACE hub for integrated primary/behavioral/long-term care for dually eligible rural older adults, reducing hospitalizations and supporting aging in place via scalable urban-rural model
	Rural Hospital Transformation & Rural Health Facility Right-Sizing and Infrastructure	Help rural/rural-serving hospitals achieve financial stability, efficiency, and value-based care readiness via multi-year technical assistance, planning, and grants, with vendor guiding state-approved modernization prioritizing independent, university-affiliated, chronic disease, and Tribe-operated facilities.
	Care Coordination Support for Primary Care Practices	Develop performance tracking for primary care in coordinated care models, with ASOs providing data/support for small practices and Medicaid PCMH providers earning per-member-per-month payments to coordinate across social/behavioral/dental partners, improving rural outcomes.
	Regional Collaboratives	Create regional coordination anchors to align Rural Health Transformation Program initiatives, foster state/local collaboration, and improve service integration by convening leaders to coordinate efforts, reduce duplication, gather input, and secure funding for sustained health/social services.

OEC	Universal Nurse Home Visiting Expansion	Expand Family Bridge nurse home visiting (Family Connects model) to Northeastern and Northwestern CT, serving approximately 3,600 births/year with 1–3 nurse visits and 6 months of Community Health Worker (CHW) support for family health needs.
OPM/OHS* **(OHS) and its function to be integrated into other state agencies*	Consumer AI-Powered Care Management Tools	Modernize rural healthcare via CT AI-Powered Virtual Care initiative, enabling providers to adopt Artificial Intelligence (AI) remote monitoring/digital tools integrated with Connie to enhance home-based care, reduce hospitalizations, and address workforce gaps through training and advisory input.
	Connecticut Rural Predictive Analytics and Care – Coordination Platform	Launch Rural Predictive Analytics and Care Coordination Platform to integrate clinical/social data, identify high-risk patients, reduce avoidable hospitalizations, build data standards, develop predictive tools, and train workforce for statewide prevention, chronic care, and health equity
	Health Information Exchange (HIE) Expansion for Rural Providers, EMS, and Skilled Nursing Facilities	Expand Connie HIE participation for rural/community providers via onboarding, technical assistance, and training to improve care coordination with real-time alerts, EMS integration, and consent management, led by a team for stronger rural health outcomes.
	Rural Health Transformation through Shared Infrastructure and Telehealth Innovation	Implement secure, cloud-based IT infrastructure for rural hospitals, FQHCs, and providers to expand telehealth, modernize clinical systems, enhance data integration/cybersecurity/broadband, and support remote care, behavioral health, and sustainable rural health.
	CT Healthcare Bed Capacity Tracking System	Create statewide real-time hospital capacity tracking system to monitor beds, streamline transfers, reduce overcrowding, improve coordination/efficiency/equitable access via existing infrastructure and cost-sharing.
ORH	Community Health Navigator	Pilot regional community health navigator program to link rural residents to preventive/essential services, support health tech use, and promote wellness via care coordination and home visits addressing transportation/access barriers.
SDE	High Acuity School-Based Behavioral Health Programming	Build a comprehensive model to strengthen rural school mental/behavioral health via assessment, Multi-Tiered System of Supports (MTSS) training (trauma-informed, suicide prevention), integrated supports, community/telehealth links, and provider in-person/virtual/mobile care for early intervention and equitable access.
UCHC	Area Health Education Center (AHEC) Expansion	Build coordinated rural health workforce pipeline from high school to licensed practice to boost retention, sustainability, and access in underserved areas, engaging 5,000 learners and 1,200 annual rotations for more rural placements, employer participation, and data-driven policy.

Sign up!

If you haven't already joined our RHTP email distribution list, it's a great way to be kept appraised of all the latest happenings. You can sign up here:

https://portal.ct.gov/dss/rural-health-transformation-program/public-engagement

ANNUAL MEDICAID FINANCIAL REVIEW

Presentation Overview

- Financial Trends Review
- Review of Medicaid Spending by Service Category
  - State Share by Medicaid Service Category
- Review of Medicaid Per Member Per Month (PMPM) Trends
- Medicaid Cost Drivers
- SFY 2027 Budget Highlights

Financial Trends Review

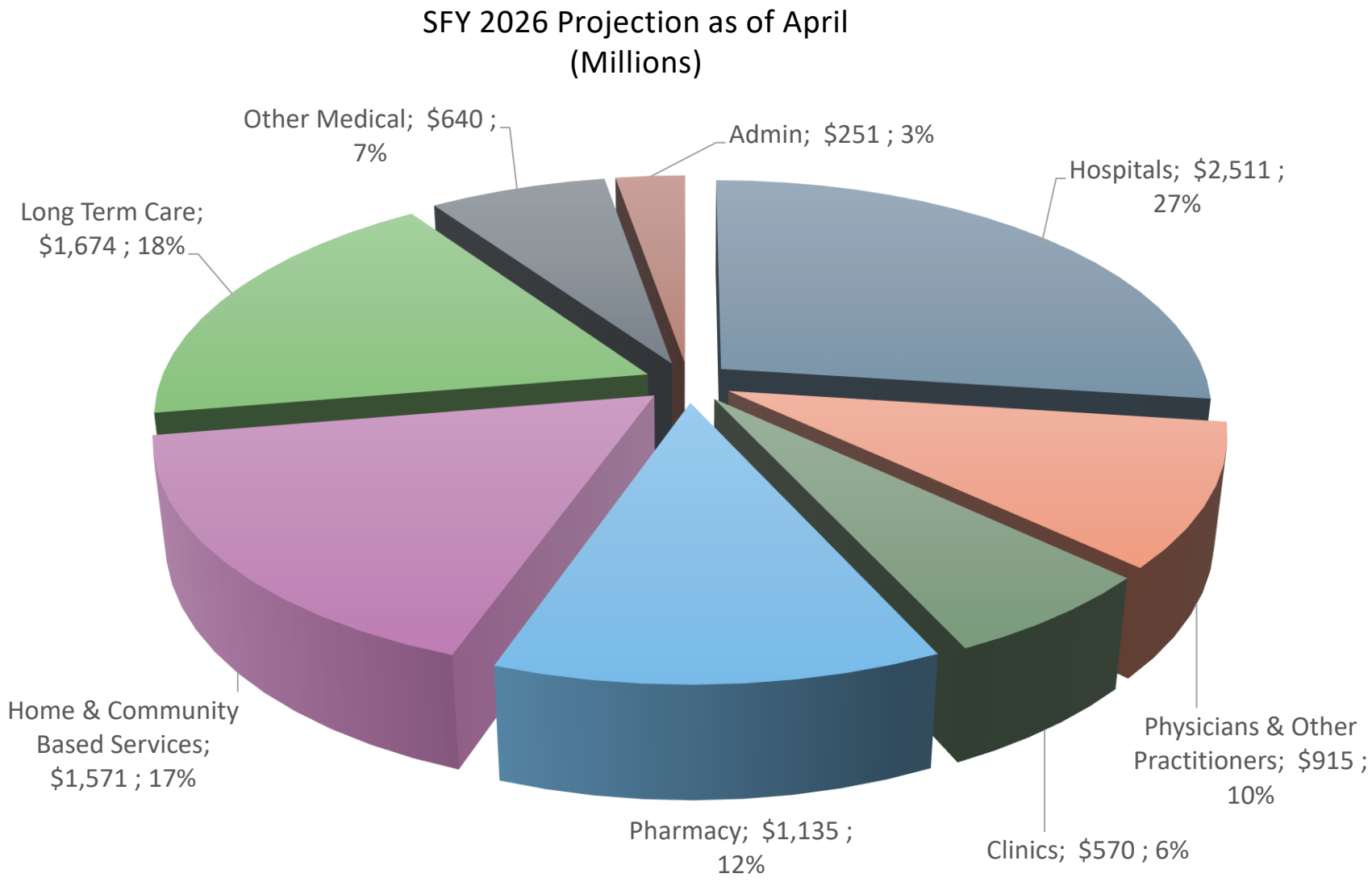
What trends are we seeing?

