July 16, 2026 Complex Care Committee Zoom Meeting

Meeting summary

Quick recap

The Complex Care Committee met to discuss issues related to dually eligible Medicare and Medicaid beneficiaries, focusing on hospital discharge processes, Medicare Advantage plans, and the impact of HR-1 on vulnerable populations. Bill Halsey from the Department of Social Services presented on their ongoing work to analyze the dually eligible population, including efforts to obtain claims data from Medicare Advantage plans and coordinate with CMS for better transparency. The committee discussed concerns about early hospital discharges, authorization denials for home health care, and issues with Medicare Advantage plans including marketing practices to vulnerable populations and network limitations that can restrict access to appropriate care settings. Matt Barrett raised important concerns about the upcoming loss of TPS status for hundreds of healthcare workers, particularly Haitian TPS holders who make up a significant portion of the long-term care workforce, which could exacerbate existing staffing shortages in nursing homes and home health care. The committee also addressed issues with Institutional Special Needs Plans (iSNPs) in nursing homes, including problems with provider networks, upcoding practices, and concerns about palliative care being promoted over hospice services, which could affect patient choice and reimbursement rates.

Action Items

- **DSS (Bill Halsey/Brittany Kane):** Present fee-for-service dually eligible utilization data at September meeting
- **DSS (Bill Halsey/Brittany Kane):** Share detailed work plan based on this meeting's discussion
- **Claire:** Present broker/MA market shift trends at September meeting
- **Tracy Wodatch:** Locate and share UConn/Long-Term Services & Supports Working Group recording on hospice/dual research
- **Melanie Lambert:** Consult Toby Edelman on palliative care vs. hospice iSNP issue for potential policy brief update
- **Rep. Hughes/Johnson:** Explore co-authoring public piece on TPS workforce crisis

Decisions Made

- DSS to build a **readmission/utilization reporting template** using existing fee-for-service data, ready to load MA data once obtained
- **September agenda** confirmed for: broker/advertising trends (Claire), DSS data presentation on dually eligible population, and UConn Center on Aging hospice/dual research
- Committee co-chairs to consider **co-authoring a public article** on the impending healthcare workforce crisis from TPS expiration

Key Issues Identified

Medicare Advantage / DSNP Concerns

- MA plans increasingly dominate CT Medicaid enrollment, now exceeding fee-for-service duals
- **Broker commissions** are higher for DSNPs; several major insurers cut broker compensation this cycle, leading nefarious brokers to steer enrollees into poor-fit plans
- **QMB-only enrollees** (partial duals without full Medicaid) are being marketed DSNP benefits they don't actually receive — some states prohibit this practice
- CMS final rule on Parts C & D will **lift advertising restrictions**, enabling MA plans to make largely unchecked claims during fall open enrollment

Hospital Discharge & Readmissions

- MA plans routinely deny or limit home health authorizations (2–3 visits vs. 7–8 on traditional Medicare), driving readmissions
- **Post-payment claim denials** used as attrition strategy against providers
- Capitated hospital contracts incentivize MA plans to **keep patients in hospitals** rather than transition to appropriate post-acute settings; few MA plans contract with long-term care facilities
- Nursing homes at **90% occupancy** in CT; staffing constraints — not bed availability — are the primary barrier to throughput

iSNP-Specific Issues

- iSNPs (Institutional Special Needs Plans) marketed aggressively to nursing home residents, sometimes **without proper consent**
- Nursing homes promoting **palliative care over hospice** to retain iSNP monthly capitated payments; hospice enrollment triggers transfer to fee-for-service, losing the iSNP rate
- Narrow provider networks cause care disruptions when residents must relocate (e.g., nursing home evacuations)

HR1 & Eligibility Impacts

- Dually eligible members should be in **Husky C** and are largely protected from HR1 Medicaid cuts; DSS runs batch eligibility updates automatically
- **Retroactive eligibility** for Husky C and Medicare Savings Programs (SLMB, ALMB) reduced from 3 months to 2 months, effective January 1, 2027
- Lawfully present immigrants (refugees, asylees, TPS holders, etc.) losing **Medicare eligibility** as new enrollees now; existing enrollees lose status January 4, 2027

