October 28, 2026 Care Management Committee Zoom Meeting

Quick recap

The meeting focused on the PCMH+ program and the implementation of HR-1 work requirements. Brad Horman from Marsh presented the financial results of PCMH+, reporting over $87 million in savings and nearly $70 million in payments to participating entities over eight years. He also shared a landscape analysis of other state payment models, noting that many states use a mix of risk arrangements and that some programs are sunsetting while others evolve. Dr. Larry Magras presented quality measure performance, showing that PCMH+ members outperformed non-PCMH+ and statewide averages on 17 of 26 measures, though results were mixed across different categories. Committee members raised concerns about the lack of entity-level data, the need for longitudinal comparisons, and the uniqueness of Connecticut's non-capitated managed care system. Peter Hadler and Morgan Leary from DSS provided updates on HR-1, explaining the member journey for renewals and new applications, the use of self-attestation, and the role of the Access Health shared operations call center. They discussed the 30-day notice period for noncompliance and the 12-month look-back for medical frailty at application. Committee members expressed concerns about outreach to vulnerable populations, the clarity of the self-attestation process, and the capacity of the call center to handle complex cases. The conversation ended with a brief mention of peer support reimbursement and the upcoming 1115 waiver for incarcerated individuals, which were deferred to the next meeting.

Next steps

Brad Horman

- Recirculate the 2025 quality measure results by participating entity to the committee.

David Seifel

- Connect offline with the committee regarding the peer support/community health worker reimbursement update and schedule it for the next meeting.

Larry Magras

- Work with DSS to add a comparison of PCMH+ performance specifically against PCMH non-Plus practices (excluding unattributed members) for the next meeting.
- Update the quality measure data to include 2025 results for the next meeting.
- Plot quality measure performance over time (e.g., 3 years) to show improvement trends for the next meeting.

Peter Hadler

- Review and share the training materials and protocols for the Access Health shared call center staff regarding work requirements and the triage/escalation process to DSS.

Bill Halsey

- Take back the request to provide per member per month (PMPM) payments to providers by entity for 2024 and 2025.

Collaboration

- DSS: Provide an update on the new 1115 waiver for incarcerated medicine and Medicaid for folks coming out of the incarceration system at the next meeting.

Summary

Care Management Committee Meeting

The Care Management Committee meeting began with Representative Lucy Dathan convening the session at 10:33 AM. The meeting was being covered live on CT-N. The committee was scheduled to discuss PCMH+ financial results and the state payment landscape, with Brad Horman from Marsh set to present on behalf of VHN.

PCMH+ Financial Results Review

Brad Horman presented financial results of the PCMH Plus program over an 8-year period, showing $87 million in reported savings with $70 million in payments to participating entities, resulting in approximately $17 million in net savings. Brad Horman also shared a landscape analysis of chronic condition payment models across multiple states, highlighting reported outcomes including hospital admission reductions in Massachusetts, cost reductions in Pennsylvania, and behavioral health improvements in New York. Ellen Andrews raised concerns about the presentation focusing on positive outcomes while potentially overlooking challenges and noted that attributing success across different states to specific payment models may not account for other variables in their healthcare systems.

Alternative Payment Models Review

The meeting focused on reviewing a report on alternative payment models (APMs) across different states, with participants discussing the limitations and comparability of savings data. Sheldon Toubman highlighted that Vermont's non-capitated managed care system provides significant cost savings compared to other Northeast states, while participants raised questions about the unit of participation and specific payment structures. Steve Colangelo requested detailed per-member-per-month payment information for 2024 and 2025, which the department was asked to provide, as this data is necessary for proper financial analysis of the program.

Connecticut PCMH+ Review

The meeting focused on reviewing Connecticut's Chronic Condition Alternative Payment Model (PCMH+) through a state-by-state analysis. Brad Horman highlighted key insights from various states, including Minnesota's outcome-based asthma measures, Rhode Island's focus on race/ethnicity data and social determinants of health, New York's flexibility in risk arrangements, Pennsylvania's high quality rankings, and Tennessee's integrated behavioral health model. Bill Halsey noted CMS's shift toward outcome-based measures and emphasized that Connecticut is paying particular attention to pediatric conditions like asthma and behavioral health, while Benita Toussaint pointed out Massachusetts's significant contributions to multi-payer initiatives.