- Overall membership continues to decline – this membership trend has been consistent since the end of the public health emergency (PHE).
- Connecticut Medicaid spend by category of service continues to shift.
- Increased utilization in many areas of the Medicaid program, including pharmacy and home and community-based services, are driving the PMPM increase.

Review of Medicaid Spending by Service Category

SFY 2026 Medicaid Expenditures

In SFY 2026, the total gross spend is projected at $9.27 billion. **Hospital services** account for the largest share of the DSS Medicaid spend at 27%, followed by **nursing homes and long-term care facilities** at 18%. **Home & community-based services** account for 17%. **Pharmacy** expenses comprise 12%.



Medicaid by Service Category

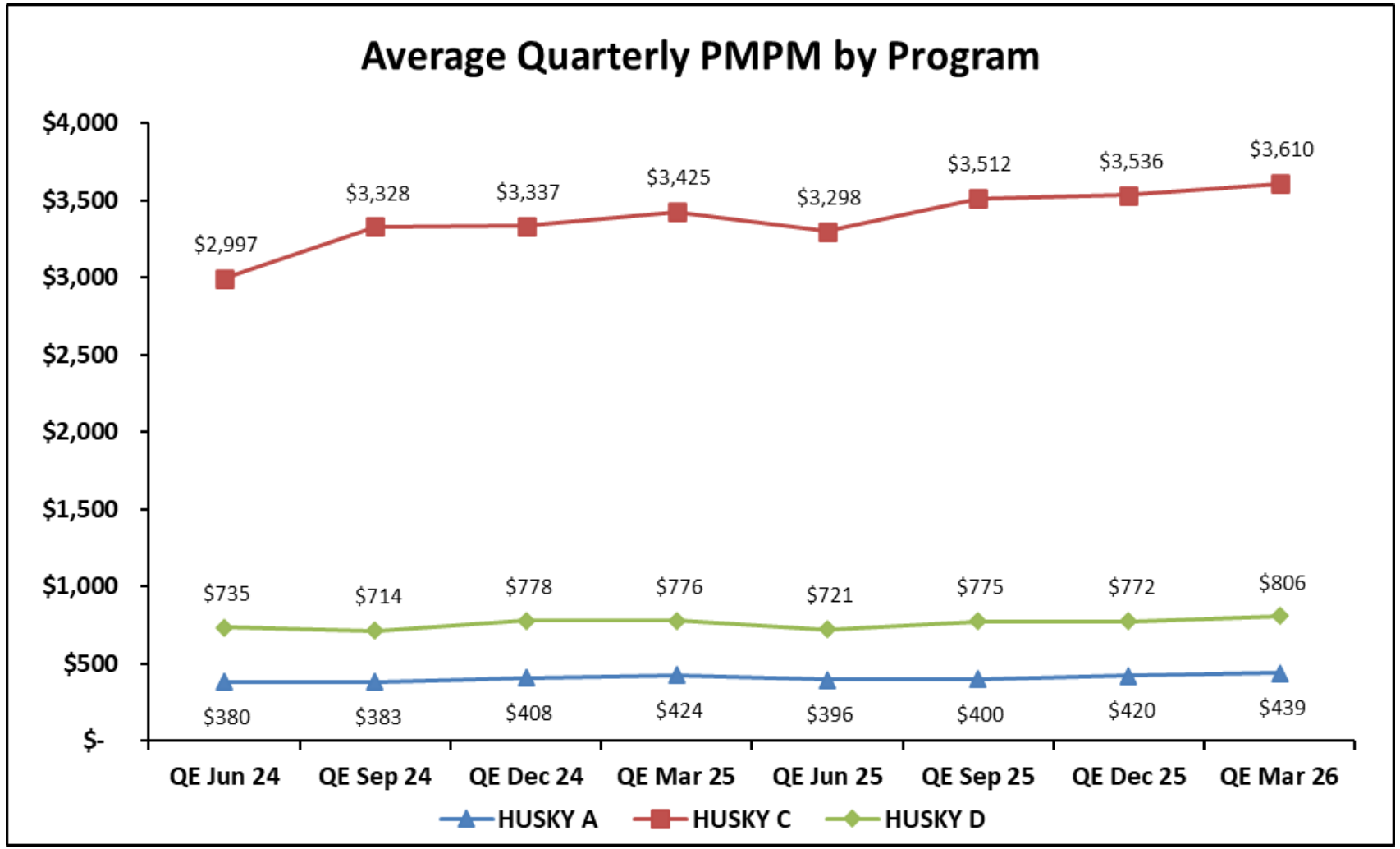
Category of Service	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026	5-Year Change
Hospitals	30.8%	30.3%	29.2%	28.1%	27.1%	-3.7%
Physicians & Other Practitioners	11.2%	11.0%	10.5%	10.1%	9.9%	-1.4%
Clinics	6.7%	6.2%	6.6%	6.0%	6.2%	-0.5%
Pharmacy	10.3%	10.5%	12.0%	12.3%	12.2%	2.0%
Home and Community-Based Services	14.1%	13.9%	14.3%	16.1%	17.0%	2.8%
Long-Term Care	18.3%	18.0%	18.0%	17.9%	18.1%	-0.3%
Other Medical	7.0%	8.0%	6.9%	7.2%	6.9%	-0.1%
Admin	1.6%	2.1%	2.6%	2.4%	2.7%	1.2%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	

Over the past five years, the Medicaid budget has seen shifts in the percentage of costs for several categories of service. The largest increase being a 2.8% shift in home and community-based services (i.e., home health, home care and waiver costs), and the largest decrease under hospitals of 3.7%. It should be noted that the enrollment growth and wage increases for home and community-based services continue to increase costs in that category of service.

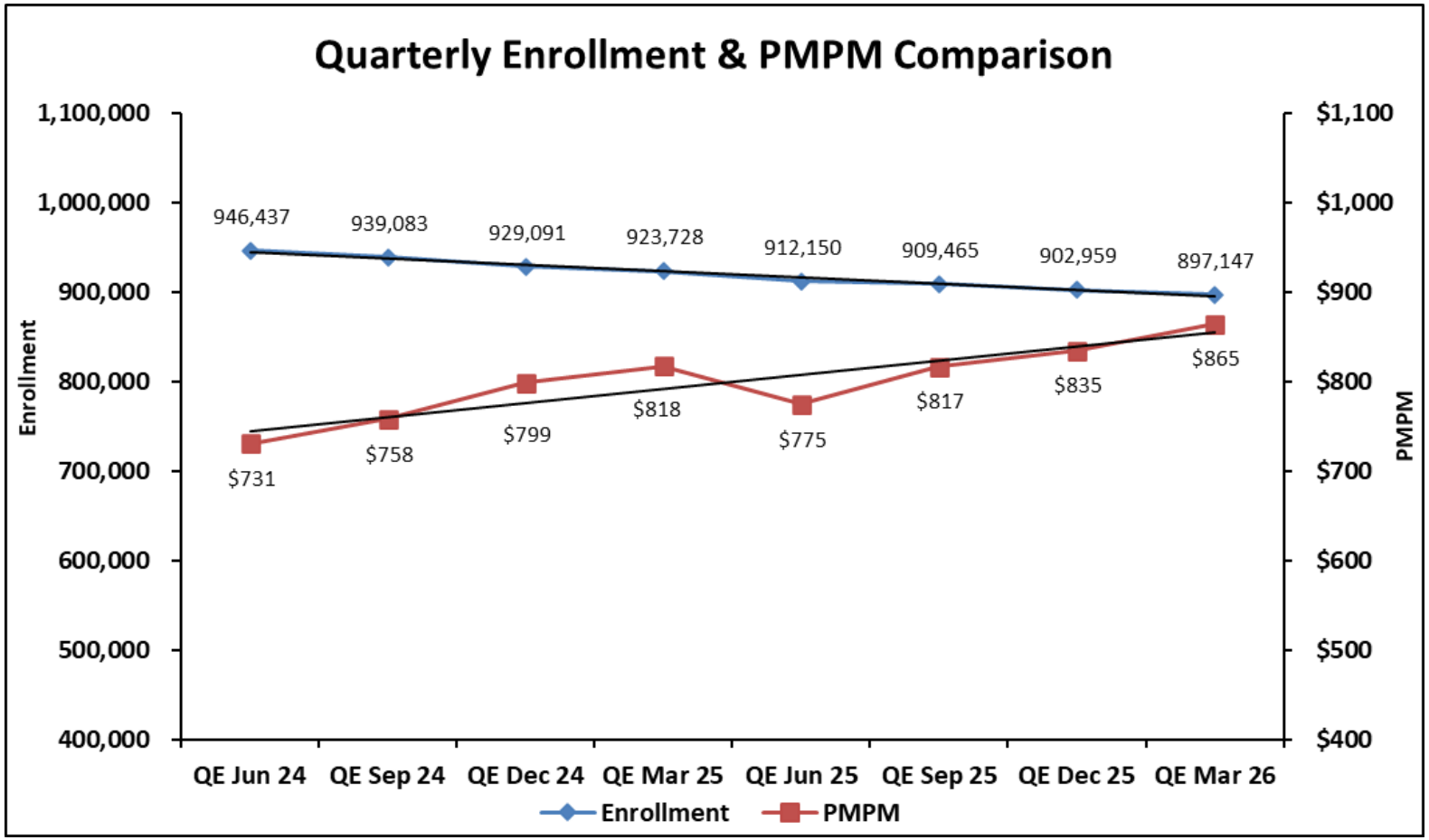
Review of Medicaid Per Member Per Month (PMPM) Trends

