KEEP YOUR HEALTH COVERAGE FAILURE POINT FRAMEWORK

SUMMARY OF COVERAGE RETENTION RISKS AND OPPORTUNITIES TO SUPPORT PLANNING

The Clock is Running

A federal mandate effective January 1, 2027 will require most HUSKY D adults to prove they qualify — Connecticut has only months to prepare. [1]

Implementation Deadline
Jan 1, 2027

CMS Projected Disenrollment

15% National disenrollment rate projected by CMS

Failed hours	**9%**
Paperwork/admin	**6%**

Who Is Affected
Non-pregnant adults ages 19–64
Medicaid expansion group (HUSKY Part D)

Rule Issued
CMS-2454-IFC
CMS Interim Final Rule issued June 1, 2026

Hours Requirement
80 hours/month
Employment, job-training, school, community service, or approved programs — may be combined

Reporting Cadence
Every 6 months
Compliance must be verified by the state at least every six months

Income Alternative
$580+/month earned
80 hrs × federal minimum wage (2026)

Scope
43 States + CT
All Medicaid expansion states required to comply by the deadline

Who Is at Risk of Losing Coverage

Over 300,000 Connecticut adults must meet the new requirements — the most vulnerable are those who qualify but cannot navigate documentation. [2]

300K+
CT adults subject to new requirement

≈50%
Already working/in school ≥80 hrs/mo or otherwise exempt*

≈50%**
Face significant documentation challenges

**Note: The term exempt or exemption is used here to refer to federal exclusions (individual is not required to comply) and hardship exceptions (individuals are deemed compliant).*

For example, an individual who is medically frail is excluded and is not required to meet the work requirements.

An individual who has been hospitalized is excepted, which means the individual is deemed compliant for the month in which the hospitalization occurred.

Either a documented exclusion or an exception will enable an individual to retain coverage.

Highest-Risk Subgroups

- Adults with chronic conditions
- Low-wage workers in informal, seasonal, or gig employment — hard to verify hours
- Rural populations — geographic barriers to in-person reporting
- Individuals with limited English proficiency — language and digital access barriers
- People recently released from incarceration — coverage and documentation gaps
- Unhoused or housing unstable persons

**Assumes ALL medically frail individuals will be required to document impairment

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.

Initial Application — The First Failure Point

Initial application is the first point at which a new HUSKY D applicant can be denied — when the state cannot verify compliance, exclusion, or deemed compliance for the month before the application, eligible people are turned away before coverage ever begins.

Initial Application Pathway

Application Filed
A new HUSKY D application is initiated — often when an uninsured patient presents for care during an emergency visit, inpatient admission, discharge, or financial counseling

Lookback Month Set
DSS reviews the month immediately preceding the month of application; Connecticut requires one month of compliance, deemed compliance, or exclusion

Verification & Response Window
If DSS cannot verify status from existing data, the applicant must supply documentation within the response period or risk denial

Outcome
Application approved — or denial at the first coverage gate

1-month lookback

the single month immediately before the month of application that decides whether a new applicant meets, is deemed to meet, or is excluded from the requirement

Why Initial Application Could Fail

- The applicant does not know the month before application must be documented, or cannot produce proof of income, work, job training, school, or activity
- An exclusion or qualifying hardship — such as an inpatient stay — is never identified, requested, or verified
- Application timing misaligns the lookback month with the applicant's strongest compliance or deemed-compliance month

Regulatory Basis

The federal rule looks to the month or months immediately preceding the month of application; a qualifying inpatient hospitalization in that month may establish deemed compliance for an otherwise eligible applicant

High-Impact Intervention Point

Screening at the point of care for exclusions, hardship, and prior-month compliance — and timing the application to the strongest lookback month — keeps eligible applicants covered

Connecticut must clarify the application lookback month and screen for exclusions, hardship, and deemed compliance so eligible applicants are not denied at the first gate — before January 1, 2027

Key failure point: eligible applicants are denied at initial application when the prior-month requirement is undocumented, or an exclusion, hardship, or deemed-compliance month is missed

Renewal Notice — The Second Failure Point

The renewal notice is the second contact in the compliance pathway — when it never arrives, is not understood, or is not returned in time, eligible people lose coverage before they ever engage with the requirement.

