

HUSKY and work requirements – How to make it work

Updated: June 30, 2026

Overview

Connecticut faces significant health and social service challenges from the federal budget bill, HR-1, that passed in July 2025. **Only thorough, user-centered, and well-supported state implementation can prevent the troubles seen elsewhere and protect state residents' health and financial stability.**

Background

Among other things, [the federal HR-1 budget bill mandates work requirements](#) for many Medicaid members. **By 2034, 137,000 people in Connecticut could lose Medicaid coverage due to the work requirements**, potentially raising uninsured rates to a 20-year high.

- The state stands to lose up to \$118 billion in federal funding over the next ten years.
- **Connecticut's Medicaid program is [a national leader](#) in quality, access, and cost control. Federal cuts threaten that progress.**

Who Is Affected

- **The HR-1 work requirement applies to adults who gained Medicaid starting in 2014 though the Affordable Care Act expansion, covered under [HUSKY Part D](#) in Connecticut.** Over 300,000 adults in Connecticut must meet the new requirements.
- **The work requirements do not apply to other HUSKY members** including people covered by [HUSKY Parts A, B or C](#).
- Thankfully, **HR-1 includes some exemptions to work requirements.** Pregnant people, caregivers for children under age 14 or people with health conditions, some past foster youth, those in drug/alcohol treatment, current/former inmates, in school or training programs, those with disability/medical frailty, and people covered by certain other public programs are not subject to the work requirement.
- **The changes place a [massive new burden](#) on state Medicaid agencies. By January 1st, they must reprogram eligibility systems, find reliable data sources for verification, redesign the consumer portal and applications, update user manuals and train staff, and educate members on who is affected and what they need to do. There must be sufficient time for testing the system to avoid errors. Also starting in January, states must review HUSKY Part D members' eligibility every six months rather than the current one-year schedule.**

- The federal [Interim Final Rule \(IFR\)](#) guiding states on the details of implementation were published by the Centers for Medicare and Medicaid Services (CMS) on June 1, 2026. Much of the IFR regulations address how people can comply with work requirements or qualify for an exemption and how the state can verify compliance.
- Unfortunately, states have only a few months and few resources to implement and educate members about these complex changes. In contrast, states were given far significantly more guidance, time, and resources to implement the Affordable Care Act's changes and to unwind Medicaid eligibility after COVID.
- Twenty five states, including Connecticut, and the District of Columbia, have [filed a lawsuit](#) against the federal Medicaid administration for going beyond the language of the law
- Most HUSKY adults are already working or qualify for an exemption, but the verification challenges are likely to result in many people incorrectly losing coverage.

Work Requirement Details

- Beginning January 1, 2027, HUSKY Part D members must work, study, or volunteer a combined 80 hours/month (earning at least \$580 minimum monthly income), or document that they are exempt.
- HUSKY D members will have to document their exemption every six months, twice as often as current redeterminations.
- [It is estimated](#) that 66% of HUSKY D members are working or in school for 80 hours/month, meeting the HR-1 work requirement.

Anticipated Impact

- **Major coverage losses are expected due to red tape, especially among those with chronic illnesses.** Almost nine in ten Americans affected by the work requirement have chronic conditions, rising to 97% for people ages 50-64.
- Economic fallout includes an expected **loss of 2,100-2,900 Connecticut jobs** and a **contraction of up to \$950 million in Connecticut's economy**, mostly in healthcare.
- **Implementing work requirements will be very costly for Connecticut; federal funds are not sufficient to cover the cost.**

Experience in Other States

- Only Georgia and Arkansas have tried Medicaid work requirements. In both states, **few people were able to comply, and administrative costs were very high.** In Arkansas, thousands lost coverage, while almost all of them should have been exempt, and there was no improvement in employment rates or hours worked.
- **Key issues included confusion, technical failures, long wait times, and administrative burdens, especially for exempt populations.**

Connecticut's Strengths and Weaknesses

- **Strengths:** Connecticut Medicaid does very well in application processing, renewals, and using data to verify eligibility, which minimizes unnecessary paperwork. Connecticut's Medicaid call center wait times have improved considerably.
- **Weakness:** Call Center demand will increase when people need help with work requirement compliance. Also, verification of the caregiving exemption in other Connecticut programs has been problematic. **Resources devoted to essential communications are not sufficient.**

Policy Recommendations

- **Reduce Administrative Burden:** Use all available options for compliance and verification. Streamline administrative hurdles for both HUSKY members and for DSS staff.
- **Continue to Improve Call Center Performance:** DSS deserves credit for improving their Benefit Call Center performance for SNAP, cash assistance and complex cases by hiring and training new staff and updating the system. Wait times and callers giving up are down significantly. **But disconnecting from calls after ten minutes will leave many people without the assistance they need to comply with the changes.**
- **Data:** Use a variety of data sources, including paid services, to verify earnings and exemptions.
- **Consultants:** To limit costs and improve long-term performance, use consultants sparingly and for short terms. Limit roles for consultants. Build internal DSS capacity to address the needs.
- **Outreach:** Effective outreach and communications are critical to clearing up confusion. Use clear, simple communications at a fourth grade reading level. Prioritize direct, community-based outreach with trusted partners. Repeat information across all channels. Provide trusted sources for assistance with reporting located in communities.
- **Support for Exemptions:** Streamline processes for documenting caregiving, medical frailty, and other exemptions. Allow broad sources of verification beyond clinicians, especially include people who visit the patient's home to assess the needs.
- **Employment Support:** Connect members with individually tailored job training, transportation, and employability supports. Connect state agencies, employers, **schools, job training,** and community groups to build effective job pipelines.
- **Continuous Evaluation:** Collect and publicly report monthly detailed performance data, including outcomes, barriers, challenges, and best practices. Respond rapidly to data findings, expand best practices, and fix problems.
- **Prepare Connecticut's Healthcare System:** Recognize that increased uninsured rates will drive up uncompensated care costs and lower access to care, affecting all state residents. Work with providers planning now.

Lessons from Other Sectors and States

- **Build on what already works.** Connecticut's experience with SNAP work requirements and COVID unwinding is encouraging. Don't replicate failures seen in Arkansas and Georgia.
- **Avoid over-reliance on mass media.** "Word of mouth" and community organization partnerships are most effective for outreach.
- **Recognize the importance and challenges of the caregiving exemption.** Publicize the exemption. Streamline documentation and support caregivers.

Critical, proactive improvements will be needed to address this crisis. **Connecticut is preparing now to minimize harm.** It's important to build data-driven, continuous improvement and targeted outreach to high-risk and marginalized groups, including older adults, people with disabilities, language barriers, and chronic conditions.

KFF has an excellent [work requirements tracker](#), with a Connecticut page.

DSS has begun outreach to members and stakeholders on the changes. Information for members on the changes is on DSS's [HR-1 website](#). The site includes a very helpful [pre-screener](#) for members to understand if they are affected and leads to resources for assistance and help to comply.

To ensure all members are notified of their specific circumstances, DSS is reaching out to members to [update their contact information](#).

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HUSKY and work requirements – What do we know?

Editor's note: Research findings are repeated across this report as needed, allowing readers to skip to relevant sections.

Background

The federal budget bill, HR-1, passed on July 4, 2025. The law is controversial and likely faces numerous challenges in court. Experts expect that 150,000 Connecticut residents [will lose healthcare coverage](#) across programs, most from Medicaid. **This will bring our state's uninsured levels to the highest rate in two decades.**

The law's impact on Medicaid is profound. As of January 2026, [it is expected that](#) between 78,000 and 128,000 Connecticut Medicaid members will lose coverage by 2034. It is [also estimated](#) that Connecticut will lose \$118 billion in federal funding by 2034.

We have a lot to lose. Connecticut's Medicaid program is [a national leader](#) in quality, access, and cost control. Federal cuts threaten that progress.

It is likely that [most Medicaid losses](#) will be due to mandatory new work requirements for members who became eligible under the Affordable Care Act (ACA) Medicaid expansion, HUSKY Part D in Connecticut. In 2014, Connecticut was the first state to expand Medicaid through the ACA to childless adults. [All but ten states](#) have now exercised that option.

[HR-1 requires](#) that 316,000 HUSKY members eligible under the ACA expansion (HUSKY Part D) are [working for pay, volunteering, in school, or fit into a list of exemptions](#) to keep their health coverage. Exemptions include pregnancy, former or recent foster youth, and caretaking for a child under age 14 or a disabled individual. Unlike other members, eligibility for HUSKY Part D members will need to be redetermined twice a year under HR-1.

Under HR-1, Medicaid work requirements will be implemented January 1, 2027. **[As the regulations on how to implement the new requirements were only published earlier this month, states have been doing their best since the bill passed to prepare.](#)**

[Parts of the regulation were a surprise to states, particularly the process to qualify as medically frail. States must not only identify members with serious medical conditions but also verify that their condition prohibits them from work. Existing processes to verify an inability to work for other purposes are complex, lengthy, and vary a great deal. The regulations give states no guidance on how to verify members' inability to work but does include a threat that getting it wrong could have significant budget impacts for states.](#)

The federal Medicaid cuts are also expected to result in downstream harms. [It is estimated](#) that Connecticut's economy will contract by \$678 to \$950 million next year due to HR-1, and we will lose 2,100 to 2,900 jobs, mainly in healthcare.