PMPM by Enrollment Type

- **HUSKY A** – Parents / caregiver relatives, pregnant individuals, postpartum coverage, and children.
- **HUSKY C** – Individuals aged 65 and older; individuals aged 18-64 who are blind or have another disability may also qualify.
- **HUSKY D** – Individuals aged 19-64, no dependent children, are not pregnant, and do not receive Medicare.



Connecticut Trends – Per Member Per Month

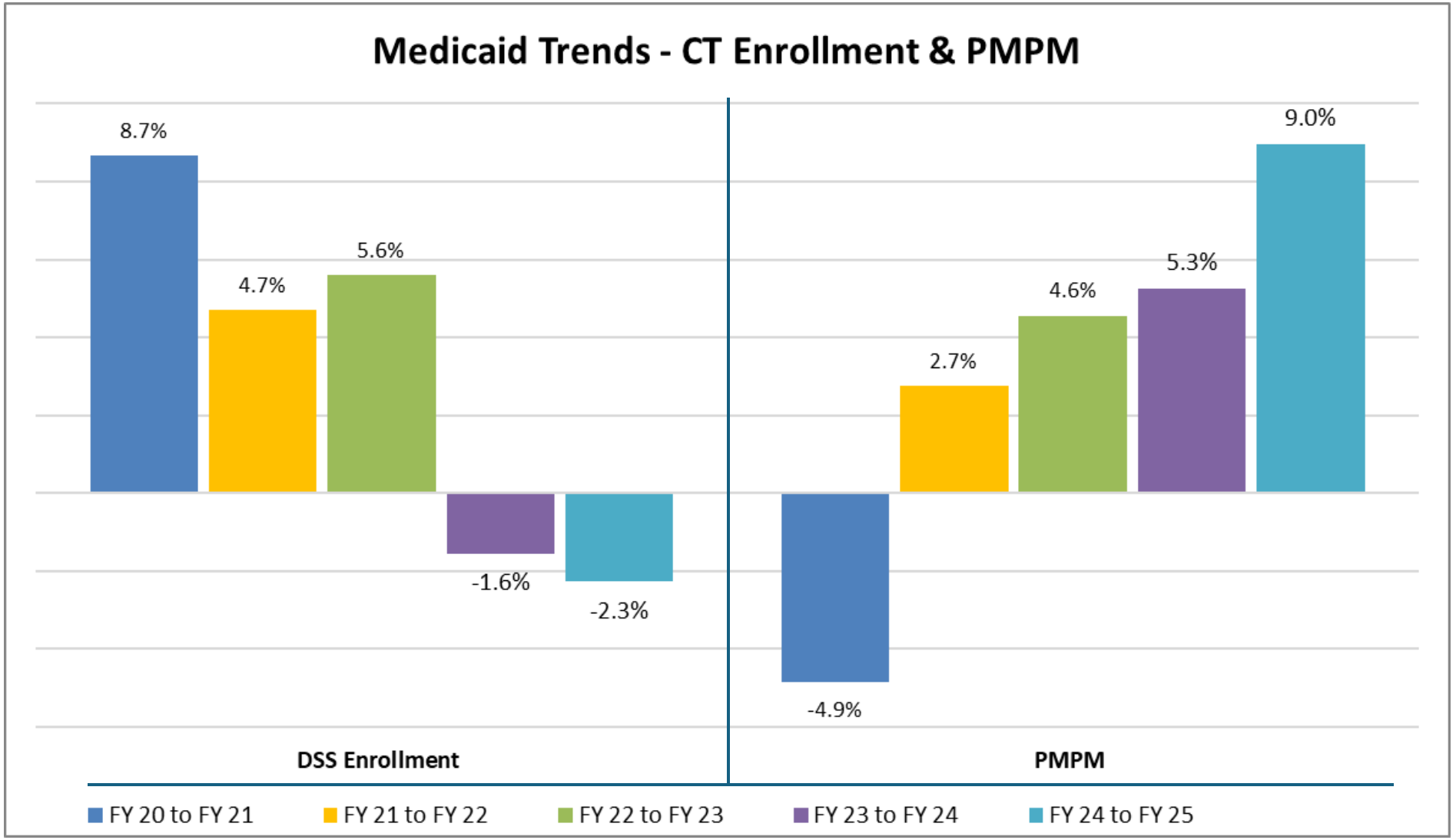


- HUSKY enrollment has continued to steadily decline in SFY 2026. Most recently, the rate of membership decline has slowed.
- HUSKY quarterly average PMPM has had an inverse relationship with membership. The PMPM has steadily increased and has been a multi-year trend.
- HUSKY A and HUSKY D had membership decline but HUSKY C, the group with the highest PMPM, has shown membership to be fairly stable.

Enrollment and PMPM Trends

- Medicaid enrollment trends have varied from a high of 8.7% during the PHE from SFY 2019 to SFY 2020 to a 2.3% decrease from SFY 2024 to SFY 2025, as the PHE unwinding continued.

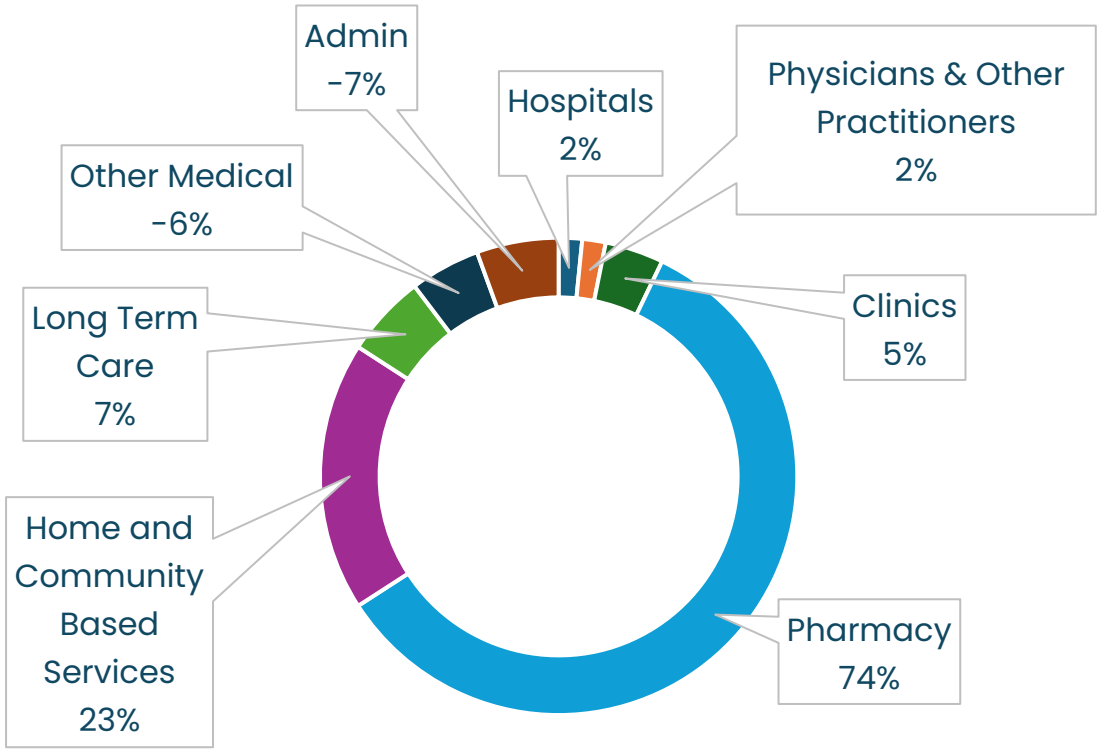
- Medicaid PMPM cost decreased by 4.9% during the PHE. However, it has continued to rebound since SFY 2021, reaching a high of 9.0% from SFY 2024 to SFY 2025.



