January 15, 2026 Complex Care Committee Zoom Meeting

Meeting summary

Quick recap

The Complex Care Subcommittee of MAPOC held its first meeting of 2026, focusing on home care services for medically complex children and adults. The meeting featured powerful testimony from two families about their experiences caring for children with severe medical needs, highlighting the critical importance of skilled nursing care and the challenges posed by inadequate reimbursement rates. The committee discussed concerns about workforce shortages, particularly among LPNs, and the need to increase rates to attract and retain qualified nurses. They also addressed issues with prior authorization requirements for certain medications and explored ways to improve hospital discharge planning for Medicaid patients. The conversation ended with a discussion of the Rural Health Transformation Grant and its potential impact on community-based services.

Next steps

- Tracy Wodatch (CT Association for Healthcare at Home): Provide a flow chart or detailed mapping showing how current home care reimbursement rates do not cover all required costs (e.g., supervision, case management, regulatory requirements) to the committee for use in advocacy and budget requests.
- Bill Halsey (DSS): Check whether complex nursing services were included in the current rate study conducted by Myers and Stauffer; if not, explore the possibility of including complex nursing as part of a future rate study.
- Bill Halsey (DSS): Provide the committee with a breakdown of the number of Medicaid members currently affected by the new prior authorization requirements for the 200 specified drugs.
- Co-Chair Rep. Susan Johnson (Rep): Obtain and share with the committee information on Massachusetts' Medicaid agreement language regarding home care nurse reimbursement, and compare with Connecticut's to identify potential improvements.
- Bill Halsey (DSS)/Committee: Schedule a future Complex Care Subcommittee meeting with the Hospital Discharge Planning Work Group to discuss discharge delays and the impact of home care workforce shortages on hospital discharges.
- Bill Halsey (DSS)/Committee: Schedule a public presentation/meeting to detail the Rural Health Transformation Grant projects, including any PACE program(s), and explain implementation, budget, and compliance plans to stakeholders.
- Sheldon Toubman: Send contact information to Rachel Botts to discuss offline the issue of DME suppliers not providing certain equipment due to low reimbursement rates.
- Sheldon Toubman: Share the list of drugs subject to new prior authorization requirements in the chat and provide a copy of the bulletin for committee review.

- Bill Halsey (DSS): Have Dr. Jody Terranova join a future meeting to update the committee on the latest research and developments regarding oral GLP-1 medications and the BALANCE CMS initiative.
- Committee: Keep Medicare Advantage plan tracking and dually eligible issues on the agenda, including monitoring for access and advocacy concerns.
- Committee: Keep HBCS exploration and analysis of PACE pilot program on the agenda for future updates.
- Committee: Elevate the workforce crisis in complex care nursing (including LPN pipeline issues) and reimbursement rate concerns to the full MAPOC committee and relevant legislative bodies for action.
- Committee: Monitor and respond to the implementation of new prior authorization requirements, including advocating for proper notice and due process for affected Medicaid members.
- Bill Halsey (DSS): Resubmit the revised budget for the Rural Health Transformation Grant to CMS within 30 days and report back to the committee on the status and included projects.
- Steven Colangelo: Share methodology/information on how to identify Medicaid clients enrolled in Medicare Advantage plans using the "H indicator" with the committee.

Summary

Complex Care Home Services Review

The MAPOC Medicaid and Oversight Committee's Complex Care Subcommittee met after a six-month pause to discuss home care services for complex children and adult patients. The meeting, was being broadcast live on CT-N. The committee planned to review rate review study implications, hear from DSS about rapidly occurring changes affecting complex care patients, and receive presentations from Aveanna Healthcare and patients/consumers regarding home care services.

Challenges of Nemalin Rod Myopathy

Rachel Botts, a parent of a 13-year-old girl with nemalin rod myopathy, shared his daughter's daily challenges, including the need for a liquid diet, wheelchair use, and breathing treatments. She highlighted the impact of reimbursement rates on the availability of medical equipment, such as the IPV machine, which is no longer carried by respiratory therapy DME providers in the state. Despite these challenges, Ella maintains a high academic performance and participates in extracurricular activities like robotics and school plays.

Medicaid's Role in Home Care

Rachel and Patricia shared powerful testimonies about their children's complex medical needs and the critical role of Medicaid funding in enabling them to receive necessary care at home. Rachel described how his daughter, Ella, requires frequent hospital stays and specialized medical equipment, while Patricia detailed her son Kevin's 40-year journey with a chromosome deletion,

including his need for a tracheostomy tube, oxygen support, and around-the-clock nursing care. Both mothers emphasized the importance of high-quality nurses and Medicaid funding in allowing their children to live at home rather than in institutions, while also highlighting the financial and emotional toll of their children's medical conditions. The discussion revealed significant challenges in accessing specialized medical equipment and supplies due to low reimbursement rates, with Sheldon offering to provide further information on addressing these issues.

Medicaid Cuts Impact Family Caregivers

Patricia and Rachel shared their experiences caring for their children with disabilities, highlighting the critical role Medicaid funding plays in supporting their families and the broader community of vulnerable individuals. They expressed concern about potential Medicaid cuts and the ripple effects on healthcare providers, nursing services, and the quality of life for their children. The representative echoed these concerns, emphasizing the human costs of such cuts and the need to reframe the value of this work, while also criticizing the broken system that forces family caregivers to work outside the home to afford basic needs.

