ACKNOWLEDGEMENTS

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INTRODUCTION

Retaining eligible children and adults in HUSKY Health, Connecticut’s Medicaid and CHIP programs, is a key strategy for reducing the number of uninsured Connecticut residents and increasing efficiency within state agencies. One known obstacle to retaining eligible enrollees is various bureaucratic obstacles at the point of annual renewal. However, a concrete understanding of the causes of gaps in coverage for Connecticut’s HUSKY enrollees remains elusive. This paper seeks to evaluate the likely causes of temporary coverage loss for HUSKY members and then proposes options to ensure that fewer individuals experience these gaps in coverage.

To assess the causes of gaps in HUSKY coverage, Connecticut Voices for Children (Connecticut Voices) partnered with Health Equity Solutions with support from the Advancing Strategies to Align Programs (ASAP) project—led by the Center for Law and Social Policy (CLASP) and the Center on Budget and Policy Priorities (CBPP)—to conduct focus groups on challenges faced by HUSKY enrollees and individuals providing assistance when navigating the enrollment and renewal processes.

BACKGROUND

Addressing gaps in health insurance coverage could reduce disparities in insurance coverage rates in Connecticut and simultaneously advance health equity through improved access. Barriers that make it difficult to maintain HUSKY coverage impose high costs on Connecticut’s most vulnerable residents, and particularly on low-income families and people of color, who are disproportionately insured through HUSKY. These barriers make it difficult for eligible recipients of state aid to receive the assistance for which they qualify. By the same token, there is little to no evidence that burdensome renewal mechanisms, such as requiring frequent submission of paperwork, are necessary to or effective at screening out applicants who are ineligible for such assistance. Rather, cumbersome processes may lead eligible HUSKY enrollees to lose coverage.

Gaps in coverage are associated with discontinuity of care—meaning patients may not receive continuous care for chronic medical conditions, such as major depression or diabetes. Additionally, coverage gaps reduce ambulatory care, increase emergency room use, raise health care costs for both hospitals and the community, and lead to worse patient outcomes. The HUSKY program’s income eligibility rules, which are based on federal Medicaid and CHIP rules, mean that these challenges are borne exclusively by low-income residents, and disproportionately people of color. Both residents with low income and people of color are more likely to be exposed to adverse social determinants of health—such as food insecurity, limited access to transportation, and housing instability—which make managing chronic health conditions and access to preventive care challenging.

While the Connecticut Department of Social Services (DSS) has not released the complete data needed to evaluate coverage gaps for several years, a 2016 study by Connecticut Voices found 23.4 percent of children in HUSKY A and B lost coverage at least once within one calendar year. These children were likely still eligible when they lost coverage. Further, comments made at the Council on Medical Assistance Program Oversight (MAPOC) indicated as many as 20 percent of a representative subset of the Medicaid population—both adults and children—were disenrolled and then re-enrolled within 60 days. Additional research has shown that non-disabled adults under the age of 65 have even lower levels of continuous coverage. Roughly 40-80% of children disenrolled from HUSKY A (Medicaid) each month are disenrolled due to “failure to comply” with renewal procedures, suggesting administrative barriers. DSS has made efforts to limit gaps in coverage for enrollees in the Patient Centered Medical Home Plus (PCMH+) program by notifying their primary care provider when the renewal date is approaching. Additional steps could remove barriers for all enrollees (not just those enrolled in PCMH+) without adding to the primary care provider’s long list of obligations. One promising avenue for filling these coverage gaps is removing bureaucratic obstacles for re-enrollment. The national Covering Kids and Families (CKF) initiative found that procedural problems, such as frequent renewals and complicated and confusing renewal processes, commonly interfere with retention.
**METHODS**

This paper analyzes data from three focus groups held in September 2019 in New Haven, Hartford, and Bridgeport. The New Haven focus group consisted of HUSKY members, while those in Hartford and Bridgeport consisted of certified application counselors (CACs), community health workers (CHWs), and facility-based patient advocates. We asked each group to identify positive and negative experiences with HUSKY eligibility systems and to offer recommendations for addressing barriers to retaining eligible HUSKY members. We transcribed each focus group discussion with Trint, a digital transcription service. We then coded discussions using Dedoose, a web application for coding, managing, and analyzing qualitative data. From this, we determined overarching themes within the coded data.

**RESULTS**

The focus groups primarily consisted of CACs and CHWs (50 percent) and HUSKY members or family members of HUSKY enrollees (20 percent). A more detailed breakdown of focus group participants’ roles is listed in Table 1.