What is the Medicaid work requirement?

DSS has an excellent [pre-screener](#) to help members understand if they are impacted by the work requirements.

What is it:	Must work earning at least \$580/month, be enrolled in school, or volunteer in their community for at least 80 hours/month, (can combine categories to reach 80 hours) for at least one month before enrolling or renewing HUSKY
Who it applies to:	316,000 Connecticut ACA expansion Medicaid members, HUSKY Part D in Connecticut
Exemptions:	Disability, medically frail and unable to work , caring for a child under age 14 or someone with a serious medical condition , former or current foster youth under age 26, current or recent inmate in a public institution, participating in drug or alcohol treatment, pregnant or postpartum, enrolled in SSI, SSDI, SNAP, TANF, or Medicare
How often to verify:	Currently, the state must verify, or redetermine, Medicaid members' eligibility once a year. HR-1 requires twice-yearly redeterminations, including the complex work requirements, but only for HUSKY Part D members, the ACA expansion population.
When it starts:	January 1, 2027

Note: \$580 equals 80 hours at the current federal minimum wage. Reaching the \$580 monthly standard would take 34 hours at Connecticut's minimum wage (for 2026). However, applicants and enrollees must not exceed \$1,836/month for a single person to maintain eligibility for HUSKY Part D (2026). That is 108 hours/month at Connecticut's [minimum wage](#) (\$16.94/hour) and 107 hours/month at Connecticut's average wage working for [Amazon](#) (\$17.09/hour).

More information on work requirements is [here](#), [here](#) and [here](#). More information on other provisions of HR-1 [are here](#).

The number of Connecticut residents affected by town [is here](#).

Connecticut Medicaid population at-risk under work requirements

Connecticut's ACA Medicaid expansion covers 328,002 [Connecticut residents](#), mainly childless adults. To qualify this year, they **must have annual incomes below \$22,032 for a family of one or \$29,868 for a family of two**. The work requirement will apply to all of this group. [According](#)

to [DSS](#), almost all (97%) are ages 18 to 64. The program covers slightly more men (56%) than women (43%).

The [most recent analysis](#) by DSS from June 2026 estimates that 35% or 110,000 Connecticut Medicaid members are at risk of losing coverage.

According to [a KFF report](#), just **one third (36%) of Connecticut adults covered by Medicaid were not working in 2023. The most common reason given for not working is caring for home or family.**

Connecticut Medicaid adults that are working (2021, all adults)

- 212,100 total
- Average 33.6 hours/week
- 71% have a high school diploma

Where Connecticut Medicaid adults are working

- 20% work in retail jobs
- 20% work in health care and social assistance
- 10% work in accommodation or food service jobs
- 10% self-employed
- 7% work in manufacturing
- 7% work in educational services

Ages of Connecticut Medicaid workers

- 19-34 years 45%
- 35-49 32%
- 50-64 23%

Source: [Medicaid Enrollees Who are Employed: Implications for Unwinding the Medicaid Continuous Enrollment Provision](#), ASPE, accessed 7/17/2025

Many in this population have multiple chronic conditions. The [most recent analysis](#) by DSS from June 2026 found that 206,000 HUSKY D members may be exempt due to medical frailty. For the estimate, DSS searched Medicaid claims for thousands of diagnostic codes previously approved by CMS for medical frailty exemptions in other state programs and codes that fit into the definition in HR-1.

A national study recently [published in JAMA](#) found that 87% of Americans subject to Medicaid work requirements have at least one chronic condition; that number rises to 97% for those ages 50 to 64 years. Most are taking prescription drugs, likely to manage those conditions. If they lose Medicaid coverage, they will lose access to those medications, putting them at risk of worsening health outcomes, costly ED visits, and hospital admissions.

	Total pop %	Ages 50 to 64 %
Number of chronic conditions		
0	13.2%	3.0%
1-2	45.7	30.7
>2	41.1	66.3
Number of prescriptions		
0	35.6%	18.7%
1-4	52.3	62.3
>4	12.1	19.0
Source: Clinical Characteristics of Adults at Risk of Medicaid Disenrollment Due to HR 1 Work Requirements , JAMA, 10/1/2025		

Learning from other states, other programs

Just two states have implemented Medicaid work requirements, and **it hasn't gone well**.

Georgia is the only state currently operating a Medicaid work requirement program, beginning in July 2023. As of January 31, 2026, the [Georgia Pathways to Coverage](#) program had **enrolled only 14,001 of the estimated 250,000 eligible state residents**. It has **cost taxpayers \$132 million in total program costs**. [Problems have included](#) the enrollment portal repeatedly crashing, inability to confirm applicants' work status, very long waits on the helpline, unreturned voicemails, widespread misunderstandings about the program, state understaffing, and a massive backlog of applications.

Arkansas's Medicaid work requirement began in June 2018 and ended ten months later when a federal court ended the program. **It failed on every goal**. A [study found](#) that **in the first year 17,000 Arkansans were dropped from the program, the state uninsured rate for people ages 30 to 49 years rose by 4%, and there was no increase in either employment rates or hours worked in the affected population**. [Another study](#) of two-year impacts of Arkansas's work requirement found that, by the end of the program 18,000 people had lost Medicaid coverage and employment hadn't increased. **The researchers also found half of the affected population had difficulty paying medical debt, 56% delayed care, and 64% delayed taking medications due to cost**.

Both studies found mass confusion among Medicaid members, providers, and community organizations about who was subject to the work requirement, how to document compliance, and how to access help.

Implementing work requirements in Connecticut will be expensive. [According to the US Government Accountability Office](#) (GAO), costs for previous states' work requirements with population sizes similar to Connecticut ranged from \$35 million to \$272 million. [HR-1 only devotes \\$200 million](#) in total in 2026 for all 50 states to administer work requirements.

The independent Arkansas Center for Health Improvement conducted an excellent, very useful evaluation of their experience with Medicaid work requirements. The [Arkansas Medicaid Work and Community Engagement Requirement: Community Response Report](#) outlines barriers encountered and how the state addressed them, in very practical terms. **The report found that 95% of people who lost Medicaid coverage in Arkansas were compliant with the work requirement or exemptions and never should have lost coverage.** The report details what worked and what didn't in communications, outreach, making the reporting process user-friendly, reporting assisters, the Call Center, engaging community organizations, data tracking, and how to protect at-risk populations including people with disabilities and homeless people. Lessons from Arkansas are woven throughout this report. Strongly recommended reading.

A [recent assessment](#) by the Georgetown McCourt School of Public Policy of states' readiness for work requirements found that **more than half of states are not ready to implement Medicaid work requirements. Connecticut performs above the US average on six of eight performance metrics**, according to the researchers.

In response to the challenges of implementing HR-1, DSS has [significantly improved](#) the Benefits Call Center performance by hiring and training new staff and updating the system. Wait times and callers hanging up without receiving help are down significantly. **However, the new system requires callers to choose a call-back option, or their call will be disconnected at ten minutes.**

Connecticut Medicaid did very well in facing a similar challenge. Starting in April of 2023, eligibility protections after COVID ended and states had to review eligibility for all members. **Connecticut performed very well among states in this “unwinding” with only 17.9% of members disenrolled, the 5th lowest in the US.** Eligibility for the large majority was verified by matching data sources, without needing member documentation (ex parte). [According to Connecticut's Office of Legislative Research](#), DSS engaged partners in helping educate members on the process with toolkits, webinars, flyers (in English and Spanish), billboards, bus ads, text messages, and other publications. **Medicaid administrative services organizations (ASOs) directed outreach to people at high risk of poor outcomes.** Most of those who lost coverage were in the ACA expansion population, who are also targeted by the new HR-1 work requirements.

What is currently working (or not) in Connecticut

It makes sense to build on and improve what is working in HUSKY. In contrast, creating costly, new systems failed miserably in Arkansas and Georgia. Starting over would also use precious tax dollars we will need to address HR-1 cuts for state residents and would waste staff time that is better spent addressing the increased demand.

Works -- [Changes to federal law in 1996](#) included a work requirement for food assistance. By all accounts, Connecticut's current work verification process for SNAP food assistance works well.

Connecticut legal aid reports very few SNAP cases (personal communication Matt Dillon, CT Legal Services). The state currently uses several data sources to verify earned income for SNAP recipients. When necessary, applicants can provide paystubs and other verification to document earnings.

Doesn't work – Qualifying for Connecticut's caregiving exemptions under SNAP work requirements is complicated and difficult. According to [AARP and the John A. Hartford Foundation](#), there are over 60,000 caregivers in Connecticut with incomes below \$25,000/year. For the caregiving exemption, members must download and print out a pdf form. The provider of the person they are caring for must complete the form and mail it to DSS. It's reported that Connecticut providers are hesitant to complete this process. We are very encouraged that DSS recently shortened the form from 12 pages to just two.