Connecticut Medicaid Cost Drivers

2026 Medicaid State Cost Drivers

Cost Drivers By Service Category



Pharmacy

Higher costs due to reduced rebates and new high-cost drugs entering the market. This is a national trend.

Home and Community-Based Services

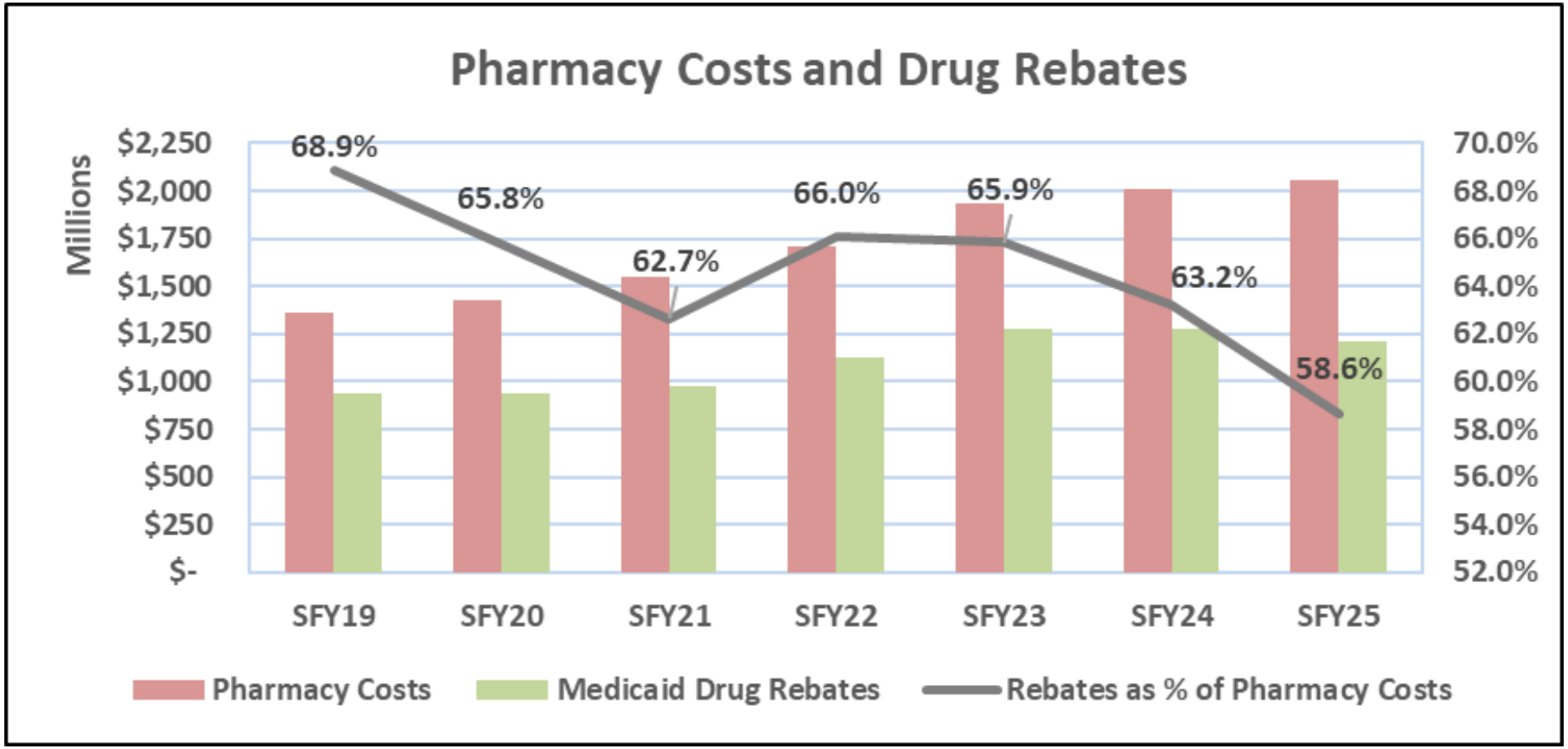
Costs in home and community-based services are higher than originally projected due to an increase in the enrollment trend.

Pharmacy Costs and Drug Rebates

- Compared to pre-pandemic levels, drug rebates as a percent of pharmacy costs have been decreasing. Each 1% drop is a loss of approximately $20 million gross ($8 million state share).

Comparing SFY 2024 to SFY 2025:

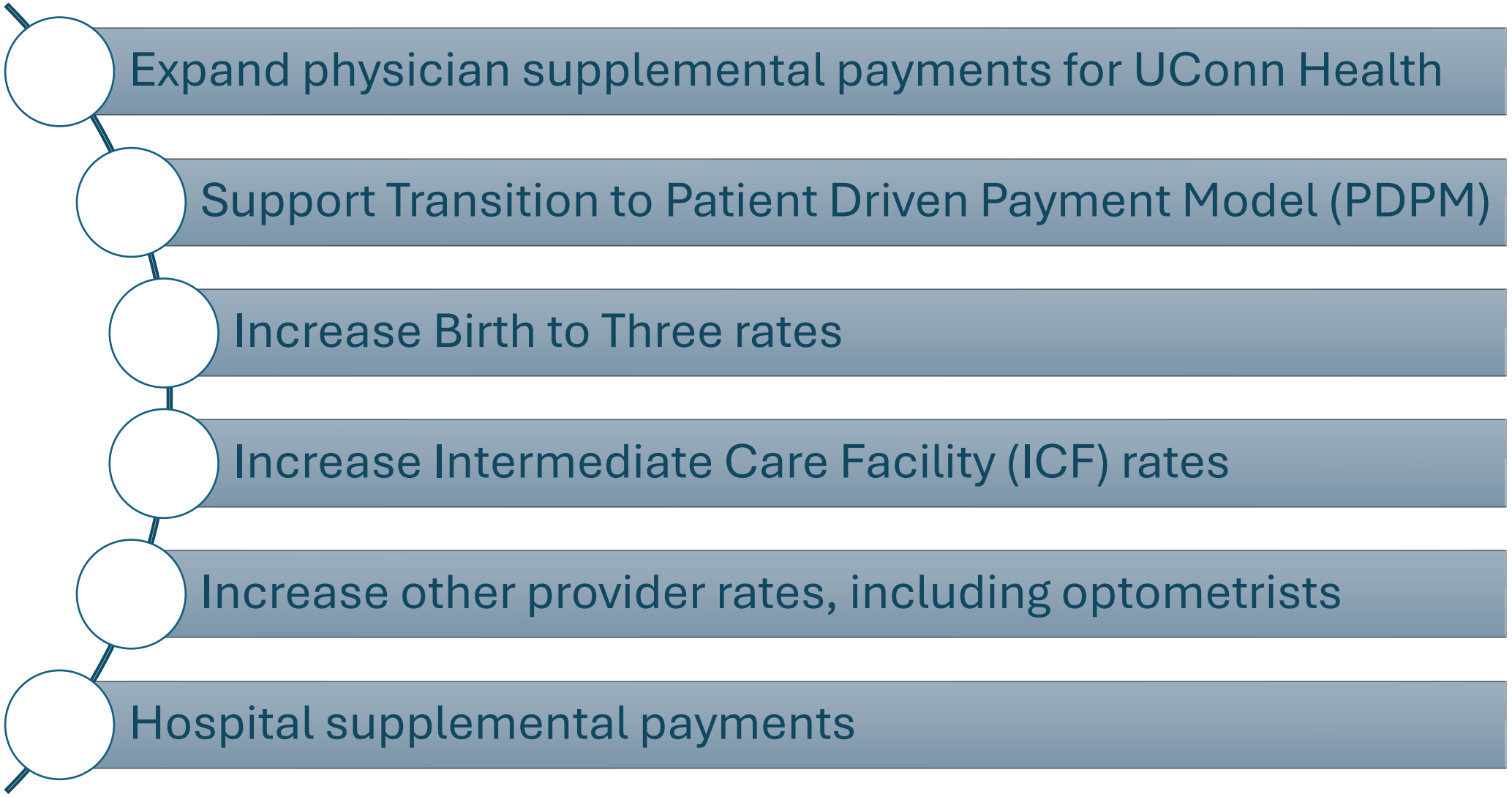
- Overall, net pharmacy costs increased by $112 million.
- PMPM increased by 19.9%.



