HUSKY D WORK RULES: TECHNICAL PROVIDER TRAINING

SEPTEMBER 18, 2026

Medicaid Eligibility Changes Affecting All HUSKY Programs

Non-Citizen Coverage Rules Effective October 1, 2026

STILL ELIGIBLE FOR MEDICAID

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

* 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.

NO LONGER ELIGIBLE AS OF 10/1/26

- Refugees, asylees, and parolees
- Victims of trafficking
- Victims of domestic violence
- Afghan or Iraqi Special Immigrant Visa holders**

** 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

EXPECTED IMPACT / PROVIDER MESSAGE

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

These changes in non-citizen eligibility are separate from the HUSKY D work-rule changes. It has a different effective date, affected population, and eligibility pathway. Source: DSS Medical Assistance Program Oversight Council (MAPOC) Presentation, September 11, 2026.

HUSKY D: What Changes January 1, 2027?

Four shifts for HUSKY D adults — details follow on the next slides

NEW HUSKY D WORK RULE

For certain adults enrolled in HUSKY D, maintaining eligibility will require one of the following:

- Meeting the work rule through income or qualifying activities;
- Being a specified excluded individual for whom the rule does not apply; or
- Qualifying for an exception that deems the individual compliant for the relevant month.

APPLICATION

For a HUSKY D applicant who is subject to the rule:

- Connecticut's current provider guidance calls for a 1-month lookback at work-rule compliance
- Note: New rules apply to new applications beginning January 1, 2027

RENEWAL

- **HUSKY D renewals move from every 12 months to every 6 months.**
- Connecticut materials describe a 6-month lookback at renewal to determine whether the individual met the work rule or was deemed compliant at least one calendar month during this 6-month period.
- Note: New rules apply to renewals beginning March 1, 2027

RETROACTIVE COVERAGE

Retroactive coverage for HUSKY D applications is reduced from 3 months to 1 month.

This is especially relevant in hospital settings where applications are often initiated after services are rendered to enable coverage for an acute event.

Separate Medicaid eligibility changes for certain non-citizens take effect October 1, 2026; those are distinct from the HUSKY D work-rule requirements addressed in this section. Approximately 4,000 non-pregnant adults are expected to lose Medicaid coverage. These individuals are not eligible for subsidized plans on the exchange (AHCT) starting 1/1/27 but can get hospital emergency services through Emergency Medicaid.

Who Is Subject to the Rule? — Specified Exclusions

POTENTIALLY SUBJECT TO THE RULE

Adults enrolled in HUSKY D, generally ages 19–64, who are not a specified excluded individual.

ALSO OUTSIDE THE WORK-RULE POPULATION

- HUSKY A, B, and C members are not subject to the HUSKY D requirement.
- The rule also does not apply to people under 19, age 65+, and those with Medicare A/B.
- Medicare is a mandatory exception under the federal rule and ordinarily makes an individual ineligible for HUSKY D in Connecticut.

SPECIFIED EXCLUDED INDIVIDUALS

For these individuals, the work rule is not a condition of eligibility:

- Former foster care youth under age 26
- American Indian or Alaska Native
- Parent, guardian, caretaker relative, or family caregiver of a dependent child under age 14, or of an individual with a disability
- Veteran with a total VA disability rating — CT materials describe 100% schedular or TDIU
- Medically frail or otherwise having special medical needs — see next slide
- Already compliant with TFA/TANF work requirements
- Member of a SNAP household who is not exempt from the SNAP work requirement
- Participating in a recognized drug or alcohol treatment and rehabilitation program
- Currently an inmate of a public institution
- Pregnant or entitled to postpartum Medicaid coverage

Technical definition — caregiver exclusion: Federal rules permit more than one qualifying caregiver. A qualifying family caregiver may live with the dependent person, be a qualifying relative providing regular care while living elsewhere, or—if neither related nor co-residing—provide at least 80 hours of assistance per month.