Renewal Notice Pathway

Renewal Triggered
State begins periodic redetermination; automated ex parte renewal is attempted first using existing data

Notice Mailed
When data is incomplete, the state mails a renewal notice requesting documentation to confirm continued eligibility

Member Response Window
Member must read, complete, and return the renewal packet with any proof by the stated deadline

Outcome
Coverage renewed — or procedural disenrollment

6-month lookback

the six months immediately before the renewal date; the beneficiary must document a qualifying exclusion or document **one month** of compliance or a hardship exception during this period

Why the Renewal Notice Could Fail

- Notice never arrives — wrong address
- Packet too dense, or not in the member's language
- Response deadline missed — no reminder or help to respond

Regulatory Basis

Federal rules (42 CFR 435.916) require states to attempt automated ex parte renewal first, and to give members written notice and a reasonable period to respond before terminating coverage

High-Impact Intervention Point

Keeping member contact information current and helping members read and return renewal packets on time prevents procedural disenrollment of people who remain eligible

Connecticut must ensure renewal notices reach members, are understood, and are returned on time — before January 1, 2027

Key failure point: eligible members lose coverage when renewal notices never arrive, are not understood, or are not returned on time; 69% of Medicaid disenrollments during the recent unwinding were procedural — paperwork and notice failures, not findings of ineligibility [5]

Exemptions* — The Third Failure Point

Many at-risk individuals qualify for exclusions or a hardship exception but will lose coverage simply because they never knew to claim one or lacked help to document it.

Statutory Exclusion Examples

- Pregnant & postpartum individuals
- Disabled or medically frail
- Parents/caretakers of children under 14 or people with disabilities
- American Indians & Alaska Natives
- Former foster youth
- Individuals in drug/alcohol treatment

Short-Term Hardship Exceptions
Inpatient care • County unemployment ≥8% or 1.5× national avg • Natural disaster/emergency areas • Travel for extended period to get medical care

26% of expansion adults projected to qualify for an exclusion — but each exclusion must be actively claimed and verified

Exemption Pathway

Exemption Identification
- Screen at point of care — hospital and CBO intake
- Medical frailty requires documentation
- CMS limits categories to five statutory types and requires documented impairment

Documentation Support
- Navigator assistance to gather required proof
- Language-accessible materials and digital support essential

State Verification
- DSS reviews and approves exemption claim
- Verified at least every six months along with reporting cycle

Key failure point: individuals who qualify for an exemption but do not know to apply, lack documentation support, or miss deadlines will be disenrolled

**The term exemption is used here to refer to federal exclusions (individual is not required to comply) and hardship exceptions (individuals are deemed compliant)*

Work Rule Compliance — The Fourth Failure Point

Most at-risk adults can do the work — but lose coverage when variable hours, caregiving, or limited local opportunities make it hard to reach or document 80 qualifying hours every month.

Compliance Pathway

Qualifying Activity
Member works, studies, trains, or volunteers toward 80 hours of qualifying activity each month

Hours or Income Met
Activities may be combined, or met through earnings of about $580/month (80 hrs × minimum wage)

Documentation & Reporting
Member must track and report qualifying hours or income to the state at least every six months

Outcome
Coverage retained — or disenrollment for unmet hours

9%

of expansion adults nationally are projected to lose coverage for not meeting the monthly hours requirement [6]

Why Work Rule Compliance Could Fail

- Variable, seasonal, or gig hours that are hard to reach or document
- Unstable housing, caregiving, or transportation barriers limit available hours
- Mild-to-moderate health or cognitive challenges that fall short of an exclusion
- Few nearby job, education, or volunteer options to reach the threshold

Regulatory Basis

CMS Interim Final Rule (CMS-2454-IFC) requires 80 hours/month of work, education, community service, or an approved program — or equivalent income, $580/month — verified at least every six months

High-Impact Intervention Point

Connecting members to qualifying activities, combining hours across multiple activities, and helping them document and report keeps eligible people enrolled

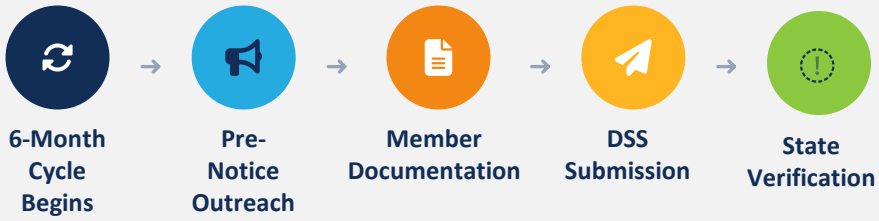
Connecticut must connect at-risk members to qualifying activities and help them document hours before January 1, 2027