<table>
<thead>
<tr>
<th>Title Provided</th>
<th>Percentage</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Application Counselor</td>
<td>25 percent</td>
<td>10</td>
</tr>
<tr>
<td>Community Health Worker</td>
<td>25 percent</td>
<td>10</td>
</tr>
<tr>
<td>HUSKY member</td>
<td>17.5 percent</td>
<td>7</td>
</tr>
<tr>
<td>Financial counselor</td>
<td>12.5 percent</td>
<td>5</td>
</tr>
<tr>
<td>Health care advocate</td>
<td>10 percent</td>
<td>4</td>
</tr>
<tr>
<td>Social worker</td>
<td>5 percent</td>
<td>2</td>
</tr>
<tr>
<td>Department of Children and Families Caseworker</td>
<td>2.5 percent</td>
<td>1</td>
</tr>
<tr>
<td>Family of HUSKY member</td>
<td>2.5 percent</td>
<td>1</td>
</tr>
</tbody>
</table>

Participants’ experience with HUSKY programs ranged from ten or more years (37.5 percent) to one year or less (15 percent).

Focus group discussions centered on the process of enrolling in and renewing HUSKY health coverage. Most participants praised the role HUSKY plays in their lives or their clients’ lives overall, and indicated that wait times for the call centers had decreased in recent months. Both application counselors and HUSKY enrollees expressed concerns about the challenges they face when using the Access Health CT and DSS call centers, visiting the DSS office in person, and navigating communication between agencies and information technology (IT) systems.

The following themes arose most frequently during the focus group discussions: call center procedure (15 percent), call center accuracy (13 percent), in-person navigation (9 percent), and interaction between agencies (9 percent). Other themes, such as notification letters, resolution of application problems, and verification process, appeared less than four percent of the time. When looking at top themes, while in person navigation only appeared 9 percent overall, the theme was disproportionately mentioned as a concern in the New Haven focus group which consisted of HUSKY enrollees.
Call center accuracy presented significant challenges, particularly for certified application counselors (CACs). Several CACs referenced receiving incorrect or conflicting information from call center staff, particularly from the Access Health CT call center. For example, one CAC explained, “We try not to ever call the call center because of the lack of knowledge the reps have.” Call center procedure related to authorization to speak on behalf of a client was also a common frustration. Echoed by other focus group participants, one CAC noted, “We collect [the client’s] information before we call in, so why do they keep making the process longer [by requiring the client to speak]? So to me, it’s very time-consuming when you’re calling in. So, why can’t we give the information? It will take five minutes to get through the call.”

Focus group participants commented on the process of visiting DSS offices in-person. While experiences varied, several presented concerns with the experience. Finding transportation to and from the DSS office presents an initial barrier, as do accommodations for elderly and disabled people who may find waiting in line uncomfortable and taxing. One enrollee noted, “At one point I waited for 8 hours…I can’t stand for long.” In addition, focus group participants found the experience to be time-consuming and stressful. Another enrollee noted, “In Manchester and Hartford, they come out and call your name and have you come in. You go up to the desk and tell them what you need. They will tell you to have a seat. You can ask how long you’re going to wait, because sometimes you’re there a couple hours and other times you’re there all day.”

Participants also reported challenges related to computer system interactions. Multiple systems collect and verify eligibility information, including a shared enrollee-facing portal called HIX for enrollment and renewal in HUSKY A, B, D, and the state health insurance exchange. DSS also maintains a self-service portal called ConneCT, for HUSKY C and other social services programs. Finally, DSS maintains a comprehensive eligibility and enrollment database called ImpaCT, which is not consumer-facing. Individuals enrolled in either HUSKY A, B, or D and another social service program must navigate both HIX and ConneCT. HIX makes eligibility determinations for HUSKY A, B, and D$^{15}$ in real-time, and information is later transferred to ImpaCT. Information sharing among systems is in one direction only. ImpaCT cannot send data to HIX or ConneCT. This creates challenges for enrollees who may have to navigate two self-service portals that may not have the same stored information. ImpaCT is an internal data management system and is not accessible to enrollees or most application support personnel. For example, many CACs and enrollees noted that after seeing a positive enrollment notice online, individuals might “receive a letter stating they’re no longer eligible.” However, when calling DSS, the client may be told they are eligible. Because systems don’t share information quickly, bi-directionally, and without error, clients may receive confusing, inaccurate, and conflicting notices regarding their HUSKY status.