Exclusion = threshold determination. If DSS determines the person is a specified excluded individual at application or renewal, DSS does not assess work-rule compliance for the review period.

Medical Frailty: A Specified Exclusion With a Two-Part Test

THE FEDERAL TEST

An individual is medically frail or has special medical needs only when:

1. The person has a qualifying condition, including:

- Blindness or disability under Social Security Act §1614
- Substance use disorder — excluding stable recovery of 5 years or more
- Disabling mental disorder
- Physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living
- Serious or complex medical condition

AND

2. The physical, mental, or behavioral condition "significantly impairs" the individual's ability to comply with the work rule.

Key point: A diagnosis alone is not sufficient. CMS's interim final rule created this two-part analysis. DSS states it will use claims from the prior 12 months as part of its analysis.

SERIOUS OR COMPLEX CONDITION

The federal definition includes conditions that may be:

- Life threatening or seriously disabling
- Associated with significant pain or disruption of life activities
- Requiring substantial caregiver time
- Requiring frequent monitoring
- Affecting multiple organ systems
- Requiring tightly controlled physiological parameters
- Requiring coordination among multiple specialties
- Requiring treatment carrying significant complication risk
- Requiring adjustment of non-medical environments

TWO SUD PATHWAYS

Medical frailty based on SUD

- SUD is a qualifying medical-frailty condition.
- The person must also satisfy the significant-impairment test.
- "Stable recovery" of 5+ years does not qualify on this pathway.

Active treatment

- Participation in a recognized drug or alcohol treatment and rehabilitation program is a separate specified exclusion.
- It does not depend on the medical-frailty impairment test.
- DSS cites outpatient counseling and medication-assisted treatment as examples; AA and NA alone are not recognized programs here.

Operational point: The state must maintain an auditable list of qualifying conditions and provide a process for someone with a condition not on the list to seek consideration.

How an Applicable Individual Can Be Compliant

TWO WAYS AN APPLICABLE INDIVIDUAL CAN SATISFY A MONTH

A. DEMONSTRATE THE WORK RULE

Meet at least one of the following:

- **Monthly income ≥ $580** — 80 hours × $7.25 federal minimum wage
- **80+ hours of work** — paid work, work in exchange for goods/services, or other unpaid work
- **80+ hours community service or volunteer work** — must be through a structured public or nonprofit program that oversees the activity and can track and confirm activity, dates, and hours
- **80+ hours in a qualifying work or training program**
- **Enrollment at least half-time in a qualifying educational program**
- **A combination of qualifying activities totaling 80 hours**

Technical details:

– A seasonal worker can qualify based on average monthly income over the preceding six months.

– If monthly earnings are below $580 and actual hours are unavailable, the State may convert earnings to hours by dividing income by the federal minimum wage; those hours can be combined with other activities.

– Less-than-half-time education may contribute actual hours spent in class or educational activities toward an 80-hour combination; half-time enrollment independently satisfies the educational pathway.

B. BE DEEMED COMPLIANT — EXCEPTIONS

The individual remains an applicable individual, but the month counts as compliant.

Mandatory exceptions

- If, for part or all of that month, the person was under age 19; had Medicare Part A or B; was in one of the specified mandatory Medicaid eligibility groups; or was a specified excluded individual during that month, even if that exclusion no longer applies when DSS later reviews the case.
- If the person was an inmate of a public institution at any point during the 3-month period ending on the first day of the month being assessed.

Short-term hardship exceptions

- **Receipt of inpatient or similarly acute services**, including inpatient hospital, nursing facility, ICF/IID, inpatient psychiatric hospital, and certain other services of similar acuity;
- **Extended travel outside the community** for necessary treatment of a serious or complex medical condition, either for the individual or a dependent, when the needed services are unavailable in the community.
- **Residence in an area** affected by a qualifying federally declared emergency or disaster or an area meeting the federal unemployment threshold

Excluded now: the rule does not apply. **Exception during a reviewed month:** the rule applies, but that month is treated as compliant.