Nursing Shortage Funding Solutions

The committee discussed the critical shortage of nurses, particularly LPNs, in home care and nursing homes, with Rachel and Patricia sharing personal experiences about the challenges of finding adequate nursing care for their children. Teri presented data showing that Connecticut's reimbursement rates for skilled nursing are significantly lower than Massachusetts', with approximately 35% of nursing shifts going unfilled due to insufficient funding. The committee agreed that increasing funding and reimbursement rates for home care nursing services is essential to ensure access to care for vulnerable individuals and support the nursing workforce.

Home Healthcare Reimbursement Rate Challenges

The meeting focused on home healthcare funding challenges, where Tracy Wodatch from the Connecticut Association for Healthcare at Home highlighted that current RN and LPN reimbursement rates of $59 and $50 respectively are insufficient to cover supervision costs and other expenses, while also noting that hospitals spend $10,000-12,000 daily on patients who could be cared for at home for $1,000-1,200. The group discussed the need to increase reimbursement rates and examine their federal Medicaid agreement, with Representative Johnson suggesting they could learn from Massachusetts's approach to reimbursement language. The committee agreed to explore these issues further at their next Complex Care Committee meeting, including examining Senate Bill 1 regarding nurse protection in home care settings and potentially changing their federal Medicaid agreement language.

Medicaid Reimbursement Rates Discussion

The group discussed reimbursement rates for DSS providers and federal matching funds for different Medicaid programs. William explained that federal reimbursement rates are non-negotiable but outlined how state plan amendments can affect provider payments. Rep. Johnson agreed to consider this information and check with Massachusetts for further details. Steven inquired about a rate study comparing Connecticut and Massachusetts, which Bill Halsey said he would verify and potentially include Complex Nursing as part of the study. The group also touched on accelerating rate increases for the medically fragile population and increasing access to GLP drugs for Medicaid patients.

GLP Medication Coverage and Initiatives

The meeting discussed medication coverage and federal initiatives related to weight loss and diabetes treatments. William explained that they cover GLP medications for diabetes, sleep apnea, and other FDA-approved uses, but not for weight loss. The group reviewed two federal partnership initiatives, Generous and Balance, which they are considering joining. Steven Colangelo mentioned a state-mandated report on GLP-1 usage due the next day. Tracy inquired about oral weight loss medications, and Bill confirmed they are tracking the development of oral GLP-1s. The conversation ended with a brief discussion on long-term care concerns, including staffing shortages in complex care settings.

Long-term Care Policy Challenges

The subcommittee discussed several long-term care issues, including limited waivers, lack of care coordination for community-first choice program participants, and PCA payment problems. Sheldon Toubman raised concerns about new prior authorization requirements for 200 drugs affecting thousands of people, which violate state law and lack proper notice. The department was asked to provide a breakdown of affected individuals, and Sheldon agreed to share a list of affected drugs. The committee also noted the ongoing need to explore and analyze the PACE pilot program, as previously legislated.

Medicaid and Healthcare Policy Updates

The committee discussed several key topics related to healthcare and Medicaid. Bill explained that the Rural Health Transformation Grant received $154 million, less than the full $200 million requested, but noted this was due to rural population considerations. Sheldon clarified that the new prior authorization process for 200 drugs, starting April 1st, would not include written notices for patients whose doctors did not request authorization. Rep. Johnson raised questions about APRN prescribing abilities under the new Medicaid changes, which Sheldon confirmed were applicable. The committee also discussed concerns about Medicare Advantage plans and a new CMS initiative called Geo Ahead, which Sheldon warned could lead to involuntary enrollment in risk-based entities. The committee agreed to keep these issues on their radar and plan for future discussions.

From the Chat:

Here is the DSS bulletin issued 12/1/25 re the extensive new drug PA requirements: Connecticut Department of Social Services

The chart of the 11 categories of drugs affected is on page 2 of the FAQ and the detailed list of some 200 drugs involved is at the end of the FAQ. The DSS Medical Director said on 12/12 that there is no intent to provide due process notice before people are cut off of their existing drugs starting 4/1/26, if by then their doctor has not requested and obtained PA. In addition, the bulletin makes clear that the standards applied in deciding prior authorization requests will be narrower than those mandated under state law, see Conn. Gen. Stat. §17b-259b.

How HETS Works for Medicare Advantage (MA):

1. **Eligibility Check:** Providers use HETS to send HIPAA-compliant 270 requests to see if a patient has Part A/B and/or is in an MA plan.
2. **Response (271):** HETS returns a 271 file showing the beneficiary's enrollment status, confirming if they are eligible for MA benefits or Original Medicare.
3. **Payment Determination:** This confirms which entity (Original Medicare or the MA plan) pays for services, directly affecting claims processing and cost-sharing

ETS is for eligibility checks, indicators define payment rules, and while related to Medicare, distinct processes handle Medicaid or dual-eligible status, with specific codes signaling various billing & payment conditions.