Workforce Crisis

- Haitian TPS holders losing work authorization ~July 24; survey of just 13 CT nursing homes found **50 affected workers** including RNs and LPNs
- Five-month gap between permit loss and potential asylum work authorization; no clear bridge pathway
- Home health agencies currently absorb 3-month retroactive eligibility risk; reducing to 1 month will cause agencies to **drop Husky D behavioral health cases**, risking institutionalization or incarceration

Pending Confirmation

- Whether CT has data on the number of immigrants losing coverage under HR1 (Rep. Hughes noted Insurance Committee may have figures)
- Exact scope of Haitian TPS workers in home health and community-based settings — no centralized database exists *21*
- CMS receptivity to sharing MA claims data with CT DSS via Westat

Next steps

Rep. Anne Hughes

- Find and share the data on the number of people affected by HR-1 changes to Medicare/Medicaid eligibility.

Tracy Wodatch

- Share the recording of the Long-Term Services and Supports Working Group meeting, which includes UConn Center on Aging research on hospice and palliative care challenges for the dually eligible population.

Bill Halsey

- Develop a more detailed work plan based on the meeting discussion and present it at the September meeting.
- Check with contractor (Westat) to see if a presentation on available Medicare and Medicaid data for the dually eligible population can be prepared for the September meeting.
- Work with CMS and Westat to obtain claims data for Medicare Advantage plans to allow for integrated analysis and outcome measures.

Collaboration

- All participants: Send relevant reports, information, and expertise to David Kaplan to help distill and distribute to committee members.
- Committee: Consider adding a discussion on broker compensation and advertising trends in the Medicare Advantage market to the September meeting agenda.
- Committee: Consider adding a discussion on the workforce crisis related to TPS holders in healthcare to the September meeting agenda.
- Committee: Consider adding a discussion on issues related to Institutional Special Needs Plans (iSNPs) and hospice/palliative care to the September meeting agenda.

Summary

KFF Profile of Dual Eligible Individuals

KFF Five Key Facts about Spending and Enrollment for Dual Eligible Members

Dually Eligible Discharge Process Review

The Complex Care Committee meeting focused on examining hospital discharge processes and dually eligible populations, particularly those in Medicare Advantage plans. Bill Halsey from the Department of Social Services presented an ongoing project to understand dually eligible utilization, costs, and needs, noting that Medicare Advantage members are exceeding fee-for-service numbers in Connecticut Medicaid. The team is seeking CMS technical assistance, collaborating with other state Medicaid agencies, and reviewing national literature to gain better transparency and data on DSNP programs.

Medicare Advantage Dual-Eligible Challenges

Bill and Representative Susan Johnson discussed challenges with Medicare Advantage plans and the movement of dual-eligible beneficiaries between Medicaid and Medicare Advantage. Rep. Johnson raised concerns about brokers potentially limiting access to necessary healthcare by steering dual-eligibles toward Advantage plans with restrictive networks, even though these individuals already qualify for full Medicaid benefits. William clarified that their current focus is on understanding how people flow between fee-for-service and Advantage plans without imposing limitations and mentioned their rural health transformation program is implementing a PACE program which presents an opportunity for population health analysis.

Dual-Eligible Medicare and Medicaid Costs

The group discussed the higher costs and complex care needs of dual-eligible Medicare and Medicaid beneficiaries. Bill emphasized the importance of conducting a deeper analysis of utilization costs and needs before launching major initiatives for this vulnerable population. Matt Barrett and Melanie Lambert provided insights on the unique challenges faced by duals, including potential cost shifting between Medicare and Medicaid, and the need to examine DSNP enrollment practices and marketing restrictions. The discussion highlighted concerns about care denials and access issues related to Medicare Advantage plans, with participants agreeing on the importance of further investigation into these matters.