When and How Compliance Is Checked

1 | APPLICATION

For an applicant who is subject to the rule:

- A 1-month lookback.
- DSS first determines whether the person is a specified excluded individual.
- If not excluded, DSS determines whether the person met a qualifying activity/income test or was deemed compliant through an exception.

2 | COVERAGE PERIOD

- Members are not required to submit monthly compliance reports to DSS
- Connecticut's current process checks compliance only at application and at the six-month renewal; **there are no interim checks**

3 | RENEWAL

Current Connecticut provider guidance describes:

- A 6-month review period.
- Verification that the individual met the requirement or was deemed compliant during at least one calendar month in that review period.

Before asking the member for information, DSS must first check all reliable information available to the state.

This automatic check of available information is referred to as ex parte verification (see next slide)

4 | IF DSS CANNOT VERIFY

DSS must issue a notice of noncompliance and provide:

- 30 calendar days from receipt of the notice for the client to show the work rule was met, an exception applied, or the person was a specified excluded individual.
- Continued Medicaid coverage for an enrolled beneficiary until the eligibility determination is completed.
- Determination whether the individual qualifies for Medicaid under another eligibility category.
- Fair-hearing rights and the ability to reapply; federal rules prohibit a lockout period based on prior noncompliance.

DSS Ex Parte Verification: Use Existing Data Before Asking the Member

FEDERAL SEQUENCING REQUIREMENT

Before requesting additional information from an applicant or member, DSS must use all reliable information available to the State to determine whether the person:

- Is a specified excluded individual;
- Is deemed compliant through an exception; or
- Demonstrated compliance through work, income, education, or another qualifying activity.

Reliable information can include electronic data sources, other state/federal records, eligibility files, payroll data, and the prior 12 months of relevant claims and encounter data.

DSS: current ex parte / data-driven methods

- wage records
- SNAP beneficiary/work-rule status
- SSI
- student status,
- medical frailty
- other eligibility factors

MEDICAL FRAILTY — DSS PLANNED CLAIMS ALGORITHM

DSS describes a two-step algorithm:

1. Qualifying condition — medical frailty

- Built from CMS Chronic Condition Data Warehouse codes and diagnoses used in other states' Alternative Benefit Plans
- Reviewed by multiple physicians
- Intended to identify conditions that are not easily cured, are likely to last at least six months, require ongoing care, and limit ability to work at moderate-to-high severity
- Approximately 6,000 distinct ICD-10/NDC/HCPCS codes in the planned algorithm

2. Severity indicator — significant impairment

- At least one of: any inpatient hospitalization, or 2+ qualifying outpatient procedures reflecting moderate-to-high clinical intensity
- DSS identifies 287 CPT/HCPCS severity-indicator codes and a 12-month lookback at adjudicated claims, paid or denied

If ex parte data are not enough: DSS may then seek information from the individual. The interim federal rule permits self-attestation or other qualifying statements during CY 2027 in circumstances described by the rule; DSS has indicated that final documentation and verification procedures are still being developed.

Medical Frailty – Planned Algorithm

Preliminary and subject to change

DSS's planned medical frailty algorithm applies a two-prong test: a qualifying condition indicating medical frailty AND a qualifying severity indicator showing significant impairment in the ability to work.

1. Qualifying condition

Indicating "medical frailty"

CMS's Chronic Condition Data Warehouse (CCW)
>7,300 ICD-10 diagnosis codes

Other diagnoses in Alternative Benefit Plans (ABPs)
from other states' plans

Independently reviewed & reconciled by multiple physicians

Approximately 6,000 distinct ICD-10, NDC and HCPCS codes

Each code must meet all three criteria:

Not easily curable with treatment **AND** Likely to last 6 months or longer **AND** Likely to require ongoing medical care or limit ability to work

2. Qualifying severity indicator

Indicating "significant impairment"

500 most frequently billed CPT/HCPCS codes*
Associated with qualifying diagnoses

Independently reviewed & reconciled by multiple physicians
Indicative of moderate-to-high clinical intensity (e.g., evaluation & management visits, level 3+)

287 CPT/HCPCS codes

Used to indicate "significant impairment":

Any inpatient hospitalization **OR** 2+ outpatient procedures requiring moderate-to-high clinical intensity

Lookback: 12 months

Claims types: Paid or denied

* 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.