Requiring clinical healthcare providers to certify caregiving necessity is problematic. A [study found](#) correlations between physicians' willingness to certify qualified work requirement exemptions and the physician's political affiliation, the level of administrative burden, and physicians' perceptions of the applicant. The 2019 study surveyed practicing primary care physicians in the first states approved for Medicaid work requirement waivers. The study tested errors in both approving inappropriate requests and not approving appropriate requests.

Primary care providers are not the best source to verify caregiving need. Connecticut primary care providers are overwhelmed, adding to their administrative burden fuels burnout. Caregiving need depends on more than clinical status. Home environments are important to determining caregiving need, including one floor vs. multiple floors, stairs vs. elevator, laundry facilities in the home, and many other circumstances. Few clinical care providers are familiar with their patients' homes. There are multiple options for more appropriate certification sources. **For determining medical frailty, the IFR allows states to accept documentation from "many types of practitioners, including physicians, nurse practitioners, physician assistants, psychologists, counselors and therapists, clinical social workers, and other practitioners credentialed by the State, that are qualified to determine that an individual's condition qualifies them as medically frail or having other special medical needs under State scope of practice laws."**

Works – As described above, Connecticut Medicaid performed very well on redetermining eligibility during the COVID unwinding. The [state tracker](#) associated with the [Georgetown study](#) of state readiness for work requirements found that Connecticut is better than the US average in six of eight performance areas – application processing time, renewal rate, ex parte redeterminations (automatically determining eligibility by matching with data sources), disenrollment rate at renewal, procedural disenrollment rate, and pending renewals.

Much Better – The AccessHealthCT/DSS call center has historically had short wait times and call abandonment rates. As described above, DSS's Benefit Call Center has [made good progress](#) in reducing wait times including a new phone system and hiring more Call Center staff. However, demand for information on the complex work requirement and exemptions will tax both call

centers. Both DSS and AccessHealthCT are working on training and capacity to ensure that all callers get accurate, helpful information quickly from both call centers.

Best practices/what to avoid

Policy recommendations

To [minimize administrative burdens](#) on both HUSKY members and state staff, maximize [alternative eligibility pathways](#)

- Maximize ex parte verifications – using all available employment data sources, private sources (see below), DSS’s Medicaid claims data, and other state and federal agency sources.
- Use the shortest “lookback” option – HR-1 allows states to consider earnings and exemptions for just one month prior to application or redetermination.
- Maximize redetermination intervals, HR-1 allows states to redetermine every six months.
- Use the least burdensome verification methods.
 - [Accept self-attestation wherever possible](#) -- there is precedent in Connecticut Medicaid’s PCA waiver and Community First Choice programs and in state Alternative Benefit Plans (ABPs) [medical frailty exemptions](#).
 - **[Nebraska, which has elected to implement their Medicaid work requirement program early, is utilizing self-attestation for many verifications.](#)**
 - Allow longer durations for long-term exemptions (particularly medical/disability).
- Allow automatic approvals in stable cases, e.g. fixed retirement income, public program income.
- Maximize exemptions allowed under regulations.
- [Consider the unique needs](#) of older adults, caregivers, and people with disabilities.
- Ensure the system records all exemptions each member qualifies for, even if they meet the work requirement. If their circumstances change, DSS can follow up to determine if the other exemptions still apply.

Allow **maximum grace periods** for

- Members trying to get documentation -- Send multiple reminders via text, phone calls, email, and home visit, if necessary.
- Job loss or loss of hours – this recognizes the unstable nature of low-wage employment.
- If people lose transportation – a common barrier to employment.
- Other barriers such as illness or family emergency.

Arkansas Medicaid created **ongoing workgroup meetings with relevant agencies and critical consultants** (similar to HUSKY ASOs) to assess progress and gaps, and to develop solutions. This workgroup developed and implemented the communication plan. These regular meetings were critical to improving the system.

Communications

DSS has begun outreach to members and stakeholders on the changes. Information for members on the changes is on DSS's [HR-1 website](#). The site includes a very helpful [pre-screener](#) for members to understand if they are affected and leads to resources for assistance and help to comply.

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Lessons learned from Connecticut's experience and other states, [especially Arkansas](#).

- **Nebraska has a robust public education campaign for their early Medicaid work requirement program.**

- Center communications on people's lived experience.
- Expect mass confusion – Verifying employment and exemptions will be confusing, complicated and burdensome.
- Quality control in messaging will be critical. Be very clear about:
 - Which population it applies to (HUSKY Part D), who is not affected, and how to find out which population members belong to.
 - **When the work requirement starts for applications and redeterminations.**
 - What is at stake – consequences for not meeting the work requirement or verifying an exemption.
 - Exactly how to meet the requirement – step-by-step.
 - Where to get assistance.
- Expect many to be unaware of the requirement, despite multiple notices.
 - Many will not hear the messages, losing coverage will be a surprise to them, and potentially to their providers.
- Expect that your message will be overwhelmed by messages from within communities. Monitor for this and correct misinformation.
 - Community information is far more salient to members than official communications.
- Arkansas found that most community organizations were not strong partners, especially if healthcare is not their mission.
 - The strongest partners were providers who serve HUSKY members.
- Monitor understanding of communications through surveys and focus groups.
- Use effective language appropriate for different populations including older adults, caregivers, and people with disabilities.

“There is a ton of confusion around health insurance. DHS will send them a letter telling them that they need to do something regarding eligibility to keep their coverage and some of our members will disregard the letter because they think they do not have DHS Medicaid [Arkansas Works].”

[Arkansas Medicaid Work and Community Engagement Requirement: Community Response](#), ACHI

Messages

Monitoring in Arkansas found that literacy was a challenge, so they revised outreach materials to make them more clear.

- Target messages specifically to those affected (HUSKY Part D, childless adults) so as not to cause confusion.
- Use consistent terminology and language across all communications.
- Fourth grade reading level.

Members affected by work requirements need to understand the balance of working to meet the HR-1 requirement, and how much income will disqualify them from HUSKY coverage.

HUSKY eligibility and HR-1 work requirement monthly, for a single person, 2026		
HUSKY Part D eligibility income limit	Up to \$1,836	
	Minimum hours for work requirement	Maximum hours for HUSKY Part D coverage
At minimum wage	At least 34 hours	Up to 108 hours
Working for Amazon in CT	At least 34 hours	Up to 107 hours
Sources: CT Dept. of Social Services , CT Dept. of Labor , Zip Recruiter		

Modes of communication

- Arkansas developed a Microsoft SharePoint resource including county-specific guides for enrollees to locate employment and volunteer opportunities, education and training, and social service resources (e.g., shelters, food pantries), as well as information on accessing available public computers and/or Wi-Fi.
- Arkansas found that most successful outreach was by phone, email, and texts. Getting valid, updated contact information was a challenge.
- Use traditional and social media, websites, local transportation (buses, etc.).
- Offer flexible programming for outreach and education – in person, hybrid, and asynchronous.
- Send lots of reminders to the affected population. Especially follow up if they started verification but didn't finish or had too few hours to qualify. Even to the point of annoying them.

Community partners

Arkansas conducted an analysis of community organizations with relevant service offerings.

- They surveyed 100 organizations but only 32 responded. For many organizations, most of the people they serve were exempt – a lost opportunity for outreach.
- Only 12 of the 32 organizations knew about the work requirement.
 - Organizations that had prior involvement with Medicaid or SNAP were the most likely to know about the new requirement.
- Few organizations got any requests for assistance.
 - Only 10 of the 32 organizations reported having capacity to assist clients with the new requirements.
 - Assistance included calling or portal access, offering information, assistance with documentation, offer computer for public use, website navigation, work referrals, offer volunteer opportunities, skills development, work application assistance, and exemption documentation assistance.

- Surprisingly, medical clinics were the least likely to have knowledge about work requirements.
- Food pantries and local cooperative extension offices were also unaware.
- Libraries had good knowledge and understanding of the new requirement.
- Some staff believed that people looking for work would be able to find it.
- Arkansas worked with educational institutions for outreach to students, sharing the message that school hours count toward the work requirement.

Arkansas's SharePointe resource was very helpful with “county-specific guides for enrollees to locate employment and volunteer opportunities, education and training, and quality of life resources (e.g., shelters, food pantries), as well as information on accessing available public computers and/or Wi-Fi.” The site made it easy to find resources and updates in one place.

Community outreach

- Invest in developing a network of local, trusted partners.
- **DSS's plan to engage CHWs offering assistance in community settings is an excellent addition. Publicize these opportunities well and coordinate with broad, diverse, non-medical community opportunities such as food pantries, senior centers, and schools.**
- **The CT Hospital Association's HR-1 [outreach efforts and resources](#) are excellent.**
- Focus on organizations that serve Medicaid populations and childless adults.
- Visit community meetings that are already happening. Don't expect people to come to you.
- Be respectful of organizations' cultures and their members.
- Reach out to trusted messengers and local/state elected officials to find partners.
 - Each community is unique and diverse. No one type of organization is trusted or engaged in every community across the state.
- Budget for plain language translations into the top spoken non-English languages in the state.

