

May 21, 2026 Complex Care Committee Zoom Meeting

Meeting summary

Quick recap

The Complex Care Committee meeting focused on healthcare data analysis and Medicaid program insights. Representative Johnson and Representative Hughes co-chaired the meeting with participants from various agencies including the Office of Health Strategy, Department of Social Services, and healthcare advocacy groups. Alex Rieger from the Office of Health Strategy presented comprehensive healthcare spending data showing that Medicaid per capita spending grew 14% from 2023 to 2024, with long-term care representing the largest spending category at 46% of total Medicaid spending. The discussion revealed challenges in obtaining data about Medicaid members enrolled in Medicare Advantage plans, with participants noting that DSS possesses this information but has not yet provided it to the committee despite multiple requests over six months. The meeting also covered the newly established Diabetes Caucus and explored potential policy implications for early diabetes detection and management, particularly regarding gestational diabetes and its connection to postpartum depression. Participants discussed value-based payment models and their potential impacts on healthcare providers, with advocates expressing concerns about financial risk being placed on providers. The committee addressed ongoing issues with hospital discharge planning for Medicaid beneficiaries and the challenges faced by dual eligible Medicare-Medicaid recipients, particularly those enrolled in Medicare Advantage plans where cost-shifting concerns exist.

Next steps

Alex Rieger

- [Send presentation slides to David Kaplan for posting online](#)

Carolyn Grandel

- [Share information about CHNCT Care Management Program's current approaches to diabetes management for future Diabetes Caucus meeting](#)

Deb Migneault (UConn Center on Aging)

- [Coordinate with DSS to present data comparison of Medicaid costs for Medicare Advantage vs traditional Medicare beneficiaries at future meeting](#)

Collaboration

- [Rep. Anne Hughes/Rep. Susan Johnson: Schedule DSS representatives to present at next meeting about Medicare Advantage plan member data](#)

- [Rep. Anne Hughes/Rep. Susan Johnson: Schedule future presentation about hospital discharge planning issues with Public Health Committee chairs](#)
- [Rep. Anne Hughes/Rep. Susan Johnson: Schedule future meeting with OHS staff from different agencies to explain their new responsibilities and contacts](#)

Summary

Scheduling Meeting Issues

David Kaplan clarified that the next meeting would be on July 16th (corrected from the 17th) and confirmed he had updated the calendar.

Diabetes Caucus Formation Meeting

The meeting began with introductions from committee Co-Chairs State Rep Johnson and State Rep Hughes, along with other participants including representatives from the Office of Health Strategy, UConn Center on Aging, and Department of Social Services. State Rep Susan Johnson announced the formation of a new Diabetes Caucus at the Capitol and mentioned their first session focused on discussing policies for addressing type 1 and type 2 diabetes under the Medicaid program, including potential cost savings and access to healthcare.

Diabetes Caucus Planning Discussion

Rep. Johnson explained their vision for a diabetes caucus focused on early detection and prevention, including newborn and prenatal testing, particularly for Medicaid recipients. Rep. Hughes suggested exploring the intersection with care management programs, particularly regarding Medicaid coverage for gestational diabetes and postpartum care. Carolyn Grandell offered to share information about the current CHNCT Care Management Program's approach to diabetes, and Rep. Johnson invited further participation and input for future caucus discussions.

Connecticut Healthcare Spending Trends

Alex Rieger from the Office of Health Strategy presented data on healthcare spending trends in Connecticut, highlighting that per capita spending grew statewide by 8.5% from 2023 to 2024, with Medicaid experiencing particularly high growth at 14%. The data showed long-term care as the largest spending category in Medicaid, comprising 46% of total spending, with retail pharmacy growing at the highest rate overall. When excluding long-term care, Medicaid growth dropped from 14% to 9.1%, suggesting that long-term care is a significant driver of Medicaid spending increases.

Mental Health Data Transparency

Alex explained that their office publishes transparent Medicaid data annually to help stakeholders understand trends and costs, with particular growth noted in long-term care for an aging population. Rep. Johnson expressed appreciation for the data coordination with Human Services and mentioned

its potential value for preventing unnecessary cost shifting between insurance programs. Rep. Hughes asked about per capita spending trends and whether the benchmark growth law is effectively containing costs, to which Alex responded that while cost containment is a goal, the data also highlights areas needing focus, particularly long-term care for Connecticut's aging population.

Retail Pharmacy Cost Analysis

Alex discussed the impact of retail pharmacy costs on healthcare markets and mentioned various approaches to reduce prescription drug expenses, including incentivizing biosimilars and generics. Rep. Johnson inquired about the analysis of pharmaceutical costs, specifically mentioning the 340B program, to which Alex responded that their program does not capture 340B data separately. Kathy Holt questioned the low hospital inpatient spend per capita figures presented by Alex, suggesting a breakdown by population groups like dual eligibles could provide more insights for focusing efforts. Alex acknowledged the request and mentioned their data covers about 950,000 Medicaid patients and 215,000 dual eligibles, but did not commit to providing specific trend breakdowns.