Medicaid Work Requirements: August Impact Analysis*

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 *Using 6,539 medical diagnosis codes*	133 k	42%
Wage records *Monthly income at least 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*	34 k	11%
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

Members can appear in multiple categories

**Preliminary estimates - subject to change: Adapted from DSS reported data, updated as of August 2026*

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.

KEEP YOUR HEALTH COVERAGE FAILURE POINT FRAMEWORK

Mapping points of vulnerability and complex challenges that may increase the risk of coverage loss and complicate prevention strategies.

WHERE COVERAGE CAN BE LOST — THE SIX POTENTIAL FAILURE POINTS

POPULATION SEGMENTS (Who's most at risk)	1 INITIAL APPLICATION Apply for HUSKY D and clear the prior-month work/community engagement check	2 RENEWAL NOTICE Receive renewal and noncompliance notices with response requirements	3 EXEMPTIONS Document eligibility for exclusions or hardship exceptions	4 WORK RULES Engage in qualifying activities to meet the hours or income threshold	5 REPORTING & VERIFICATION Document and verify hours or exemption status	6 CURE PERIOD Receive renewal and noncompliance notices with response requirements
COMPLEX NEEDS **Highest acuity** Frailty, SUD, LTSS, housing	Medical frailty, SUD treatment, or LTSS not identified or documented at application	Renewal packet misses an unstable address; too dense to act on alone	Missed or undocumented exclusions (frailty, SUD, LTSS, etc.)	Unable to meet requirement due to unstable housing, mild health or cognitive challenges	Cannot navigate complex digital systems; lacks digital access or skills	Can't act on the cure notice alone; needs a navigator before the window closes
WORKING MEMBERS **Largest group** Variable hours, caregiving	Prior-month work or income hard to document for variable, seasonal, or gig hours	Misses the renewal deadline; needs help to gather and return proof	Confusion about exclusion rules and hardship exception criteria	Variable or inconsistent work hours; caregiving responsibilities	Misses reporting cycles; difficulty tracking or submitting	Unsure what proof resolves noncompliance; little time to cure
UNDERSERVED POPULATIONS **Place-based and Social barriers** Limited transport, broadband, jobs	Applies through a hospital in a month that misaligns the lookback; hard to reach after discharge	Notice never arrives or isn't in the member's language	Hardship exceptions not available or inconsistently applied	Limited job opportunities; transportation or childcare barriers	Limited digital infrastructure; no internet access	Cure notice arrives late or unread; no trusted local help in time

INTERVENTION LAYER (What Must Be Built)

MITIGATION SUPPORT (CHW / Navigators)

- Outreach and enrollment help
- Care management
- Cultural/linguistic responsive support

REPORTING SUPPORT

- Easy-access reporting tools
- Multilingual reporting channels
- In-person support for applications

OUTREACH & TRUSTED MESSAGING

- Plain-language notices
- Multilingual communication
- Trusted messengers and reminders

ACCESS PATHWAYS (Childcare / Transport / Digital)

- Connect to care or childcare
- Transportation assistance
- Digital access points & local programs

OUR GOAL Prevent avoidable coverage loss by co-designing solutions with the people and communities most affected — advancing equitable, outcome-driven strategies that sustain access and eligibility.

Complete Failure Point Framework, available here

Materials to Support Outreach and Education

1

HUSKY D Messaging Starter Kit

Patient- and provider-facing materials including flyers, posters, FAQs, and digital content in English, Spanish, and Portuguese — ready to download, modify, and co-brand.