Avoid 2012 [HUSKY expansion outreach mistakes](#) –

- **Target outreach broadly, spread any grants thinly** -- DSS and their consultant, the Children's Health Council, focused outreach resources on a small number of easy-to-find, usual suspects who approached them. They already had relationships with their selected partners, often because a staffer served on a state committee or were selected from foundation grant lists. **Selected partner groups were inundated with requests from DSS communications grantees to speak with their members. This left other community groups unaware and their members knew nothing about the HUSKY expansion.**
- **Do not over-rely on paid media** – It's easy but it's expensive and not as effective as direct community outreach.
 - An example -- An early survey asked how the small number of applicants heard about the HUSKY expansion. Surprisingly, newspapers were the top source. This was unexpected as newspaper readers tend to have higher incomes. But based

on the survey results, DSS chose to invest heavily in expensive newspaper advertising. They only received eight responses to the ad. As it was very early in outreach; maybe they had already reached all the uninsured newspaper readers.

- **Only small outreach grants, if any at all** – In contrast to Connecticut, Massachusetts was very successful at outreach. Their lesson was -- if you give any outreach grants, make them very small. This allows granting them to everyone with a good idea; no one is left out. Large grants to a small number of organizations sharing the same networks tended to give the responsibility to one staff person at each organization. Unfortunately, it was only that person's job at the organization and other staff working with clients were not engaged.
- **Outreach must be linguistically and culturally appropriate.** In one HUSKY parent focus group for Spanish speakers, a mother explained that she had heard the word "HUSKY" but didn't know what it was. Her employer had invited a speaker to her workplace and gave her time to attend the talk. But most employees at her worksite spoke only Spanish and the HUSKY speaker only spoke English. She and others sat through the talk and heard the word "HUSKY" several times but understood nothing.
- **Do not put all your eggs in one basket** with one organization controlling grant activities and choosing who gets money in the community. This was a large part of the campaign's failure.
- **Word of mouth is the most reliable source of information.**
- **Test everything; even well-meaning ideas fail.** A few great-sounding ideas in the HUSKY outreach efforts failed, wasting time and money in the process. One example was a K-Mart/Martha Stewart Living/HUSKY partnership, in which promotional bags with Martha Stewart gifts and a HUSKY application were distributed at several Connecticut stores on subsequent Saturdays for two or three months. Thousands of bags were distributed, but only about a dozen applications were returned from the campaign.
- **Thank people.** It's critical to demonstrate appreciation to outreach workers and their organizations that help enroll Medicaid members. Recognition goes a long way. Massachusetts held large convenings for all outreach workers that were motivating and informative.
- **Providers don't need grants.** It's the right thing to do for their patients. And it's in their best interest to keep patients enrolled to avoid uncompensated care.

"Trusted networks grow organically over time; it is not possible or advisable to build from scratch in the timeframe available."

[HUSKY expansion outreach evaluation](#)

Public education campaign

Target industries that employ Medicaid members to inform their workers. Employers should be motivated to keep employees covered and healthy. Connect through state licensure, customizable fact sheets to facilities/companies, trade associations, and employee resources.

There is some information on where Medicaid members are working nationally and in selected states. Connecticut can use this information to target communications and employment supports (see below).

Table 4: Occupational Concentration among Wage-Earning Adults Participating and Not Participating in Medicaid and the Supplemental Nutrition Assistance Program (SNAP) in 2018

Occupations	Medicaid (%)		SNAP (%)	
	Enrolled	Not enrolled	Receiving benefits	Not receiving benefits
Sales and related occupations	13.1 (12.2, 14.0)	9.4 (9.1, 9.6)	11.9 (10.9, 13.0)	9.5 (9.3, 9.8)
Food preparation and serving	11.5 (10.5, 12.6)	5.0* (4.8, 5.2)	11.3 (10.1, 12.6)	5.1* (4.9, 5.3)
Office and administrative support	11.1 (10.3, 12.0)	11.7 (11.4, 11.9)	11.4 (10.4, 12.4)	11.6 (11.4, 11.9)
Transportation and material moving	9.3 (8.4, 10.3)	6.1* (5.9, 6.4)	9.9 (9.0, 10.9)	6.2* (5.9, 6.4)
Building and grounds cleaning and maintenance	7.5 (6.8, 8.2)	3.2* (3.1, 3.4)	8.0 (7.2, 9.0)	3.3* (3.1, 3.5)
Top five occupations	52.4 (51.0, 53.8)	35.3 (34.9, 35.7)	52.5 (50.8, 54.1)	35.7 (35.3, 36.1)
All other occupations	47.6 (46.2, 49.1)	64.7 (64.3, 65.1)	47.5 (45.9, 49.2)	64.3 (63.9, 64.8)

Legend: (#, #) = (lower bound, upper bound) of each percentage estimate at the 95 percent confidence interval.

* = Occupation did not rank among the top five occupations of wage-earning adults who did not participate in Medicaid or SNAP in 2018. Rounding out the top five occupations for non-participants were management occupations (#1); education, training, and library occupations (#4); and health care practitioners and technical occupations (#5).

Source: GAO analysis of 2019 Current Population Survey Annual Social and Economic Supplement data. | GAO-21-45

Source: [Federal Social Safety Net Programs, Millions of Full-Time Workers Rely on Federal Health Care and Food Assistance Programs](#), GAO, October 2020

Top Industries and Occupations With the Largest Number of Workers With Medicaid Coverage by Sex, 2023

Women	Men
Top 10 Industries	
Restaurants and other food services	Construction
Elementary and secondary schools	Restaurants and other food services
General medical and surgical hospitals, and specialty (except psychiatric and substance abuse) hospitals	Landscaping services
Individual and family services	Truck transportation
Services to buildings and dwellings	Taxi and limousine service
Child day care services	Automotive repair and maintenance
Home health care services	Couriers and messengers
General merchandise stores, including warehouse clubs and supercenters	General merchandise stores, including warehouse clubs and supercenters
Nursing care facilities (skilled nursing facilities)	Elementary and secondary schools
Outpatient care centers	Crop production
Top 10 Occupations	
Cashiers	Construction laborers
Maids and housekeeping cleaners	Driver/sales workers and truck drivers
Waiters and waitresses	Laborers and freight, stock, and material movers, hand
Janitors and building cleaners	Cooks
Retail salespersons	Carpenters
Customer service representatives	Janitors and building cleaners
Childcare workers	Retail salespersons
Cooks	Couriers and messengers
Receptionists and information clerks	Cashiers
First-line supervisors of retail sales workers	First-line supervisors of retail sales workers

Note: Among females and males ages 19 to 64 enrolled in Medicaid who do not receive benefits from Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and are not also covered by Medicare.

Source: KFF analysis of the March 2024 Current Population Survey ASEC Supplement

KFF

Source: [Understanding the Intersection of Medicaid and Work: An Update](#), Appendix , KFF

In 2020, the [GAO compiled available state data](#) identifying specific employers of Medicaid and SNAP recipients. Data was available from Georgia, Indiana, Maine, Massachusetts, Oklahoma, and Rhode Island. DSS could target these companies in Connecticut for outreach and to educate their workers.

Common employers across states also operating in Connecticut from the GAO report:

- Walmart
- McDonald's
- Dunkin
- Amazon
- Stop and Shop
- UPS
- CVS Pharmacy

Notices, process to verify

- Be very clear about:
 - Who is and who isn't affected.
 - Emphasize that members need to document even if they are working or exempt.
 - How to sign up for text, email alerts, and the benefits of sharing their contact info.
 - How to update contact and personal information.
- Make it easy to submit questions or report problems on every communication and at the bottom of every webpage
 - Solicit input with pop-ups.
 - Don't expect website visitors or readers to find where to submit feedback.
 - Be diligent with timely answers – not just an auto-message.
- Make communications regular and relevant to readers. Craft different messages and media for members, stakeholders, partners, providers, and the public.
- FAQs – collect questions, answer quickly, and update frequently.
- Customizable template fact sheets for posting and blurbs colorful/graphics for newsletters. Offer clean versions for copying, printable in black & white.
- Online tutorials or step-by-step instructions to apply and renew. This reduces the demand for consumer assistance.
- Use multi-language, multi-channel communications.
- Repeat messages in each medium.
- Test with focus groups extensively, especially among populations at highest risk – e.g. people with disabilities, non-native English speakers, homeless.

Hire, train staff to meet member needs and confusion

- **Anticipate technology problems and have answers to the most common problems.** Update the verification platform in response to those common problems.
- **Create an intensive assistance process for most at-risk members**, including people with disabilities, unhoused people, and non-native English speakers.
- **Expect large increases in Call Center volume** – There will be lots of confusion, among both people who are subject to the requirement and people who aren't.

Employment Support

Arkansas and others identified common barriers to work including:

- Transportation
- Erratic/inconsistent schedules
- Health issues – members with multiple chronic conditions but not qualifying for SSI/SSDI
- Education/training skills
- Mental health needs – treated and untreated
- Caregiving

Arkansas sent people to unemployment offices for job search help, but very few used the service. One MCO trained staff to help with job search and outreach at community events.