	SFY19	SFY20	SFY21	SFY22	SFY23	SFY24	SFY25
Rx Costs Inc YoY	4%	5%	9%	10%	13%	4%	2%

SFY 2027 Medicaid Budget Highlights

SFY 2027 Medicaid Budget Highlights



H.R. 1 GENERAL UPDATES

Agenda Items

- **General Changes – Refresher**
- **New CMS Interim Final Rule (IFR)**
- **Medical Frailty Update**
- **State Data Evaluation Update**
- **Outreach and Communications**

Medicaid Work Requirements (Reminder)

Current State:

- No work or community engagement requirements for Medicaid eligibility in Connecticut

Future State:

- **Starting January 1, 2027**, HUSKY D enrollees (~316,000 members) will need to meet work requirements or community engagement rules to get or keep coverage
- **Work/income** – proof of at least 80 hours/month of work or income of at least $580/month (federal minimum wage x 80 hours)
- **Community engagement** – proof of at least 80 hours/month of community service or a qualified work or training program; enrolled at least half-time in an education program; or any combination of community engagement and work totaling at least 80 hours per month

Medicaid Work Requirement Exemptions (Reminder)

- Veterans with disability rated as total (100% schedular) or Total Disability Based on Individual Unemployability (TDIU)
- Medically frail (e.g., blind, disabled, children with serious emotional disturbances, adults with serious mental illness, chronic substance use disorders, serious and complex medical conditions)
- Participating in an approved drug or alcohol treatment and rehabilitation program
- Already meeting work requirements for SNAP and/or TFA
- Caregiver of a child under 14, or someone who needs help with daily activities (such as a disabled person or older adult)
- Individuals recently released from incarceration in the last 90 days
- Certain Native American & Alaska Native populations
- Foster and former foster youth
- Short-term hardship waivers (e.g., individuals receiving medical care out of state)

Medicaid Work Requirements (May update)

Preliminary estimates subject to change

Using data already available in state systems to assess Medicaid work requirement impacts, we estimated that…

- **Previous analysis:** Roughly 50% of HUSKY D low-income adults are likely exempt or compliant
- **Updated analysis:** 65% of HUSKY D low-income adults are likely exempt or compliant

Updated analysis: February 2026 Data

HUSKY D Low-income adults	February 2026 Members	% Total
At-risk of coverage loss	110 k	35%
Likely exempt or compliant using available data	206 k	65%
Total distinct Medicaid members	**316 k**	**100%**

The updated analysis includes the following changes:

- **HUSKY membership:** More recent cohort of HUSKY Health members from February 2026
- **SNAP beneficiaries:** Medicaid members are exempt if they already comply with SNAP work requirements

→ Previously, this had not been included since SNAP work requirement changes had not gone into effect

- **Medical frailty:** Medicaid members are exempt from work requirements in certain medical instances (upcoming slide)

→ Previously, medical frailty had been defined using 460 diagnosis codes; a more comprehensive list of >4,000 codes have been considered based on national proposals

Medicaid Work Requirements (May update)

Preliminary estimates subject to change

HUSKY D Low-income adults	February 2026 Members	% Total
At-risk of coverage loss	**110 k**	**35%**
Likely exempt or compliant using available data	**206 k**	**65%**
Medical Frailty	126 k	40%
Wage records *Monthly income at least federal minimum wage x 80 hours*	94 k	30%
SNAP beneficiary *Complying with SNAP work requirements*	45 k	14%
Other eligibility factor *Non-Medicaid expansion, not 19-64, Medicare, cash assistance*	39 k	12%
Supplemental Security Income (SSI) *Indicates a qualifying disability exemption*	24 k	8%
Student *Full-time or half-time (data primarily from SNAP)*	6 k	2%
Total distinct HUSKY D members	**316 k**	**100%**

Categories are **not** mutually exclusive

Among the 206k members, 88k members are likely exempt or compliant based on multiple categories.

Medicaid Work Requirements (May update)

Preliminary estimates subject to change

HUSKY D Low-income adults	February 2026 Members	% Total
At-risk of coverage loss	**110 k**	**35%**
Likely exempt or compliant using available data	**206 k**	**65%**
Medical Frailty	126 k	40%
Wage records	94 k	30%
SNAP beneficiary	45 k	14%
Other eligibility factor	39 k	12%
Supplemental Security Income (SSI)	24 k	8%
Student	6 k	2%
Total distinct Medicaid members	**316 k**	**100%**

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)

Ahead of the specifications from federal regulations provided recently, DSS reviewed national proposals for using claims data (e.g., diagnosis codes) to help implement the definition above.

Using these proposals, the updated analysis now considers over 4,000 diagnosis codes that appear in multiple proposals. This approach is subject to change with regulatory guidance.

Medicaid Work Requirements: Updated Impact Analysis

Preliminary estimates subject to change

Based on data currently available in state systems

HUSKY D Low-income adults	February '26 Members	% Total
At-risk of coverage loss	**107 k**	**34%**
Likely exempt or compliant using available data	**209 k**	**66%**
Medical Frailty *Using 6,215 Connecticut-specific diagnosis codes*	131 k	41%

	Total Codes	In CT List & Other List	Not in CT List	In CT, not in Other list	February 2026 HUSKY D Coverage *Applying code list to Connecticut membership*
Connecticut Preliminary list	**6,215**	-	-	-	**131 k**
Michigan ABP	**460**	458	2	5,757	**54 k**
Nebraska	**8,273**	4,539	3,734	1,676	**103 k**
Harvard	**6,360**	6,073	287	142	**144 k**
Western States	**7,486**	4,081	3,405	2,134	**188 k**
Pennsylvania	**14,506**	5,958	8,548	434	**137 k**

Medical Frailty

Dr. Terranova reviewed more than 6,400 codes derived from CMS' Chronic Conditions Data Warehouse (CCW). The review checked the diagnosis codes against the medical frailty regulatory language. External proposals were integrated in the review:

- **Harvard School of Public Health:** External proposals based on 2 physicians reviewing the lists and reconciling differences for final determinations.
- **Western states consortium:** Parent diagnosis codes proposed by a group of West Coast states and managed care organizations.
- **Historical precedence:** Inclusion of codes in Michigan's prior alternative benefit plan list or Nebraska's recent implementation.