While data is not publicly available to evaluate why gaps in coverage exist for HUSKY enrollees, focus group conversations suggest that gaps may be due to the challenges faced by enrollees and application counselors in renewing HUSKY coverage. Further, calls and visits, which were found to be problematic, would likely be necessary less often if systems were easier to navigate and less confusing. Therefore, the recommendations that follow focus on ways to simplify the renewal process.
POLICY RECOMMENDATIONS

Producing a more streamlined experience for enrollees, application assisters, and DSS caseworkers can reduce gaps in coverage and mitigate administrative challenges and expenses. The following recommendations are drawn from challenges noted by focus group participants and the solutions they suggested. If implemented, these recommendations could lead to greater continuity of coverage for HUSKY health enrollees.

IMPROVE DATA ANALYSIS AND INCREASE TRANSPARENCY

To assess the prevalence of gaps in coverage and evaluate efforts to reduce these gaps, it is necessary to track who is losing coverage, how many of the people losing coverage are likely still eligible, and why eligible members may be experiencing gaps in care. This analysis could be completed using data already collected and stored by the HUSKY eligibility systems. The State of Connecticut funded evaluation of gaps in coverage for children through the HUSKY Monitoring Project until 2015, indicating that such analysis is both possible and useful. Compilation and public release of the following data could help policymakers understand who is most affected by gaps in coverage and assess the likely impact of proposed policy solutions:

- Disenrollment reason: Analysis of disenrollment reason codes can clarify the proportion of HUSKY enrollees who disenroll due to changes in income rather than because the enrollee did not meet procedural or administrative requirements. This can help to differentiate between disenrollment because individuals are no longer eligible and disenrollment that could be due to administrative barriers at application or renewal.

- Reinstatement: We define reinstatement as any individuals disenrolled and then re-enrolled within 90 days. Reinstatements often represent administrative inefficiencies and result in costly gaps in coverage for HUSKY enrollees.

Having data on when and to whom reinstatement occurs can point to the most efficient changes to eliminate challenges in retaining coverage faced by HUSKY enrollees. Doing so could save DSS an estimated $400 to $600 in administrative costs per person per reinstatement—the cost of one person disenrolling and re-enrolling in Medicaid—by preventing unnecessary coverage loss.

These metrics could be added to the quarterly business analytics report shared with MAPOC. Reporting on both disenrollment and reinstatement should include demographic factors such as the program type, age groups, and race/ethnicity of impacted enrollees. Improved transparency would allow policymakers and stakeholders to track progress due to changes made to the enrollment and renewal process or that may result from policy changes at the federal level. Further, improved reporting would highlight the consequences of systems changes, whether positive or negative, and guide policymakers towards next steps.

A Note on Continuous Eligibility:
Connecticut health advocates, including Connecticut Voices, have repeatedly attempted to restore (since 2003) and expand continuous eligibility, which is defined as 12 months of continuous enrollment regardless of changes in income, household size, or other factors that could impact eligibility. As of 2019, 24 states have continuous eligibility for children in Medicaid, 26 states have continuous eligibility for children in CHIP, and just two states (Montana and New York) have continuous eligibility for adults. While enrollees are required to report changes in income as they occur, redeterminations and requests for verification documents occur only at the end of a 12-month enrollment period in Connecticut. In contrast, some other states conduct data matches and request verification documents from some households periodically throughout the 12-month enrollment period, increasing the impact of continuous eligibility and the administrative burden on the state. We have not included continuous eligibility in the recommendations here because it would likely have limited impact in Connecticut.
**UPDATE TECHNOLOGY TO STREAMLINE MEDICAID RENEWAL**

*Streamline Eligibility Determinations at Renewal*

Connecticut has made strides in increasing the rates of autorenewal for some HUSKY Health programs. The January 2020 HUSKY Health Business Analytics Dashboard estimated that on average from June of 2018 to January of 2020 65.25 percent of HUSKY A, B, and D enrollees were automatically renewed per month. Additional steps could streamline Medicaid renewals through updates and changes to IT systems. One promising change would be to utilize eligibility determinations from other means-tested social services for renewal (and enrollment) in Medicaid. This would minimize the stress enrollees in the focus groups felt surrounding renewals; in particular, it would address confusion when documents submitted to verify eligibility for one program are requested again soon after to determine eligibility for another. Some participants assumed that there was no need to resubmit verification documents a few weeks or months later for a different benefit program since multiple social services are administered by DSS and documents had been submitted to one DSS portal or office. As currently structured, such information is not linked across programs for an individual.