Experts advise:

- Identify partners, employers, and funders to develop and fund employment supports.
- Local community-based partnerships are key to supporting employment.
- Pair with local workforce development and education pathways.
- Find/create cross sector coalitions to identify employer needs and training opportunities.
- Build resources for hybrid or remote work for members with barriers to travel.
- Create closed-loop referral systems.¹ Get response reports back from referral sources and follow up.
- Collect actionable data on economics and health outcomes for improvement as well as compliance (see data collection below).
- Provide early supports while waiting for first paycheck – gas cards, bus passes, childcare and other needs .
- Scale successful programs, shutter the failures – Be ruthless, do not waste time, effort, or money .
- Re-entry supports.
- Connect to rapid training certificates, apprenticeships, and internships with the potential to move up the ladder – e.g. EMT, CHW, medical assistant, manufacturing, fire fighters.
- Student loan support .
- Offer supports to employers to retain workers new to employment.
 - Mediation services.
 - Trainings in soft skills to find and retain employment.

Public Data Reporting

Tracking performance is critical to ensuring everyone qualified is retained in the program, and those who aren't qualified get support to help them comply. It's critical to evaluate in real-time, to correct and redirect resources (money, time, staff effort, and community resources), to find

¹ 42 USC 1396a(xx)(5) discusses exparte reviews or closed loop referral systems to employment/education/volunteer/community resources. Many thanks to NHeLP for the citation.

gaps in communications, and to identify and fix challenges with the verification system. **Data must be used for improvement, not just compliance.**

[Arkansas policymakers credit](#) their progress to robust data collection and the commitment to act on gaps and findings. Their data plan included:

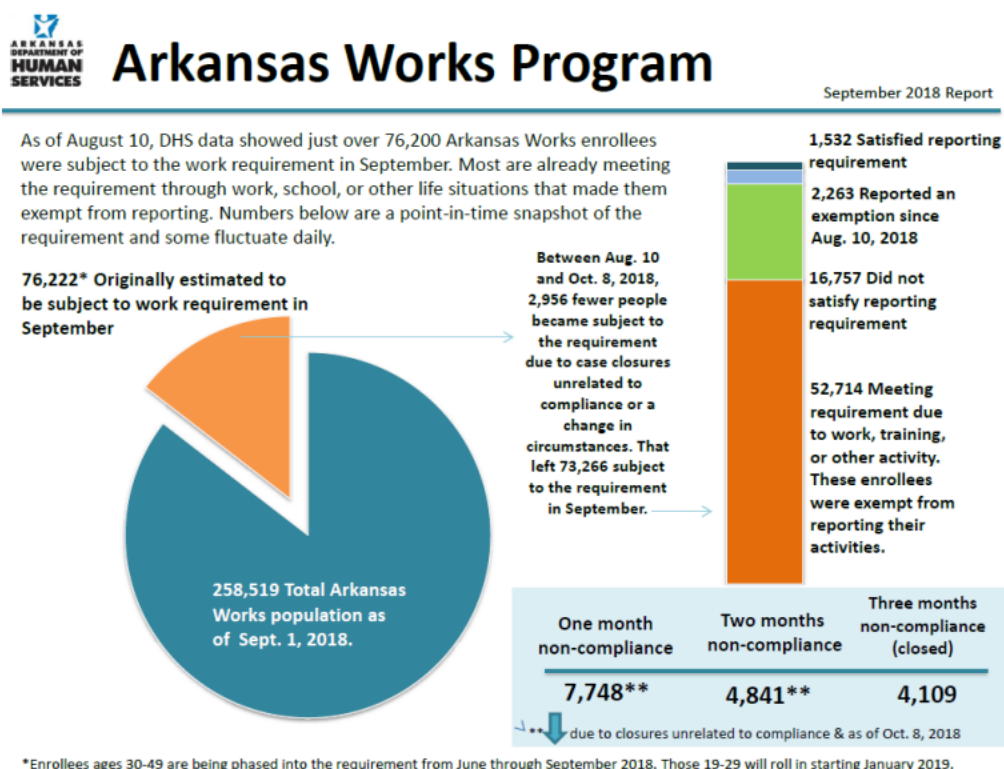
- Monthly file sharing with outreach partners
- A robust, independent, trusted evaluation of the program, at yearly intervals

Monthly reporting included:

- Enrollment
- Support services provided
- Non-compliance rates – by reason
- Case closure rates – by reason

See [report](#) Appendix E for methodology

APPENDIX C: SAMPLE PAGE FROM THE SEPTEMBER 2018 ARKANSAS WORKS MONTHLY REPORT^{xxix}



Source: [Arkansas Medicaid Work and Community Engagement Requirement: Community Response](#), ACHI, July 2019

Georgia Medicaid has a [public dashboard](#) that tracks up-to-date work requirement performance including:

- Enrollment numbers, trend

- Program costs – federal and state share
 - By category – eligibility/enrollment, MCO payments, public campaign, other administrative costs, eligibility staff

Recommendations:

An excellent recent [guide for monitoring](#) is available from NHeLP. See especially the specific suggested list of metrics to track – Appendix, p.8.

The Center for Children and Families at Georgetown University also has an [excellent reporting list](#) for eligibility verification. The list below goes beyond eligibility to outcomes and program performance.

DSS monthly reports on implementation recommendations, regarding only HUSKY D/members at risk, building on DSS's [unwinding dashboard](#), including:

- Total number subject to requirement/HUSKY D members
- **Stratify reporting by population, geography**, by new enrollment and renewals
- Number meeting work requirement and number exempt by reason
 - **Reason codes** – work/earnings, qualifying activities by type, combination, or exemption by type
 - Number approved ex parte or requiring documentation from members
 - **Follow up completed for members requiring documentation**
- Number non-compliant -- procedural denials vs. ineligible
 - By reason – see above
- Number non-compliant contacted, support services offered, number of members who follow up on referrals – through closed loop referral system
- Total number of pending applications and renewals
 - Average wait time to approval – both ex parte and those needing member documentation
- Number of cases closed, with reasons
- Employment outcomes
 - Include earnings, coverage retention
- Member surveys including – Understanding the requirements, who is and isn't included, effectiveness of communications content and modes, ease of reporting, Call Center performance, did they find effective assistance, where did they look, general well-being
 - Over-sample at-risk populations – people with disabilities, non-English speakers, people with chronic conditions, people with behavioral health conditions
 - Explore barriers encountered – what was the barrier, what did they try, did they get assistance, from who, was the assistance helpful/respectful/convenient, was the problem resolved, solicit ideas to prevent problems in future
- Population health impacts
- Number of incomplete applications – follow up by reasons, number offered reporting assistance, number re-enrolled

- Number compliant/noncompliant by subpopulation – people with disabilities, non-English speakers, unhoused
- Spending by the state – total and per member per month, on member supports services, consultants, extra staffing, communications, administration expenses including verification, medical costs
- Collect and report barriers encountered and best practices that worked for people
 - Regular reporting of problems, barriers, and resolutions, including policy changes, resources, hire more staff
 - Report on best practices, high performing programs, and efforts to share and scale
- Evaluate outreach efforts, open/response rates, feedback, follow through, best practices – test all messages and modes
- Types of activities reported – work/volunteering/education, by type, new or continuation from before work requirements
- Track healthcare utilization by HUSKY Part D members – report changes with work requirement
- Identify health changes that may allow members to become eligible in another category
- Independently track provider impacts
 - Uncompensated care -- for newly uninsured members
 - Impact of cost sharing
 - Denials of care
 - Provider financials, at-risk facilities/services

Verification, reporting, new application process

Verification will be the most important and [most costly part](#) of implementing work requirements. Overpaying is disruptive and wastes resources that could cover program service cuts.

It's important to build on what is already working in Connecticut. Pay consultants for updates to the state's current system and for access to more matching databases for verification and exemptions, not an entire overhaul of the system. DSS's [recent RFQ](#) for the SNAP process is a good start.

An [excellent resource](#), from the National Health Law Program (NHeLP), outlines data sources for income and exemption verification, and important considerations. The paper outlines detailed options for documentation with examples.

Another [excellent resource](#) from the Center on Budget and Policy Priorities collects best practices in managing the vendor landscape. The paper includes very detailed IT/eligibility functions, clear vendor roles, and expectations.

Barriers [Arkansas identified](#) included difficulty navigating the online portal, no access to Wi-Fi, limited smartphone data and text access. They found lots of confusion among members, including online portal navigation, how to meet the requirement, and whether it applied to them. The Call Center, when available, helped people navigate the portal step-by-step. Literacy was a challenge, so they revised the instructions to be easier to understand.

Arkansas found webinars and in-person trainings for members and stakeholders were helpful to guide people through the complex process.

A [recent study of technical assistance](#) provided by CMS to four states' Medicaid programs during COVID unwinding found significant improvements in the renewal process. The states that received technical help experienced 22% higher ex parte renewals (automatic, without requiring members' action), 7.7% overall renewals, and 8.3% fewer procedural denials than other states.

The assistance to states that made a difference included identifying policy barriers, such as automating cases with no current income information but with previous incomes below 100% of the federal poverty level and excluding tax information that doesn't affect eligibility. States also received technical capacity assistance, including incorporating more data sources on income and software changes that improved data matching.