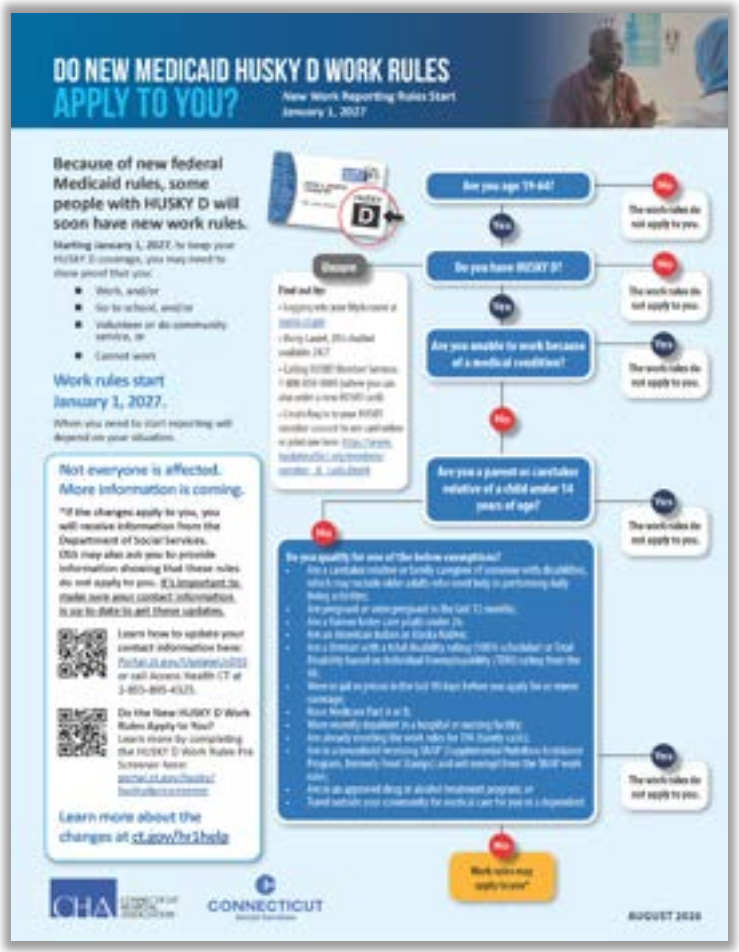
2

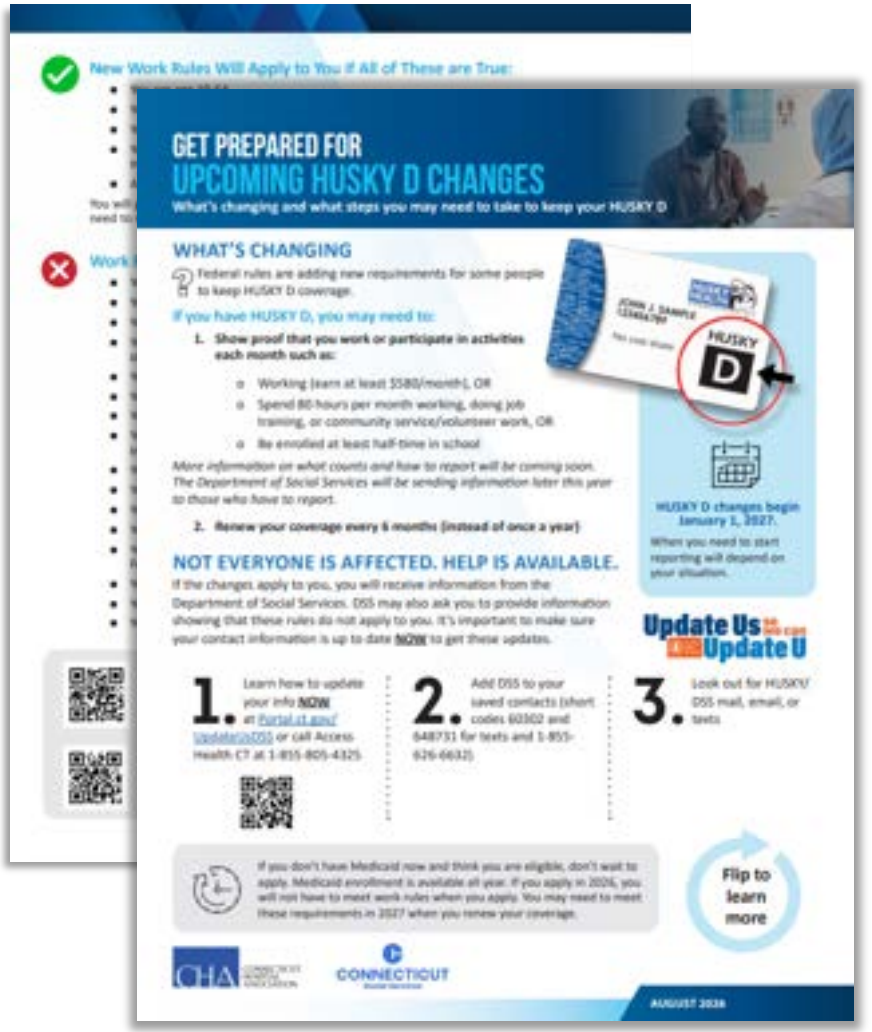
HUSKY D Work Rules Outreach and Education Guide