Simplifying administrative processes in this way mitigates the risk that income-eligible enrollees will lose Medicaid coverage because of a complicated renewal process or slow processing of documents. An option to apply this alignment for children’s renewals (called Express Lane Eligibility in some circumstances) would allow the state to align eligibility determinations across programs, such as SNAP (formerly Food Stamps) and cash assistance programs like Temporary Assistance for Needy Families (TANF) to verify family income, household size, or citizenship status. In addition, this option allows the use of income data from other programs even if the method for calculating income differs between the two programs.

Connecticut could link SNAP data to HUSKY eligibility redeterminations. HUSKY enrollment systems currently verify eligibility using information from the Department of Labor and Homeland Security. The income information verified for SNAP can be used to determine if an individual or household remains eligible for Medicaid.

To implement a similar option for adults as well as children, states have the ability, under Medicaid state plan authority, to use SNAP gross income to support Medicaid income eligibility determinations. While some SNAP-eligible adults have income in excess of the eligibility limit for Medicaid, a subset of SNAP participants are certain to have MAGI-based household income at or below the Medicaid threshold of 138 percent of the federal poverty level (FPL) for adults without dependents ($16,643/year for an individual) or 160 percent FPL for parents ($25,513/year for a family of 2). Implementing streamlined eligibility determinations for both children and adults through a state plan amendment would allow for the greatest continuity in coverage and reduce the administrative burden on enrollees to submit documents multiple times and on state workers processing verification documents.
**Develop User-Friendly Applications**

In addition, Connecticut could redesign IT systems to improve user experience. HUSKY enrollees in the focus groups found the online processes challenging and time-consuming, expressing confusion about submitting documents and then receiving notification that documents had not been submitted. These concerns aren’t surprising. First, the state has two enrollee-facing portals. Enrollees may think they are correctly submitting documents in response to a renewal request, while inadvertently submitting information to one portal that is required in the other.

A recent 50-state analysis also identified Connecticut’s online applications for social services as particularly cumbersome due to multiple applications on different websites. Today, an application in one database may generate a notice that the applicant may be eligible for other social services, but applicants are required to fill out each application separately. This requires applicants to dedicate additional time to re-entering information rather than hosting enrollee’s information under a single account or client ID. This may further result in multiple client files for one person. 27 states allow applicants to fill out a single form for Medicaid, SNAP, and TANF, which is then shared across social service programs. Further, even though many low-income Americans rely on smartphones for internet access, the Connecticut Medicaid application is not mobile-friendly.

While Connecticut has a single system for Access Health CT marketplace plans and three of the four main HUSKY Health programs, applications for other social services, such as TANF and SNAP, use a separate system. An integrated application or a single login linking user information, available both on desktop computers and mobile phones, could improve the renewal (and application) experience for enrollees and reduce demands on caseworkers and call centers.

**CONCLUSION**

Connecticut recently implemented a new eligibility database and has made strides in increasing rates of autorenewal and simplifying the processing of paperwork. Yet, focus group participants identified a variety of challenges with the HUSKY enrollment and renewal processes. Improving user experience and system challenges could reduce gaps in coverage and increase administrative efficiency. Tracking the impact of changes to eligibility systems by reporting on gaps in coverage would ensure that solutions work across HUSKY programs and populations. For the most vulnerable Connecticut residents, improving these systems would be one step towards continuity of health insurance coverage and, as a result, access to regular health care.
REFERENCES

Note: The analysis provided was specific to the Patient Centered Medical Home Plus (PCMH+) shared savings program and DSS staff noted that “churn” found in this population was similar to “churn” found across the HUSKY programs. In recent months, DSS has engaged primary care providers to help PCMH+ patients navigate the renewal process.
Note: An effort to reduce gaps in coverage within the PCMH+ program recently went into effect. Primary care providers will be alerted when re-enrollment is about to occur.
12. Trint, web-based AI transcription software, https://trint.com
14. 8 participants did not reply to this question.
15. Determinations for HUSKY A, B, and D are based on modified, adjusted gross income (MAGI) while determinations for HUSKY C (Medicaid for low-income older residents and residents with disabilities) are more complex and handled separately.
21. While HUSKY uses and individuals modified adjusted gross income (MAGI), other programs may consider additional forms of income, such as child support or veterans’ benefits.
26. Income eligibility for HUSKY A, B, and D is based on modified adjusted gross income (MAGI) and individuals can apply for each via Access Health. HUSKY C is not MAGI-based and has a separate application system.