Based on their experience, Arkansas added over time:

- [Registered Reporters](#) to help people document
 - State response to problems with the portal-only option to report work hours
 - Authorized and trained to assist with reporting
- Expanded Call Center and portal hours to 7 days/week, 7am to 9pm
- Allowed reporting by phone through the helpline
- Followed up with people who needed more time to document
 - They called people who logged work hours on the portal but not enough to qualify

[Research from Civilla](#) offers very helpful person-centered best practices for applications, redetermination processes, notices, texts, and process design. Among their recommendations:

- Include simple exemption screeners into eligibility and renewal processes with Yes/No questions
- Make notices clear and actionable – with very detailed recommendations and before/better examples of letters, notices, texts, and language

Other recommendations:

- **Borrow, buy, and use [every database available](#)** to match members with work requirements and exemptions – no single database is comprehensive or sufficient.
 - Connect with state tax and unemployment filings.
 - Look especially for info on gig and seasonal workers as well as self-employed income.

- Search Connecticut small business info at SOTS, DRS, and other state sources for self-employed workers.
- Maximize contact information source databases.
- An excellent resource from NHeLP provides evidence- based guidance on data matching, including common sources and how to use them with care.
- The Center on Budget and Policy Priorities also has an excellent list of income and exemption data sources. The paper also describes consent-based verification (members consent to employers communicating directly with DSS) and the waterfall approach to data use that reduces costs and staff/member administrative burdens.
- Use Medicaid claims to find members that could qualify as medically frail. Send them prompts for more information, if necessary to clarify. DSS's analysis of diagnosis codes in claims data is very helpful.
 - Impress upon providers the importance of reporting all applicable diagnosis codes for each patient.
- Test the portal early and often with applicants, anticipate technology problems, and make timely adjustments .
- Use self-attestation as the default policy choice, check/audit later.
 - **Nebraska, which has elected to implement their Medicaid work requirement program early, is using self-attestation for many verifications.**
 - **The IFR acknowledges that reliable information for some qualifications is difficult to find and, in those cases, allows states to accept self-attestation.**
- Early in the application/renewal process, ask questions that allow members to qualify in a different eligibility category (HUSKY Parts A or C) that are not subject to work requirements. This lessens the administrative burden on both members and staff.
- Use thoughtful skip logic rules and pre-populate forms to ensure accuracy and minimize unnecessary questions.
- Hire and train staff to meet the need. The new DSS staff approved in the latest budget is promising.
- Allow and train homecare workers to be Registered Reporters to assist **patients and caregivers with** documentation, including access to Wi-Fi.
- Collect common problems/misunderstandings, fix the system, revise FAQs and other guidance, add to regular stakeholder updates.
- Have a dedicated unit/service for people with complex barriers that interfere with ability to use the portal. (see below)
- Assisters on the Call Center should be able to walk people through the process on the phone step-by-step in real-time.
- Use National Change of Address/post office data to find current contacts.
- Engage CHNCT and care managers to work with their at-risk clients to help them get verified.
- Automatically send info from people who don't fit the work requirement to AccessHealthCT.

- Connecticut could pay the first month's premium to remove a cost barrier as [we did during the COVID unwinding](#).

Exemptions

Caregiving

The **most common reason given** by Connecticut Medicaid recipients for not working is caring for family. Be sure to alert them to the Caregiving Exemption.

[The burden of caregiving](#) for an elderly or disabled patients on families is common and growing, across the US and in Connecticut. Ensuring we **support every caregiver in Connecticut** is critical. According to [AARP and the John A. Hartford Foundation](#), over **60,000 Connecticut adults with incomes under \$25,000/year provide critical care for a family member or friend with complex medical conditions or disabilities**. One in five Connecticut caregivers spend over 40 hours/week providing care including housework, transportation, and grocery or other shopping. Two in five experience high emotional stress. **One in five caregivers has trouble taking care of their own health and only 38% are in excellent or very good health**. Almost half (42%) experience financial hardships due to their caregiving responsibilities including using up savings, taking on debt, and putting off retirement. Many are likely covered by Medicaid.

[AARP reports](#) that in the US “more than 63 million adults provide ongoing care for aging parents, spouses with chronic conditions, or adult children with disabilities and serious illnesses—a staggering 45 percent increase since 2015.” Caregivers offer services we couldn’t afford to pay for. They allow people to stay in their own homes, keeping them healthy. Avoiding institutional care and downstream health problems generates critical savings to Connecticut’s entire healthcare system and the Medicaid program in particular. **Providing healthcare coverage to caregivers is an excellent investment in the health and economics of Connecticut communities.**

The IFR is generous in defining who qualifies for the caregiving exemption.

[Under the law](#), a qualified caregiver is an adult who provides regular, ongoing care for someone with a disability, either paid or unpaid. The eligible types of care provided is intentionally broad. More than one person in a family or household may qualify as a caregiver of the same person.

The caregiver:

- can reside with the person being cared for,
- be a relative of the person being cared for, or
- provide at least 80 hours of care to the person being cared for per month.
 - If the caregiver provides less than 80 hours of caregiving per month, those hours can be combined with work, volunteering, or education to meet the work requirement.

The IRF is clear that there is no age limit on the person being cared for. The IRF state that people being care for could, “therefore, include an older adult who requires assistance of varying scope in performing activities of daily living (ADLs) (bathing, dressing, toileting, eating, etc.) or other activities that keep older adults living at home and participating in community life. We encourage States to ensure that educational materials on this community engagement exclusion are sufficiently clear so that individuals providing supports to older adults understand that they could qualify as a specified excluded individual through the family caregiver component.”

The IFR acknowledges that it will be difficult to identify caregivers, as the arrangements are often informal and there are no data sets identifying caregivers. The regulation allows self-attestation until 2028.

The person being cared for can fit the broad Americans with Disability Act’s definition of disability – “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.”

Recommendations:

- Revise SNAP’s process for the caregiving exemption from the ground up
 - The new, shorter form to verify patient caregiving need is a very good start
- Allow the patient being cared for to **self-attest who their caregiver** is and how much care they need.
 - Review patients’ claims and medical records (if available) to confirm the likely need for caregiving.
 - If patient or self-attestation is eventually not allowed by CMS, allow certification by homecare workers, CHWs, and other service providers who have visited the home.
 - Check with random audits as necessary.
- **Ensure it is easy for unrelated, non-resident caregivers to combine caregiving hours with other work, education and volunteering hours to qualify. Ask about caregiving in applications and renewals to ensure all hours are counted.**
 - [AARP reports](#) that seven in ten caregivers also work outside the home, experiencing disruptions such as arriving late, leaving early, or taking time off for caregiving obligations.
- **For 2028, expand the categories of providers and caregivers who can document the caregiver and the need for caregiving. Prioritize people who regularly visit the home of the person being cared for, who are in a better position to assess the need.**
 - **For medical frailty, the IRF allows states to accept documentation from “many types of practitioners, including physicians, nurse practitioners, physician assistants, psychologists, counselors and therapists, clinical social workers, and other practitioners credentialed by the State, that are qualified to determine**

that an individual's condition qualifies them as medically frail or having other special medical needs under State scope of practice laws.”

- If necessary, expand the relevant scope of practice for home health workers for this narrow purpose.
- Ensure that caregivers are aware for themselves of the medial frailty exemption.
 - [AARP reports](#) that 18% of US caregivers are disabled and 23% have difficulty caring for their own health.

Volunteering

Volunteers can be an essential resource for nonprofit community organizations. But they require support and training to meet both volunteer and organizational needs. There are often costs to engaging volunteer workers.

State agencies should join with nonprofits and funders to support organizations and members volunteering in their own community. DSS can create volunteer opportunities that support work requirements including as outreach workers and trained Registered Reporters.

Allow multiple methods for verifying volunteer hours

- Create closed-loop referral systems for members connected with community organizations that need volunteers. Get response reports back from referral sources.
- Very simple signed verification forms
- Use digital apps for the purpose
- Signed paper logs, such as a clipboard with a log signed by the supervisor
- Supervisor reference letters on organization letterhead
- Email confirmations
- Photos and timestamps

Medical frailty

Twenty five states, including Connecticut, and the District of Columbia, have [filed a lawsuit against the federal Medicaid administration for going beyond the language of the law](#)

The federal law's medical frailty exemption language is very broad. [According to HR-1](#) -- an individual who is medically frail or otherwise has special medical needs (as defined by the Secretary), including an individual who is blind or disabled, with a substance use disorder, with a disabling mental disorder, with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or with a serious or complex medical condition -- is exempt from the Medicaid work requirement.

However, the IFR went beyond the language of the law [making it much harder](#) for seriously ill people to keep their healthcare coverage. They limited qualifying conditions to just the five listed in the law, although the law only cited them as examples. They also added another

layer to the exemption that is not in the law. Medically frail members must also prove that their condition “significantly impairs” their ability to comply with working, volunteering, or attending school.