Step-by-step guidance and quick implementation checklist for putting the Starter Kit to work in clinical and community settings.

Materials can be found on CHA's website at cthosp.org/huskyd
Materials were first released in May and updated August/September

HUSKY D Messaging Starter Kit Materials





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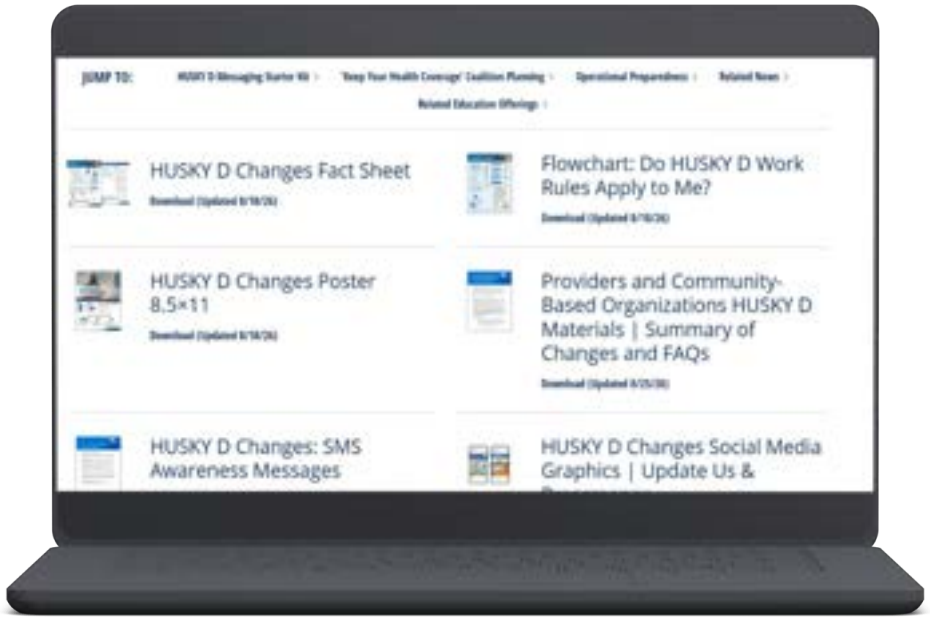
HUSKY D Messaging Starter Kit Materials

- Materials can be downloaded, modified, and co-branded
- Includes Patient-Facing and Provider-Facing materials
- Available in **English, Spanish, and Portuguese**