PCMH+ Performance Comparison

Dr. Larry Magras presented a comparison of PCMH+ program performance against non-PCMH practices and statewide averages using 2024 data from Wave 3. The presentation showed PCMH+ members outperformed non-PCMH members in 17 of 26 measures and statewide rates in 20 of 26 measures. Sheldon Toubman requested an additional comparison between PCMH+ and legacy PCMH programs, noting that comparing only to non-PCMH practices missed the significance of existing PCMH programs still operating without shared savings. Larry agreed to add this comparison if requested by committee chairs and suggested updating the data to include 2025 results once finalized.

PCMH+ Performance Metrics Review

The meeting focused on reviewing PCMH Plus performance metrics and HR-1 general updates. Ellen Andrews requested historical performance data by entity to analyze trends over time and

identify best practices, which Larry agreed to provide. The discussion revealed that unattributed members tend to be non-utilizers rather than sicker patients, explaining lower emergency department visit rates when including unattributed populations in metrics. Peter Hadler from DSS presented updates on HR-1 implementation, highlighting the January 1, 2027 effective date for new work rules and the ongoing system development efforts, including digital screener reviews and community outreach initiatives.

Client Journey System Updates

Peter presented updates on the development of a new client journey system for program eligibility, highlighting key changes in the renewal and application processes effective January 1st. He explained the 60-day renewal framework, new requirements for demonstrating exemptions or compliance with community engagement rules, and simplified self-attestation options with direct payroll verification capabilities. The system will be operated through shared operations with Access Health using familiar phone numbers and websites, with existing escalation processes in place to handle complex questions. Representative Comey raised concerns about potential gaps in outreach to elderly and disabled residents in subsidized housing units, though the discussion ended before this question could be fully addressed.

Program Implementation Outreach Planning

Deputy Commissioner Hadler discussed outreach efforts for the January 1st program implementation, including mass media campaigns, webinars, and stakeholder communications, while acknowledging that reaching everyone remains a challenge. Ellen Andrews raised concerns about the self-attestation process, particularly regarding caregiver verification and how to structure questions about work capacity for medically frail individuals. Peter clarified that the self-attestation will primarily be done through online checkboxes rather than paper forms, with ongoing work needed in 2027 to refine documentation requirements and caregiver verification processes.

HUSKY D Program Requirements Clarification

The discussion focused on clarifying details about HUSKY D program requirements and application processes. Peter explained that the current call center wait time is under a minute through Access Help, while Morgan Leary provided specific details about the work requirements look-back period, explaining that for renewals in 2027, the system looks back 12 months for initial renewals and 6 months for subsequent renewals, with a one-month look-back for non-excluded applicants. Morgan also clarified that for medical frailty, a 12-month look-back is allowed for claims and diagnosis codes, and that applicants have 30 days to provide required documentation if not automatically eligible. The conversation concluded with a question about potential penalties for application errors, which remained unanswered at the end of the transcript.

HUSKY Coverage and Medicaid Challenges

Morgan clarified that HUSKY coverage allows reapplication anytime without a special enrollment period, though those denied HUSKY D due to work requirements cannot receive advanced premium tax credits for qualified health plans. Benita Toussaint highlighted challenges with the new process, emphasizing the need for community organizations like CRT and clinics to help people at risk of falling through the cracks, particularly those with disabilities who are not employable. Sheldon Toubman noted that DSS is working to minimize Medicaid losses caused by federal requirements, particularly affecting people with disabilities whose conditions won't show up in claims data and stressed the importance of properly informing people about work impairment rules.

Medicaid Coverage Work Requirements Discussion

The meeting focused on work requirements for Medicaid coverage, with discussions about how questions will be asked and handled through the Access Health Call Center. Peter explained that while the system won't divert 92% of calls to the Access Health Call Center, it will remain the primary pathway for HUSKY D-related work requirements, with existing escalation processes in place for complex cases. The team discussed training plans for call center staff and acknowledged challenges in serving people with limited computer access or those applying through paper forms. Benita emphasized the importance of reaching people in community settings like health centers and churches to prevent individuals from falling through the cracks. The conversation ended with plans to discuss peer support services and incarceral medicine for formerly incarcerated individuals at the next meeting on November 18, 2026.