This is extremely difficult to determine, even for the five conditions listed. Trying to work with a serious illness is complicated. Health conditions change often. Some days may be fine, but when conditions flare up, patients can’t work. They need time off for medical appointments and use up sick leave quickly. They need accommodating workplaces, understanding bosses, and patient coworkers. Jobs like this are often not available to low-income HUSKY members who may not have professional degrees that allow desk jobs and flexible work schedules.

The IFR also goes beyond the law in stating that to qualify, medically frail conditions should be “life threatening, conditions that cause serious disability without necessarily being life threatening, conditions that cause significant pain or discomfort that can cause serious interruptions to life activities, conditions that require major commitments of time and effort from caregivers for a substantial period of time, conditions that may require frequent monitoring, conditions that predict or are associated with severe consequences, conditions associated with negative consequences for someone else, conditions that affect multiple organ systems, conditions that require management to tight physiological parameters, conditions whose management requires coordination of multiple specialties, conditions whose treatment carries a risk of serious complications, and conditions requiring adjustment in a nonmedical environment.”

Despite the difficulty of implementing the new medical frailty definition, the IFR gives states little guidance on how to do it. Despite this, the IFR says that if a federal audit finds that “there is frequent approval of individuals as medically frail with little to no support for the conclusion” the state will “not be in compliance with the regulation.”

A state that is out of compliance with the unspecified medical frailty regulations can have their federal Medicaid funds frozen or denied. Billions of dollars have already been withheld from other states, without specifying what the states need to fix. Connecticut relies on \$6 billion in federal Medicaid reimbursement each year.

As described earlier, the most recent analysis by DSS from June 2026 found that 206,000 HUSKY D members may be exempt due to medical frailty based on a search of Medicaid claims for thousands of diagnostic codes approved by CMS for medical frailty exemptions in other state waivers and codes that fit into the definition in HR-1’s language.

The IFR acknowledges that allowing people with new or worsening medical conditions saves lives and future costs. They also note that some people with disabilities won’t qualify as unable to work and will need modifications to work. The IFR notes that states are required to provide reasonable modifications to avoid discrimination on the basis of disability.

Thankfully, the regulators gave states and medically frail members a year to implement this very complex and unusual mandate.

A national study recently [published in JAMA](#) found that **87% of Americans subject to Medicaid work requirements have at least one chronic condition**; that number rises to 97% for those ages 50 to 64 years. Often, **these conditions interfere with the ability to work and likely comply with HR-1's medical frailty exemption, as described in the law**. Prevalence of the 14 conditions in this population ranges from 1% to 44.5%. For recipients ages 50 to 64 years, prevalence is higher, ranging from 2.1% to 56.8%.

[Arkansas](#) found that multiple chronic conditions was a common barrier to work, but that many of those members did not qualify as medically frail or disabled.

Recommendations:

- [Maximize self-attestation](#)
- **Use claims data to identify members who are potentially exempt both in having a qualifying condition but also are unable to work.**
- Identify those that meet the standard and exempt them ex parte.
- Work with members and their providers/caretakers/community service providers to lower the administrative burdens of reporting.
- Work with other agencies to identify people receiving or applying for SSI or SSDI.
- Work with providers, home care agencies, and disability groups to identify and educate members about the exemption.
- Use [longer duration exemptions](#) if allowed, to reduce member stress, administrative burden, and administrative errors for exemptions that are likely to be long-term.
- In the application and renewal processes, include initial questions that could indicate a medical frailty or other exemption.
- Engage CHNCT and hospital care managers to work with their clients to explore if they meet the standard and assist them in documentation.
- Many people who will qualify under the medical frailty exemption would not respond to that term. Use [language that explains the exemption in plain terms](#).

Education

[Arkansas](#) worked with educational institutions for outreach to students with the message that school hours count toward their work requirement hours.

Recommendation:

- Connecticut should connect with all educational institutions in Connecticut and neighboring states, especially student health plans and clinics, to check enrollment and educate students that they may qualify for the exemption.
- Schools should share enrollment info with DSS for ex parte exemptions to help students qualify.

- Schools should proactively provide all students that don't meet the 80 hour/month bar, documentation of their hours and inform them that their hours can be combined with work, volunteering, and caregiving.
 - **Schools should assist students with finding and accessing opportunities for work and volunteering that are consistent with and support their education.**
- Create closed-loop referral systems. Get response reports back from referral sources and follow up.

In Substance Use Treatment

Medicaid is the [largest payer of substance use disorder treatment](#) in the US.

Recommendations:

- DSS should use medical claims to identify people in substance use treatment, inpatient or outpatient, and exempt them ex parte.
- DSS or DMHAS should reach out to all substance use providers in the state to help them identify patients who could be covered by Medicaid and exempt.
- DSS should include this exemption in communications with all providers, regardless of specialty.

Parent or caregiver of dependent child under 14

Recommendations:

- DSS should use claims data to identify adults living with children under age 14 and exempt them ex parte.
 - DSS should also explore moving those caregivers to HUSKY Part A.
- DSS should work with other agencies – DRS (dependents), DPH (vital records), and DCF (foster and adoptive parents) – to identify exempt caregivers.
- DSS should work with the Dept. of Education to develop outreach materials on the exemption for elementary and middle school families and school resource centers.

People enrolled in other public programs

Recommendations:

- DSS should connect with state and federal agencies to identify members in treatment for complex conditions and disabilities.
 - Exempt documented members ex parte.
 - For ongoing conditions that are unlikely to change, provide a longer duration or permanent exemption.
- First, use information DSS already has (SSI, TANF, SNAP).
- Then connect with other agencies – Medicare, VA.
- Connect with DCF on current and former foster children.

- Connect with DOC on recently incarcerated members.
- Check medical claims to identify members in healthcare facilities or substance use treatment programs for exemptions.
- Use online forms for exemptions.
 - Don't require a HUSKY member or provider to find a form, download and print it, then submit by postal mail.
 - This eases the burdens on members, providers, and state staff as well as reducing errors.
- Any information that is already available to the state, especially to DSS such SSI and SSDI recipients, should be automatically entered into the work requirement verification system without needing any action by members, patients, providers, or DSS staff.

Proposals

Caregiving

- Expand validation of caregiving need and medical frailty authority beyond physicians.
 - As noted above, **primary care providers are not the best source to verify caregiving need.** They are overwhelmed, adding to their administrative burden fuels burnout. Caregiving need depends on more than clinical status. Home environments are important to determining a patient's need for a caregiver, including one floor vs. multiple floors, stairs vs. elevator, laundry facilities in the home, and many other circumstances. Few clinical care providers are familiar with their patients' homes.
 - There are multiple options for more appropriate certification sources. **Expand the categories of providers who can certify the need for caregivers. For determining medical frailty, the IRF allows states to accept documentation from "many types of practitioners, including physicians, nurse practitioners, physician assistants, psychologists, counselors and therapists, clinical social workers, and other practitioners credentialed by the State, that are qualified to determine that an individual's condition qualifies them as medically frail or having other special medical needs under State scope of practice laws."**
 - Physicians have reported the SNAP work exemption documentation is a burden.
 - As noted above, a [study found](#) correlations of Arkansas physicians' willingness to assist in filing for work requirement exemptions with their political affiliation, the level of administrative burden, and their perceptions of the applicant. The study found many physician errors in both approving inappropriate applicants and denying appropriate applicants.
- Many caregivers may not recognize the term "medical frailty". In member communications, use [accessible language](#) that fits the definition of the broad exemption.

- DSS's new two-page verification form is a good start. The form covers multiple exemptions with a simple check box, discarding ten pages of unnecessary questions, saving time and avoiding frustration.
 - However, the form is still a pdf that caregivers, their patients, or their physician needs to download and print. After completing the form, providers must mail the form back to DSS.
 - An online form would be more user-friendly. It could also be connected to the caregiver's case reducing both DSS staff time and data transfer errors.
- Allow the patient that is being cared for in the home to self-attest to their chosen caregiver. Patient-centered care empowers both patients and caregivers to make the best decisions for their health. Currently, patients in Connecticut's PCA waiver and Community First Choice programs are trusted with choosing their own caregivers.
 - If not allowed, at least expand qualifications for caregiver validation. Home health workers, CHWs, nurses, CHNCT care managers, community social service providers, and others should be allowed to certify patient need and their choice of caregiver.
 - Searches of laws and regulations, at the federal and state levels, have found no requirement for clinicians to verify caregiving need.
 - To validate, perform audits as necessary. Patients without Medicaid claims can voluntarily share their medical records with DSS, as necessary.
- Engage CHNCT and care managers to work with clients who may have or need caregivers to let them know about the caregiving exemption.
- Send outreach letters to Medicaid patients with complex needs living at home identified from claims data. Ask if anyone enrolled in or eligible for Medicaid is caring for them, to let them and their caregivers know they may be eligible for coverage and about the exemption.
- **Ensure the system accommodates and communications are clear that more than one person can qualify as caregiver for an individual who needs one.**

Build a Registered Reporters/Navigators program

When [Arkansas's program](#) was failing, the state created "Registered Reporters" who were trained and authorized to assist with verification of work and exemptions. Registered Reporters also provided a source of trusted, accurate information in communities. They also served as a rich source of actionable information for the state on challenges, barriers, and solutions that worked.