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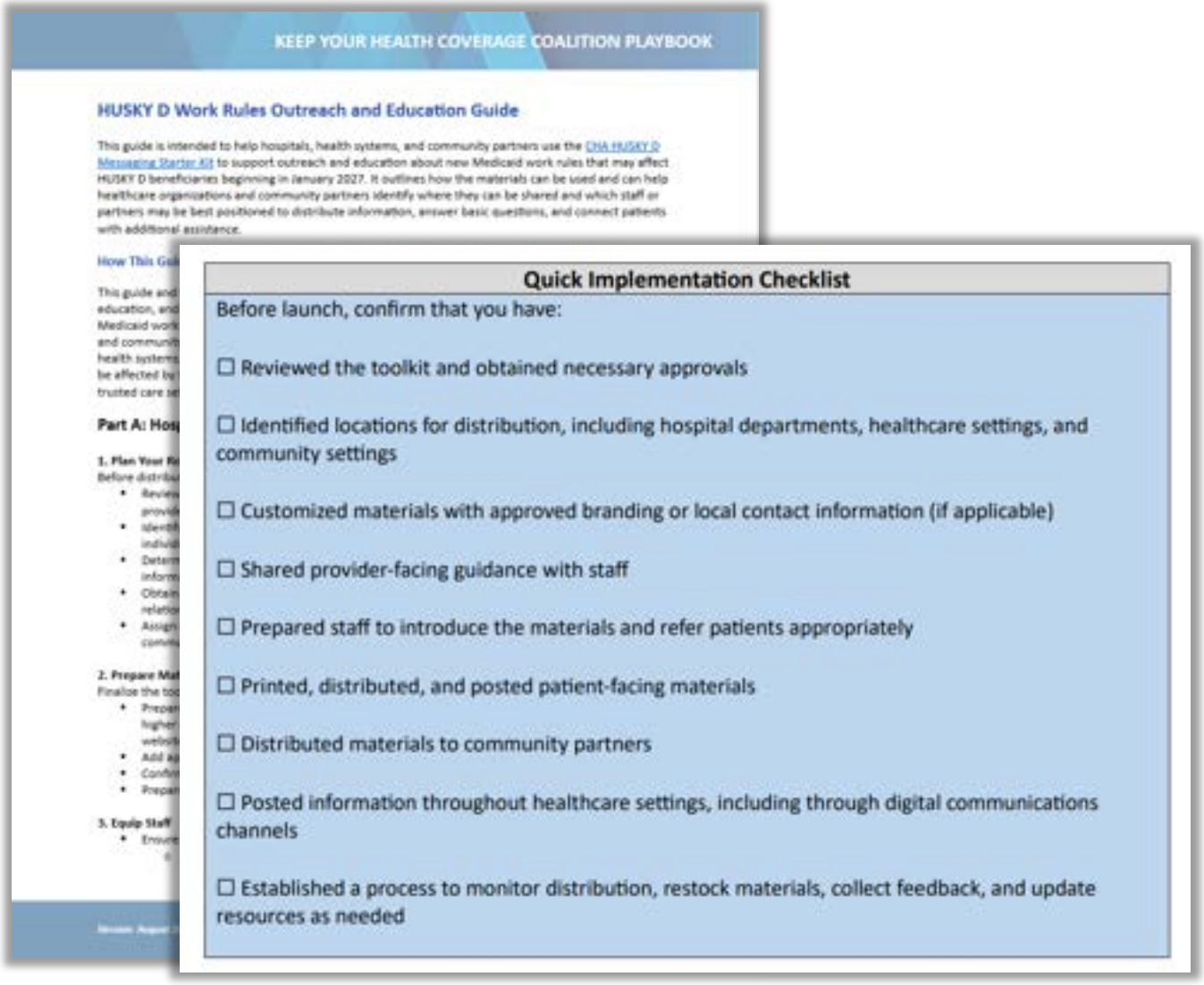
HUSKY D Work Rules Outreach and Education Guide

This guide is intended to help hospitals, health systems, and community partners use the CHA HUSKY D Messaging Starter Kit to support outreach and education about new work rules.