Overall, the initial approach to defining medical frailty was based on clinical risk, not only ability to work. This aligns with the perspective published by the Medicaid Medical Directors Network (published May 15, 2026 in JAMA Health Forum).

Medicaid Work Requirements: Updated Impact Analysis

Preliminary estimates subject to change

Based on data currently available in state systems

HUSKY D Low-income adults	February '26 Members	% Total
At-risk of coverage loss	**107 k**	**34%**
Likely exempt or compliant using available data	**209 k**	**66%**
Determination #1. Wage records *Monthly income at least minimum wage x 80 hours*	94 k	30%
Determination #2. Student *Full-time or half-time (data primarily from SNAP)*	3 k	1%
Determination #3. SNAP beneficiary *Complying with SNAP work requirements*	36 k	11%
Determination #4. Supplemental Security Income, SSI *Indicates a qualifying disability exemption*	7 k	2%
Determination #5. Other eligibility factor *Non-Medicaid expansion, not 19-64, Medicare, cash assistance*	12 k	4%
Determination #6. Medical Frailty *Using 6,215 Connecticut-specific diagnosis codes*	57 k	18%
Total distinct HUSKY D members	**316 k**	**100%**

Categories **are** mutually exclusive

Imposing consecutive checks, with medical frailty exemptions performed *last*.

Interim Final Rule on Community Engagement

- On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule (IFR) interpreting and implementing the H.R. 1 community engagement requirement
- 387 pages
- 60-day comment period for the IFR
- The IFR is scheduled to go into effect on July 31, 2026
- CMS will continue to provide clarifying guidance on implementation before July 31, 2026

IFR Implementing Work Reporting Requirements

CMS' IFR implementing Section 71119 of H.R. 1 establishes the operational framework for work reporting requirements, and in some cases goes beyond the statute and departs from CMS' preliminary guidance that states have relied on to prepare for January 2027.

Topline Takeaways of the Rule:

Details important policy and operational implications for **applicable individuals** vs. **specified excluded individuals**.	Narrows the **medical frailty exclusion** by requiring that qualifying conditions "significantly impair" an individual's ability to work.	Requires states electing **short-term hardship exceptions** to offer all of them, and clarifies that the lookback period applies to these exceptions.	Allows states to accept **self-attestation** (i.e., an individual's auditable self-declaration) in 2027, but limits self-attestation in 2028 and beyond.	Clarifies that CMS may approve **good faith waivers** for up to six months at a time, and projects approving these requests in only two states.

Source: State Health and Value Strategies

Medical Frailty – IFR Updates

"Whether a person with a serious or complex medical condition qualifies as a specified excluded individual on the basis of medical frailty will depend on the condition **significantly impairing** their ability to comply with the community engagement requirement." (IFR p. 93)

- States are required to use claims data from the prior 12 months period in determining eligibility (IFR pp. 150, 186)
- Self-attestation is allowed during CY 2027
- States must validate and document medical frailty beginning in January 2028
- A medical condition alone may not exempt anyone from work/community engagement requirements

Summary: the IFR definition is more restrictive than originally considered; DSS code analysis remains generally intact; CMS has allowed self-attestation for CY 2027; implementation options will continue to be evaluated

CT STATE AGENCY DATA STRATEGY

H.R. 1 IMPLEMENTATION

Data Workstreams

DataLinkCT Test Match

- The test match will show DSS where data exists at other agencies that can be used to exempt or verify compliance with SNAP and/or Medicaid work requirements.
- Participating agencies (listed on next slide) are sharing data from FY 25 to support the test match.
- Results will inform highest-priority datasets, for which DSS can then update or establish MOUs, share data, and develop operational workflows.

New and Updated MOUs

- New and updated MOUs currently being drafted will allow DSS to use the highest priority data, following the DataLinkCT test match.
- Enhanced data matching with DOL is a known priority, therefore updates to the DSS-DOL MOU are already underway.

Collaborating Agencies

DataLinkCT Test Match Collaborating Agencies & Relevant Data

- DOL: Adult workforce training participation
- UConn: Higher education enrollment (credit bearing)
- CSCU: Higher education enrollment (credit and non-credit bearing)
- CTECS: Apprenticeships and adult education participation
- SDE: Adult education
- CCIC: Higher education enrollment (credit bearing; limited to members of CCIC with rates of Pell recipients near or exceeding 50%, including Mitchell College, University of Bridgeport, Goodwin University, Albertus Magnus College, and University of New Haven)
- DCF: Former foster youth under the age of 26
- DOC: Individuals released or discharged from incarceration in the last 90 days
- DOH / HMIS: Individuals experiencing chronic homelessness
- DMHAS: Individuals with diagnosed substance use disorder and/or participants in drug/alcohol treatment or other inpatient stays

Outside of DataLinkCT Test Match

- CT Paid Leave: Verified serious medical conditions of beneficiaries
- OSC: State employee wages

DataLinkCT Test Match

Data and Analysis

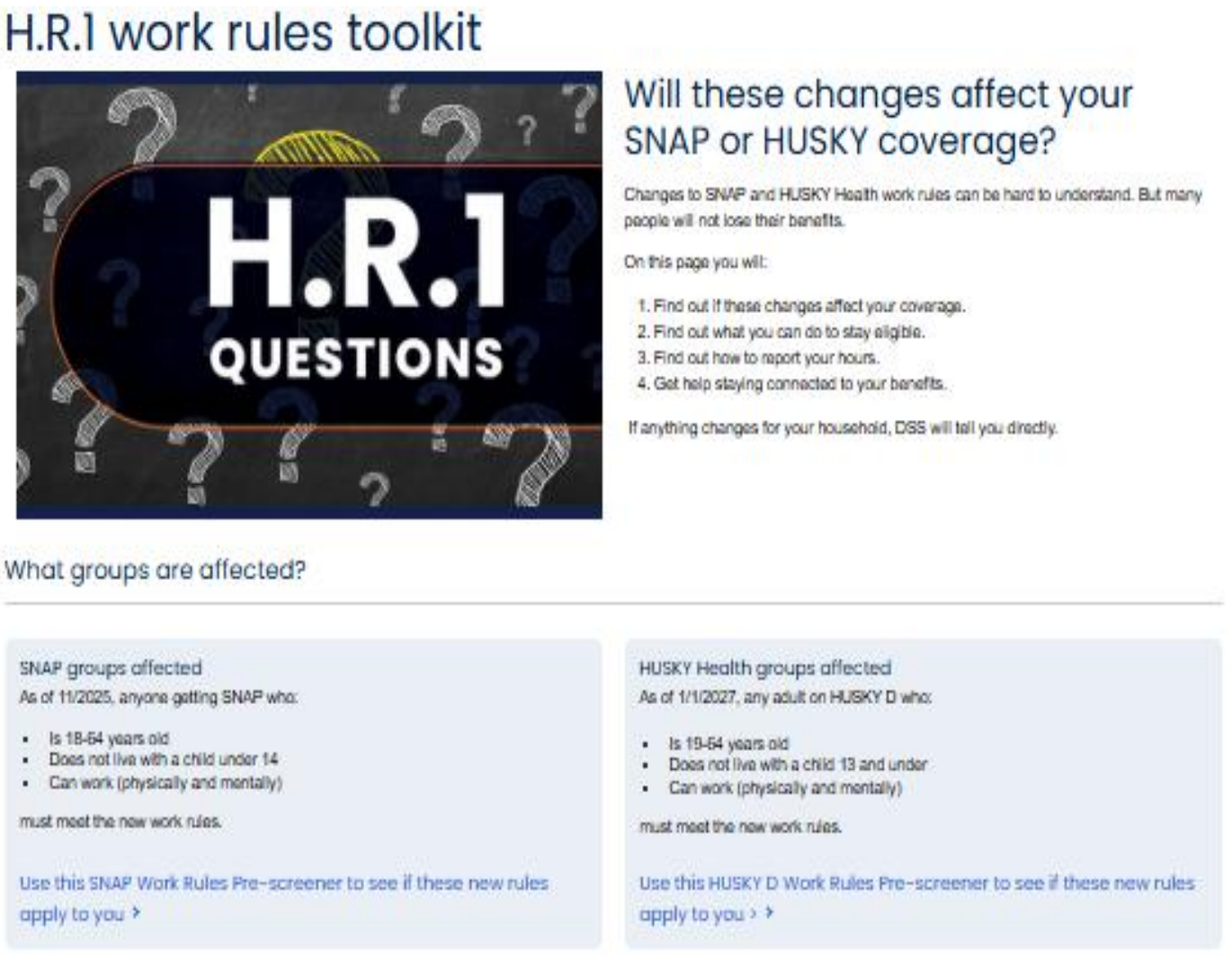
- The broad approach is to examine the types of data already collected by sister agencies, and match available data with the compliance and exemption rules in H.R. 1.* This serves a variety of needs, including:
  - Serving public benefit programs by allowing DSS a view into data that may be used to verify client eligibility for SNAP and Medicaid.
  - Serving higher education programs by allowing UConn, CSCU, and CCIC a view into H.R. 1's impact on student access to public benefits and state services.
- DSS also aims to identify which programs individuals participated in during a given month or quarter (depending on data availability), when they participated, and how much they participated.
- The types of data fields requested that DSS can examine include:
  - Program name
  - Start/end dates of participation
  - Time spent on participation that can demonstrate compliance or exemptions (could be defined by typical program hours, by full-time or part-time status, by credit hours, or by other measurements of time spent)
- The analysis also includes demographic data from collaborating agencies to support DSS' outreach and communication strategy.