Value-Based Payments Growth Discussion

Alex discussed the growth in non-claims value-based payments, noting a 100% increase but only affecting spending by several hundred dollars per capita. The group explored when value-based payments were implemented, with Deb clarifying that while HCBS had some value-based payments starting in 2020, nursing facility quality-based measures would not begin until 2027. Sheldon Toubman emphasized the importance of understanding that value-based payment terminology can mask financial risks placed on providers, though he noted the Connecticut model appears to focus on bonuses for meeting outcome measures rather than direct financial risk.

Value-Based Care Framework Discussion

Alex explained the different categories of value-based care using the HPC LAN framework, noting that while categories 3B and above with shared risk tend to be most cost-effective, the majority of value-based care dollars in Connecticut flow through non-risk-bearing instruments. Brenda Buchbinder raised concerns about the dismantling of the Office of Health Strategy and emphasized the importance of considering human impacts beyond cost containment, including quality of life and public health access. Alex clarified that their benchmark program includes three components: cost containment, primary care spending targets, and quality benchmarks, with a robust quality council meeting monthly to ensure high-quality care standards are maintained.

All-Payer Claims Database Resources

Alex presented data resources available through the All-Payer Claims Database, including public dashboards on healthcare costs and hospital trends that can be accessed on the OHS data transparency website. Steven Colangelo provided context on dual Medicare Medicaid enrollment in Connecticut, noting that only about 60,000 individuals are full duals while 140,000 are in Medicare

Savings Programs. Sheldon Toubman raised concerns about potential harm from financial risk on providers in value-based payment systems, though Alex acknowledged the debate and emphasized their efforts to inform the discussion with available data.

Dual Eligibles Data Discussion

The meeting focused on discussing data related to dual eligibles (Medicaid and Medicare beneficiaries) and challenges with Medicare Advantage plans. Alex Reger presented data showing approximately 60,000-67,000 dual eligibles, and participants discussed the difficulty in obtaining comprehensive data about Medicare Advantage plan beneficiaries, including information about care coordination and cost shifting. The group explored potential solutions, including comparing Medicaid payments for individuals in Medicare Advantage versus traditional Medicare plans, and discussed the need for better care management for dual eligibles to prevent unnecessary hospital visits and optimize resource utilization. The next meeting was scheduled for July 16th at 1 PM, and participants agreed to continue working on obtaining more detailed data from DSS and other agencies.

Steven Colangelo

[Number of Dual-Eligible Individuals | KFF State Health Facts](#)

67,149 FULL duals

[DSS Data + Dashboards](#)

Alex Reger - OHS

Link to our website: https://portal.ct.gov/ohs/programs-and-initiatives/healthcare-benchmark-initiative?language=en_US

The Benchmark Team also tracks the use of Alternate Payment Models, which includes most VBCs

Alex Reger - OHS

[ohs-alternative-payment-model-monitoring-report-2023.pdf](#)

Alex Reger - OHS

OHS Dashboards: [HCBI Data Transparency](#)

Diabetes Caucus Meeting Link

Shareable link: https://us06web.zoom.us/rec/share/vl3cBvmlDpn5IK0W-D5s_lLebnMG_ZivOCNyhaifN7XMVRjnYRDhrPWjKBJEYIIF.sHpkGhZ707j0FMws

Passcode: A4f=WU7p

Kathy Holt

link to the Draft *Hospital Community Benefit Summary and Analysis Report* notice for public review and comment for distribution to the committee.

[Notice for Public Review and Comment Hospital Community Benefit Summary and Analysis Report FY 2024](#)

Brittany Kane

Below is a screenshot from the Kaiser Family Foundation site. They broke down Medicaid/Medicare duals by Traditional Medicare vs. Advantage Plan Medicare Members. Their methodology is below, and the link I used is included.

[Full-benefit Dual-Eligible Individuals, by Medicare and Medicaid Coverage Arrangements | KFF State Health Facts](#)

Location	Traditional Medicare and Medicaid Fee-for-Service	Medicare Advantage and Medicaid Fee-for-Service	Medicare Advantage and Medicaid Managed Care
Connecticut	41,900	26,400	N/A
Delaware	800	400	4,200
District of Columbia	14,900	8,000	200
Florida	32,000	46,500	215,000

Estimates include full-benefit dual-eligible individuals in 47 states and the District of Columbia if (1) they were in both the research-identifiable Master Beneficiary Summary File (MBSF) Base and the 2020 Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files (RIF) file using a Chronic Conditions Warehouse (CCW) beneficiary identifier crosswalk (2) and if individuals were a full-benefit dual-eligible individual in March (03) 2020 using the Medicare monthly DUAL_STUS_CD_03 with values of 02,04,08 or the Medicaid monthly code (March=03) DUAL_ELGBL_CD_03 with values of 02,04,08 or the monthly code (March=03) RSTRCTD_BNFTS_CD_03 with values of 1,A,D,4,5,7. Dual-eligible individuals also had to have both Medicare Part A and B in March 2020 to be included in this analysis. The estimated total of dual-eligible individuals (7.5 million) differs from other KFF estimates due to differences in methods. Due to data suppression and rounding, subgroup estimates may not always sum to the total.