- Outlines how the materials can be used
- Can help identify where they can be shared
- Can help identify which staff or partners may be best positioned to distribute information, answer basic questions, and connect patients with additional assistance


KEEP YOUR HEALTH COVERAGE COALITION PLAYBOOK

HUSKY D Work Rules Outreach and Education Guide

This guide is intended to help hospitals, health systems, and community partners use the CHA HUSKY D Messaging Starter Kit to support outreach and education about new Medicaid work rules that may affect HUSKY D beneficiaries beginning in January 2027. It outlines how the materials can be used and can help healthcare organizations and community partners identify where they can be shared and which staff or partners may be best positioned to distribute information, answer basic questions, and connect patients with additional assistance.

Quick Implementation Checklist

Before launch, confirm that you have:

- ☐ Reviewed the toolkit and obtained necessary approvals
- ☐ Identified locations for distribution, including hospital departments, healthcare settings, and community settings
- ☐ Customized materials with approved branding or local contact information (if applicable)
- ☐ Shared provider-facing guidance with staff
- ☐ Prepared staff to introduce the materials and refer patients appropriately
- ☐ Printed, distributed, and posted patient-facing materials
- ☐ Distributed materials to community partners
- ☐ Posted information throughout healthcare settings, including through digital communications channels
- ☐ Established a process to monitor distribution, restock materials, collect feedback, and update resources as needed

Outreach and education materials can be found on CHA's website at cthosp.org/huskyd

Outreach Guide: How Clinical Teams Can Use the Materials

Purpose: Raise awareness, give patients written information, and connect them to help.

BEFORE ROLLOUT

- Review the full HUSKY D Messaging Starter Kit.
- Identify clinical and administrative touchpoints most likely to reach affected HUSKY D members.
- Add approved local contact and referral information, if applicable.
- Assign owners for distribution, staff education, digital communications, and updates.

PREPARE STAFF

- Share provider guidance, FAQs, talking points, and referral pathways.
- Train staff to introduce the issue clearly, neutrally, and supportively.
- Confirm staff know where to access the most current materials.
- Identify an internal contact for staff questions.

Source: Outreach guide, Part A.

Outreach Guide: What Staff Should Do With Patients

USE THE FLYER AS THE ANCHOR

- Give patients a flyer rather than relying only on verbal explanation.
- Highlight two or three key points.
- **Reinforce: not everyone is affected.** *These materials don't determine eligibility and are intended to raise awareness and connect to resources.*
- Encourage patients to update contact info with DSS/AHCT and watch for official notices.
- Direct individualized questions to eligibility, financial counseling, enrollment, navigation, or other approved support.

WHERE TO USE MATERIALS (Examples)

- Registration and front desk
- Patient financial services
- Outpatient clinics and exam rooms
- Pharmacy areas
- Discharge planning
- Patient portal, appointment reminders, discharge packets, and billing assistance materials

SAMPLE SCRIPT

"Some HUSKY D rules are changing. Not everyone will be affected, but this flyer explains what we know so far and the steps you can take now. Please make sure DSS has your current contact information."

Discussion

Open floor — your questions, the gaps we have not covered, and what you are doing now

What we covered: What changes January 1, 2027 · who is subject and who is excluded · medical frailty · how a month is satisfied · when and how DSS checks · ex parte verification · outreach tools and the messaging starter kit

1

What questions do you have?

Rules, timelines, or how a specific patient situation is treated.

2

What issues are unaddressed?

Gaps in the guidance, operational unknowns, or data you still need.

3

What are you doing today to prepare?

Workflows, staffing, patient outreach, and documentation practices already underway.

We recommend identifying workflow changes your organization can start before January 1, 2027.