*Compliance and exemption assumptions subject to change, pending CMS policy clarifications

OUTREACH & COMMUNICATIONS

H.R. 1 IMPLEMENTATION

H.R.1 Toolkit and Medicaid Work Requirements Pre-Screener



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:

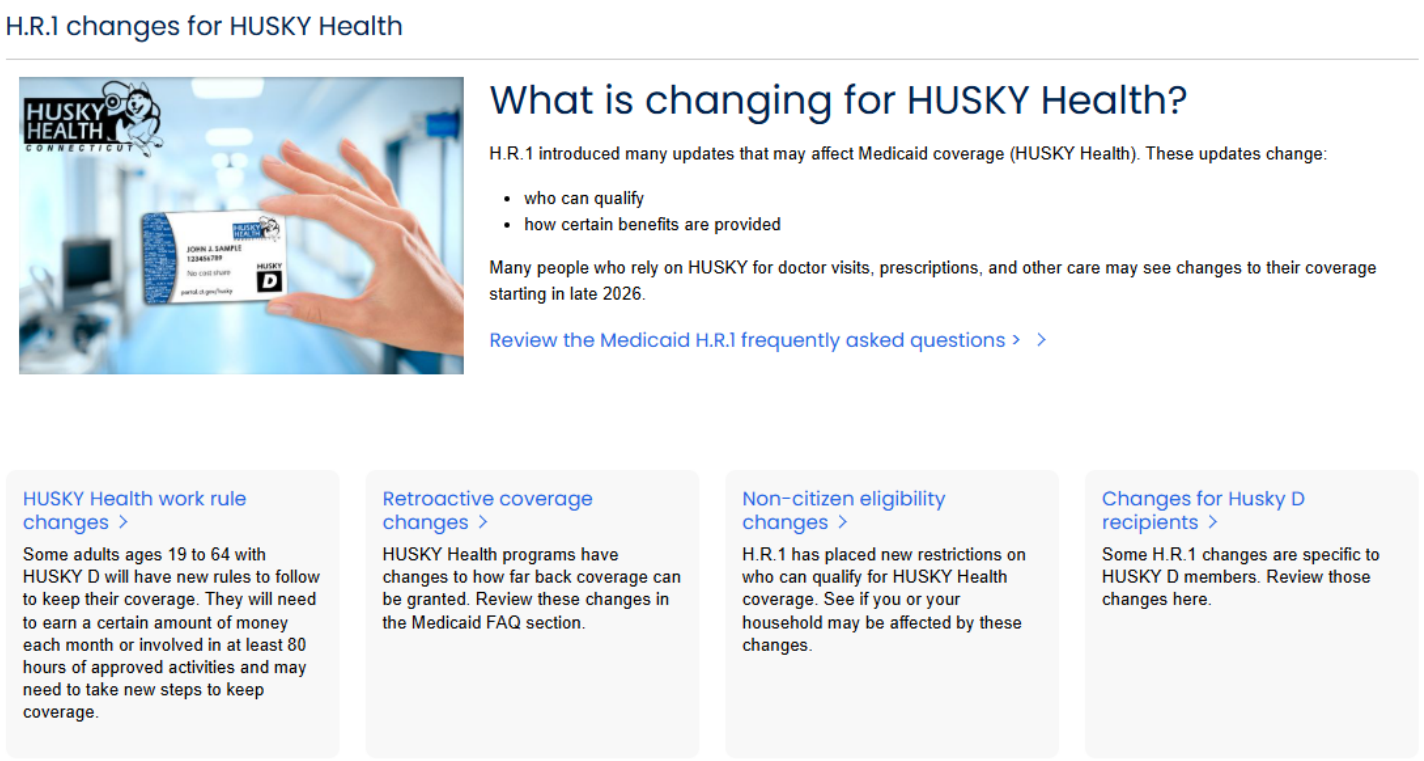
- Is 19-64 years old
- Does not live with a child 13 and under
- Can work (physically and mentally)

must meet the new work rules.