Key failure point: HUSKY D members willing to work still lose coverage when unstable housing, caregiving, or mild-to-moderate health challenges keep them from reaching or documenting 80 qualifying hours

Reporting and Verification — The Fifth Failure Point

Compliance or qualifying exemption must be reported to the state every six months — twice as often as current redeterminations — creating a high-friction recurring barrier especially for populations with low digital access. [3]

6-Month Reporting Cycle



Proactive outreach before each cycle is the critical intervention window

Primary Barriers to Successful Reporting

- Low digital literacy and inconsistent internet access
- Language access gaps for non-English speakers
- Shift workers with variable hours — hard to track 80 hrs/month
- Lack of awareness about acceptable documentation

18,000 people lost coverage

Lesson from Arkansas

Many participants were unaware of the requirement or found documentation too burdensome — 18,000 people lost coverage without measurable increases in employment. [5]

Key failure point: members who miss a six-month reporting deadline or cannot produce acceptable documentation lose coverage even after meeting the requirement

The Cure Period — The Sixth Failure Point

When someone is found non-compliant, a structured cure period is the last opportunity to prevent coverage loss — and most people in this window need active help, not just notification. [1]

Compliance Pathway

Noncompliance Finding
State determines member did not meet the 80-hour/month requirement

State Notice Issued
CMS IFC requires member notification before any disenrollment action

Cure Period Window
Final checkpoint — member must respond with documentation to cure noncompliance

Outcome
Reinstatement (cured) or disenrollment (not cured)

6%

of all expansion enrollees projected to lose coverage due to administrative or paperwork barriers — not failure to meet hours [1]

Why the Cure Period Fails

- Not receiving or understanding the notice
- Not knowing what documentation will resolve noncompliance
- No trusted navigator available to help respond in time

Regulatory Basis

CMS Interim Final Rule (CMS-2454-IFC) specifies a noncompliance process: states must notify individuals and provide an opportunity to cure before disenrollment

High-Impact Intervention Point

Hospital-based and CBO-supported cure period navigation is a time-sensitive intervention — reaching members before the cure window closes prevents otherwise avoidable disenrollment

Connecticut must build notification, outreach, and cure-period support infrastructure before January 1, 2027

Key failure point: members who never receive, understand, or act on the cure notice in time are disenrolled despite a final chance to keep coverage

Hospital and Partner Roles in Failure Point Interventions

Hospitals and community partners provide the trusted infrastructure needed to deliver targeted interventions at each potential point of failure in the compliance pathway.

Each stage below maps potential interventions to each of the six failure points, in sequence — from the initial application through the cure period.

1 INITIAL APPLICATION
First failure point intervention

- Screen uninsured patients at the point of care and file the HUSKY D application at the strongest lookback month
- Identify prior-month exclusions, hardship, or deemed compliance and gather documentation before discharge
- Track pending applications and help applicants respond to DSS requests after discharge

2 RENEWAL NOTICE
Second failure point intervention

- Flag HUSKY D members approaching renewal during clinical visits and non-clinical contact points
- Help update contact information and complete renewal paperwork
- Track renewals to prevent procedural loss of coverage

3 EXEMPTIONS
Third failure point intervention

- Screen patients at point of care for potential exemption eligibility
- Connect to navigators and assisters for documentation support
- Integrate HUSKY D status into social needs screening

4 WORK RULES
Fourth failure point intervention

- Help members log and document qualifying hours and activities
- Link to work, education, and volunteer options that count toward hours
- Refer members to community health workers for ongoing support

5 REPORTING & VERIFICATION
Fifth failure point intervention

- Remind and support patients before each six-month reporting cycle
- Provide language-accessible and digital reporting assistance
- Coordinate with community health workers embedded in clinics

6 CURE PERIOD
Sixth failure point intervention

- Identify and reach out to patients who received noncompliance notices
- Provide rapid-response navigation to help restore coverage
- Track and report coverage disruptions to inform system response

CBOs & Community Organizations
Lead outreach to hardest-to-reach populations; local coalitions coordinate across hospital service areas

References

[1] Medicaid Community Engagement Requirement for Certain...

[2] DSS Presentation to MAPOC – June 12, 2026

[3] HUSKY and work requirements – How to make it work

[4] An Examination of Medicaid Renewal Outcomes and Enrollment Changes at the End of the Unwinding

[5] A Closer Look at the Work Requirement Provisions in t...

[6] Medicaid Program; Community Engagement Requirement for Certain Individuals: Interim Final Rule