DSS's plans to engage CHWs in community settings are an excellent addition. Publicize these opportunities well and coordinate with broad, diverse, non-medical community opportunities such as food pantries, senior centers, and schools.

Thankfully, Connecticut has an existing assistance program through [AccessHealthCT](#). Trained Enrollment Specialists are available by appointment during predetermined hours at community

sites. There is also an online calendar of community events where they offer assistance. Demand for their services will increase substantially as Medicaid work requirements are implemented and more Connecticut residents will be searching for coverage. The program should be scaled up in numbers, access sites, and with training in new Medicaid rules. **DSS's efforts in pursuing this option are very promising.**

Enhanced assistance for people who need more help with verification

In response to problems, **Arkansas policymakers created a [separate safeguard process for people with disabilities](#)**. However, data systems did a poor job of identifying who qualified. Few eligible people were able to successfully navigate the complex and bureaucratic system. Unfortunately, many people with disabilities lost coverage who should've been exempt.

Recommend: Create a separate, simple, accessible safeguard verification process for people who need more help. This should include enhanced assistance and longer grace periods for compliance.

Employment Supports

The state should build on and improve SNAP's Employment and Training (E&T) supports for people to become compliant with the work requirement.

[Experience from other states](#) includes:

- One-size-fits-all approaches fail. Offer individualized, tailored work/engagement opportunities.
- Mentorship and Career Ladders foster sustainable support for employment and raise morale.
- It's important to monitor progress at the individual level as people navigate employment to prevent job losses.
- Engage employers currently looking for workers.
 - Identify skills and supports needed, including soft skills. Center E&T programs on these needs.
 - Help employers recruit HUSKY adults. Provide state support and resources for on-the-job training, especially in industries that already employ this population. (See above)
 - Support employers hiring new workers with mediation services and benefits training to overcome HR problems.
- Create closed-loop referral systems. Get response reports back from referral sources and follow up.
- Develop peer-led workforce development. Successful alumni can mentor others and help address the challenges of maintaining employment.

Education and Training

- Connecticut’s SNAP E&T program information is disjointed and confusing.
 - Coordinate the various organizations, schools, websites, and application programs under SNAP E&T.
 - Create a single point of entry, use common terms, and a common application.
 - Prominently describe free tuition opportunities.
 - Standardize and expand other supports.
- Reach out to CHW, nursing, and other health shortage workforce programs to expand capacity. Offer free tuition, as for SNAP. Prioritize people at risk of losing Medicaid coverage for admission. Market these programs and supports to Medicaid members in need of hours.
- [From Arkansas](#) – Connect to institutions of higher education to inform students that school hours count toward the work requirement.
- Create closed-loop referral systems. Get response reports back from referral sources and follow up.

Create a first-level resource for people who don’t meet the requirement

As described above, many Medicaid members at-risk of losing coverage have at least one chronic health condition. Losing coverage risks worsening health outcomes as uninsured people often wait to seek care until health problems are serious and more costly to treat.

Continuity of care for chronic conditions is critical for successful treatment and to avoid bad outcomes. Rising uncompensated care costs and capacity pressures on Connecticut’s providers will not only hurt newly uninsured state residents, but the financial fallout will also reduce access and increase healthcare prices for all Connecticut residents.

Creation of a first-level support resource with CHWs/navigators to offer simple care coordination and direct people to sliding scale or free preventive care could prevent bad health outcomes. Many people could take care of themselves or work but for one small problem that might be addressed with trusted information and someone to support them. People who lose coverage could be referred to this service.

DSS’s engagement of CHWs in community settings could serve as this resource.

The resource could include:

- Matching members losing coverage to safety net providers in their area, based on their conditions and needs. Ideally, they would be able to make appointments for members.
- Address barriers to work and accessing care with current and expanded resources. These needs include transportation (gas card, bus pass, Uber) to get to training or work, mental health support, re-entry support, afterschool program costs for children over 13, other caregiving responsibilities, erratic/inconsistent schedules, access to Wi-Fi, funding for smartphone data access, texts, and student loan payment assistance.

- Create closed-loop referral systems. Get response reports back from referral sources and follow up.

It's critical to try many ideas, evaluate, and expand what works.

Prepare for rising uninsured, uncompensated care

Connecticut's healthcare system is about to experience a significant loss of revenue. It will impact HUSKY D members and their families, but it will also have significant downstream impact on everyone. Studies found that the recent Medicaid eligibility unwinding after COVID led to [more uncompensated care](#).

The CT Hospital Association's HR-1 [outreach efforts and resources](#) are an excellent resource to minimize losses.

AccessHealthCT and insurers may find substantial changes in the individual market, as the uninsured rate rises. Potential impacts may include increased pool risks, higher premiums, higher administrative costs, and more uncertainty. **Insurers and AccessHealthCT should consider options to mitigate the risks, encourage preventive and maintenance care, and keep premiums affordable.**

Hospitals and health systems in other states are preparing for HR-1's impact, such as:

- Building community relationships with outreach, connecting with community health centers, food pantries and pharmacies, providing community-based health screenings.
- Helping patients at-risk of losing coverage navigate the new rules and retain coverage.
- Improving ED efficiency.
- Preserving access to care by altering service delivery, e.g. locations, hours, to accommodate patients fulfilling work and community engagement requirements.

Contingency planning should be underway.

- Hospitals, practices, and health systems should be planning now for increased demand for ED services, need for upfront "Good Faith" price estimates, negotiating bills with patients, increased medical debt, and demand for charity care.
- Policymakers should review current patient protections, medical debt, and collections policies to identify gaps.
- Providers should discuss care plans and strategies with patients who are at-risk of losing coverage.
- Safety net providers, especially community health centers and EDs, should plan for increased demand.
- The state, legal aid, providers, and advocates should collaborate to develop communications for people who are about to or have lost coverage including how to continue care for chronic conditions, legal rights, how to get price estimates and

negotiate payments, prescription drug assistance, and preemptively getting care while still covered.

- At the appropriate time, providers should engage patients and communities in problem-solving and priority-setting

Continue to Improve Call Center Performance

As described above, DSS has significantly improved the Benefit Call Center performance, with much lower average wait times and call abandonment averages.

Advocates are grateful for the recent system update and increase in hiring more Call Center staff. However, we are concerned that it may not be enough to meet much higher demand as HR-1 changes are implemented or, as in the past, the increase in resources will not be sustained.

However, concerns remain that callers are being disconnected after ten minutes in the new system. While the update includes a call-back option, that won't work for many callers. For example, callers who are working or caregiving may only be able to call during a limited time, such as a lunch or respite break, but are able to stay on hold beyond ten minutes.

Performance must be tracked and resources devoted to ensuring callers are getting what they need from both the DSS and AccessHealthCT/DSS call centers.

Helpful Resources

DSS HR-1 [website](#) and [pre-screener](#)

[HR-1 and HUSKY Part D Changes Resources](#), CT Hospital Association

[DSS MAPOC presentation](#), 6/12/2026, start at slide 32

[Administration's Last-Minute Restrictions Likely to Worsen Impact of Medicaid Work Requirement](#), Center on Budget and Policy Priorities, 6/3/2026

[Arkansas Medicaid Work and Community Engagement Requirement: Community Response](#), ACHI, 7/23/2019

[A Guide to Reducing Coverage Losses Through Effective Implementation of Medicaid's New Work Requirement](#), Center on Budget and Policy Priorities, 11/3/2025

[Human-Centered Work Requirements for Medicaid](#), Civilla, Fall 2025

[Work That Works: Creating Sustainable Employment Pathways for Medicaid-Enrolled Communities](#), HMA, 8/14/2025

[Got Your \(Work\) Number: The Intersection of Medicaid Eligibility Data Sources and Work Requirements](#), NHeLP, 11/20/2025

[Clinical Characteristics of Adults at Risk of Medicaid Disenrollment Due to HR 1 Work Requirements](#), JAMA Network, 10/1/2025

[Interventions To Automate Medicaid Renewals Reduce Procedural Denials And Increase Coverage](#), Health Affairs, November 2025, Open Access

[Recommendations for State Reporting of Work Requirement Outcomes: Do's and Don'ts](#), NHeLP, 5/11/2026

[Work Reporting / Community Engagement Performance Metrics](#), Center for Children and Families, Georgetown University, accessed 3/1/2026

[Federal Social Safety Net Programs, Millions of Full-Time Workers Rely on Federal Health Care and Food Assistance Programs](#), GAO, October 2020

[Medicaid Work Requirements: Mitigating Harm and Documenting Losses](#), NHeLP, 8/28/2025

[Recommendations for Mitigating Harms to People with Disabilities, Older Adults, and Caregivers from Medicaid Work Requirements](#), NHeLP, 12/3/2025

[Assessing the Medicaid Work Requirement Vendor Landscape](#), Center on Budget and Policy Priorities, 2/9/2026

[Communications Workplan: Preparing for the Implementation of Medicaid Work Reporting Requirements](#), State Health and Value Strategies, February 2026

[Recommendations on the Implementation of the OBBBA in Colorado](#), Colorado Center on Law and Policy, 10/30/2025