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

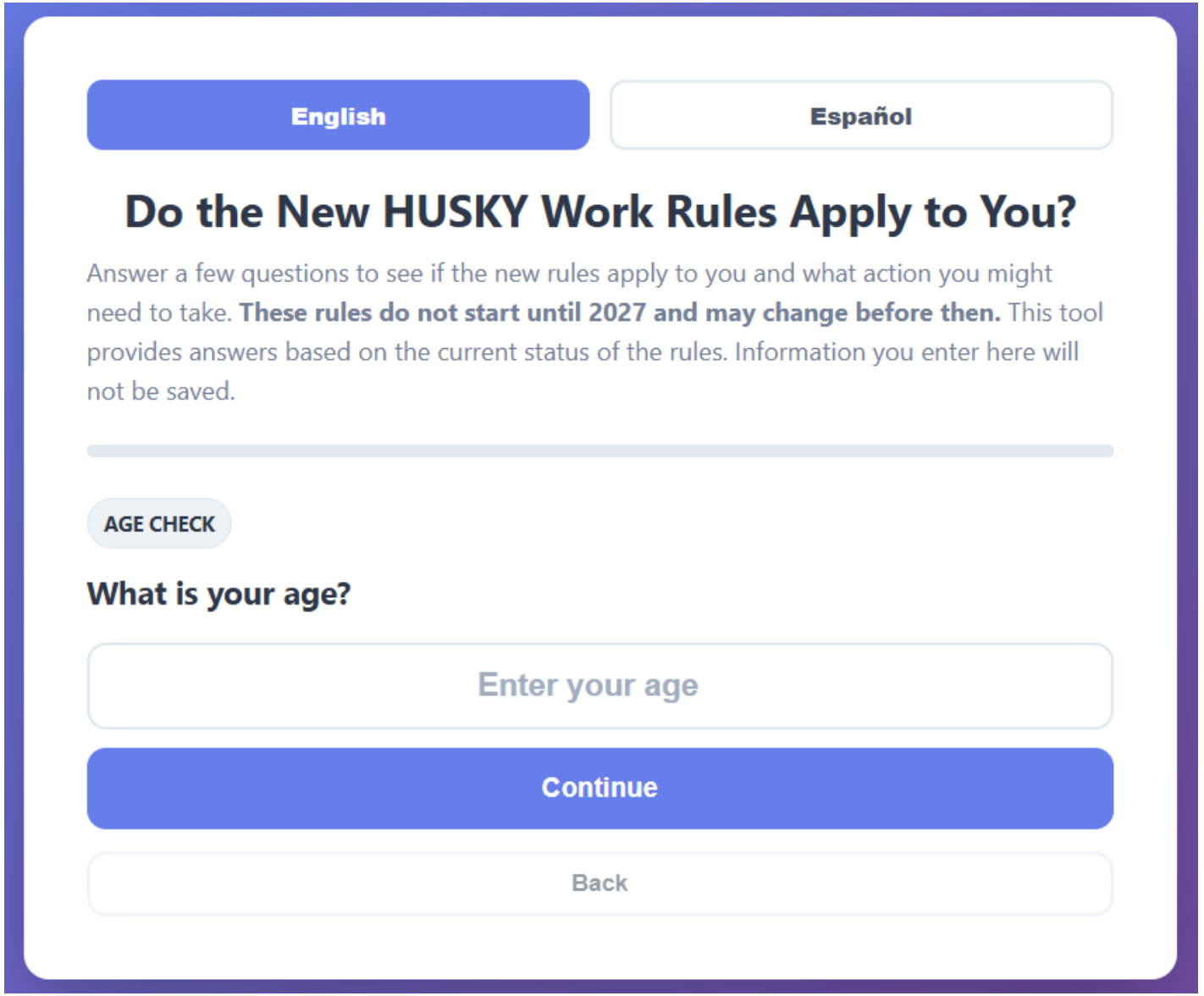
https://portal.ct.gov/dss-hr1

H.R.1 Toolkit and Medicaid Work Requirements Pre-Screener



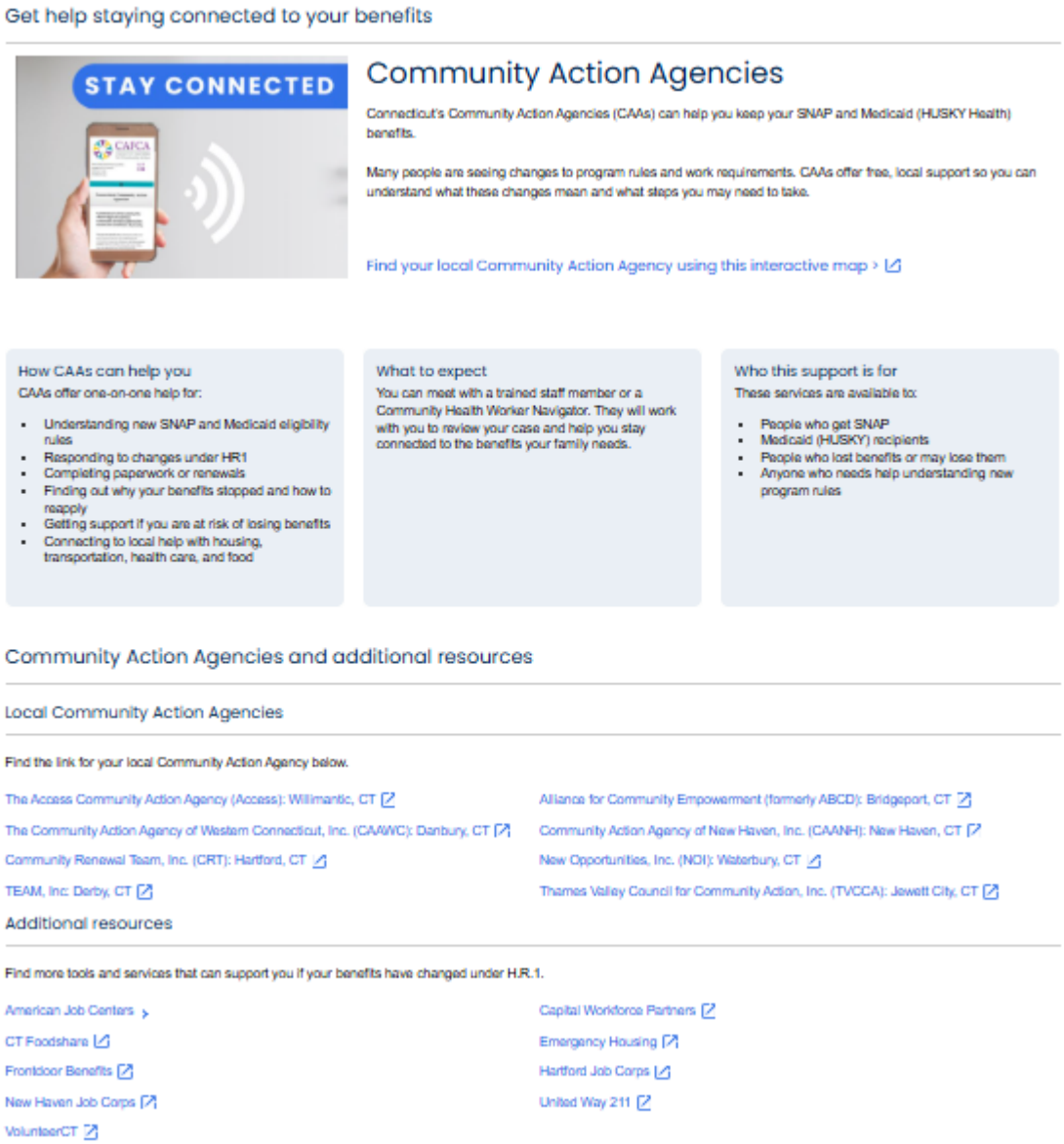
- Clear concise language that walks through the changes. We also outline the steps someone will need to take to maintain their coverage. Updates will continue to be made as operational implementation steps are finalized.

H.R.1 Toolkit and Medicaid Work Requirements Pre-Screener



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

H.R.1 Toolkit and Medicaid Work Requirements Pre-Screener



Get help staying connected to your benefits

Community Action Agencies

Connecticut's Community Action Agencies (CAAs) can help you keep your SNAP and Medicaid (HUSKY Health) benefits.

Many people are seeing changes to program rules and work requirements. CAAs offer free, local support so you can understand what these changes mean and what steps you may need to take.

Find your local Community Action Agency using this interactive map >

How CAAs can help you

CAAs offer one-on-one help for:

- Understanding new SNAP and Medicaid eligibility rules
- Responding to changes under HR1
- Completing paperwork or renewals
- Finding out why your benefits stopped and how to reapply
- Getting support if you are at risk of losing benefits
- Connecting to local help with housing, transportation, health care, and food

What to expect

You can meet with a trained staff member or a Community Health Worker Navigator. They will work with you to review your case and help you stay connected to the benefits your family needs.

Who this support is for

These services are available to:

- People who get SNAP
- Medicaid (HUSKY) recipients
- People who lost benefits or may lose them
- Anyone who needs help understanding new program rules

Community Action Agencies and additional resources

Local Community Action Agencies

Find the link for your local Community Action Agency below.

The Access Community Action Agency (Access): Willimantic, CT
The Community Action Agency of Western Connecticut, Inc. (CAAWC): Danbury, CT
Community Renewal Team, Inc. (CRT): Hartford, CT
TEAM, Inc: Derby, CT
Alliance for Community Empowerment (formerly ABCD): Bridgeport, CT
Community Action Agency of New Haven, Inc. (CAANH): New Haven, CT
New Opportunities, Inc. (NOI): Waterbury, CT
Thames Valley Council for Community Action, Inc. (TVCCA): Jewett City, CT

Additional resources

Find more tools and services that can support you if your benefits have changed under H.R.1.

American Job Centers
CT Foodshare
Frontdoor Benefits
New Haven Job Corps
VolunteerCT
Capital Workforce Partners
Emergency Housing
Hartford Job Corps
United Way 211

H.R. 1 & Connecticut Partners

Update Us so we can Update U

How can we help our fellow CT residents?

- Make sure residents have current contact information so they don't miss any important information! If they are unsure where to update their info they can go to:

  https://portal.ct.gov/updateusdss

How can we stay up to date?

- As guidance is released, we will update our H.R. 1 FAQ main page with information for members and partners.

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

  https://portal.ct.gov/snapworkrules

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