Medicare Advantage Advertising Challenges

The group discussed challenges with Medicare Advantage advertising and early hospital discharges. Rep. Hughes highlighted concerns about deceptive advertising targeting vulnerable populations and unsafe discharges, while Kathy Holt noted that CMS's new final rule will lift prohibitions on Medicare Advantage advertising. Claire Volain mentioned that insurance companies have reduced broker compensation, leading to potential misinformation and enrollment in inappropriate plans. The group agreed to address these issues, including data tracking on early discharges and Medicare Advantage denials, in their September meeting.

Medicare Advantage Denial Challenges

Tracy Wodatch discussed the significant challenges with Medicare Advantage denials, noting they are "doubly or triply as difficult" compared to traditional Medicare. The group discussed how Medicare Advantage plans typically waive the 3-day inpatient hospital stay requirement, which differs from traditional Medicare, though prior authorization requirements may still apply. Matt Barrett provided context about existing research on improper denials and mentioned that Senators Blumenthal and Murphy have been prominent in highlighting these issues, while Rep. Johnson shared constituent experiences with denials and noted that some states have successfully eliminated the 3-day hospital stay requirement.

Sharing 2 resources addressing Medicare Advantage marketing/advertising/communications deregulation changes effective with this fall's Medicare Open Enrollment:

- CMS Final Rule (issued April 2026) for private Medicare plans (Medicare Parts C and D) 2026-06600.pdf
- An accurate summary of Medicare Advantage plan marketing/communications changes effective with 2026 Open Enrollment for 2027 7 marketing changes in the 2027 Medicare Advantage Final Rule

Medicare Rehospitalization Data Analysis

The discussion focused on rehospitalization rates and data analysis challenges for Medicare Advantage versus fee-for-service Medicare populations, particularly for dual eligibles. Tracy Wodatch requested separation of rehospitalization data for different Medicare populations to better understand the issue, while Melanie Lambert noted that Medicare Advantage plans typically waive the three-day requirement but experience delays around 2-3 weeks in care authorizations. Bill Halsey explained that DSA is working with CMS through vendor Westat to obtain Medicare Advantage claims data to enable comprehensive healthcare outcome measures for the dually eligible population, similar to what is currently done for Medicaid populations.

Utilization Data Review Committee

The committee discussed reviewing utilization trends and data sets, with Bill confirming they could start building out fee-for-service Medicare and Medicaid data using information from Westat. They explored measures for PCMH performance, particularly avoidable readmissions data that CHN already has, and discussed the need to build a reporting template to compare fee-for-service data with Advantage Plan data. Kathy highlighted challenges with Medicare Advantage capitated rates affecting appropriate patient settings, noting that few plans have contracts with long-term care facilities, which can lead to patients remaining in inappropriate settings longer than needed.

HR-1 Impact on Eligibility Transitions

The meeting focused on discussing the impact of HR-1 on Complex Care members and HUSKY C eligibility. Bill and Brittany Kane met with eligibility experts who confirmed that most affected individuals should transition to HUSKY C, with DSS already handling the eligibility updates through batch processing. The group identified concerns about reduced retroactive eligibility periods and discussed how immigrants, refugees, and asylees are losing Medicare eligibility under new regulations. Bill agreed to develop a more detailed work plan and explore presenting data on the dually eligible population at the September meeting.

Complex Care Committee Healthcare Issues

The Complex Care Committee discussed several critical healthcare issues affecting vulnerable populations in Connecticut. The group addressed concerns about immigrants losing TPS status and the resulting impact on healthcare workforce shortages, particularly in nursing homes where 50 TPS holders were identified across 13 responding facilities. The committee also examined problems with Institutional Special Needs Plans (iSNPs) in nursing homes, including issues with provider networks, hospital readmissions, and concerns about palliative care being promoted over hospice services due to reimbursement incentives. Next steps include writing an article about the TPS workforce crisis and gathering additional research on iSNPs and hospice care challenges to address at the September 17, 2026 meeting.