

# September 17, 2026 Complex Care Committee Zoom Meeting

## Meeting summary

### Quick recap

The meeting of the Complex Care Subcommittee focused on issues related to Medicare, Medicaid, and healthcare advocacy for complex care members. Kathy Holt from the Office of Healthcare Advocate presented on how to read and understand Explanation of Benefits (EOB) statements, highlighting common challenges and resources available to consumers. Sean King (OHA) shared data and experiences regarding Medicare Advantage plans, noting an increase in complaints and the complexity of appeals. The discussion also covered the challenges faced by dually eligible individuals, with Bill Halsey (DSS) and Brittany Kane (DSS) presenting data on utilization and demographics, particularly focusing on long-stay nursing facility use. Laura Crews from Senior Resources explained the CHOICES program, which assists Medicare beneficiaries with enrollment and understanding their options, and emphasized the importance of the Medicare Savings Program. The meeting addressed concerns about the increasing complexity of healthcare navigation, the need for more support for complex care members, and the role of various agencies in assisting consumers.

### Next steps

#### Kathy Holt

- [Provide the fact sheet on EOBs to Rep. Susan Johnson for inclusion in her weekly e-blast.](#)

#### Sean King

- [Provide the data on the amount of money saved by the Office of Healthcare Advocate for consumers to Rep. Susan Johnson.](#)

#### Bill Halsey

- [Investigate the data on long-stay nursing facility utilization for dually eligible members not on a waiver, to understand the drivers and potential interventions.](#)
- [Isolate and analyze pharmacy utilization data for the dually eligible population.](#)
- [Investigate the possibility of using housing instability data as a predictive tool for nursing facility utilization.](#)

### Collaboration

- [Complex Care Subcommittee: Consider scheduling an additional meeting in October to address the upcoming Medicare enrollment period and potential plan non-renewals.](#)
- [Complex Care Subcommittee: Explore the issue of confusion between the Medicare Savings Program and Medicare Advantage plans, and the implications for beneficiaries.](#)

## Summary

### EOB Statements Education Meeting

Representative Susan Johnson and Representative Ann Hughes welcomed attendees to the meeting of Complex Care Committee. Kathy Holt from the Office of Healthcare Advocate presented on reading explanation of benefits (EOB) statements, sharing resources and practical tips developed by their agency to help consumers understand insurance statements and make informed decisions about their healthcare coverage.

### EOB Statement Interpretation Training

Kathy Holt presented a detailed explanation of how to interpret explanation of benefits (EOB) statements, covering key categories like provider charges, billed amounts, allowed charges, and patient responsibilities. She outlined important tips for reviewing EOBs, including verifying correct information, checking service descriptions, and understanding cost-sharing details. Representative Susan Johnson requested access to the fact sheet for inclusion in weekly e-blasts, and Rep. Anne Hughes raised concerns about supporting complex care members who may face increased cost sharing and navigation challenges.

### Medicare Advantage Case Volume Increase

Kathy discussed the significant increase in case volume and complexity following COVID, noting a 25-30% increase over recent years, particularly in Medicare Advantage plan issues. Sean King presented data showing approximately 10,000 inquiries and complaints received since January 2025, with about 10% related to Medicare issues, predominantly involving Medicare Advantage plans. The discussion included clarification about receiving Explanation of Benefits (EOB) documents for medical visits, with Sean explaining that EOBs should typically be available either by mail or online through patient portals.

### Medicare Advantage Complaint Resolution Process

Sean explained that two-thirds of Medicare Advantage complaints involve complex cases requiring case manager involvement, including collecting claims and clinical records to prepare appeals, particularly for medical necessity denials. He reported a 70-80% favorable resolution rate for complaints, achieved through education, referrals, and sometimes administrative proceedings. Sean attributed the recent increase in case volume to a legislative change requiring insurance denial letters to include the Office of Health Care Advocate's contact information prominently on page one, though this has helped more people find the office while also stretching its capacity beyond current resources.

## Healthcare Claim Denials Impact

The meeting participants discussed the significant financial impact of healthcare claim denials and appeals, with Rep. Susan Johnson highlighting the office's work in preventing costs from shifting to Medicaid. She suggested increasing the office's capacity to handle the growing workload, particularly due to potential coding errors and AI use by insurance companies. Kathy and Sean explained the challenges in appealing denials, especially with Medicare Advantage plans, and proposed strategies to intervene before claims move to medical debt or Medicaid. Deb Migneault shared personal experience with the office's support and emphasized the importance of addressing early denials in nursing homes to prevent costly transfers to Medicaid.

## Healthcare Denials and Policy Challenges

The meeting focused on challenges with healthcare denials, particularly in Medicare Advantage and skilled nursing facilities. Participants discussed how complex cases with multiple medical conditions often face denials, and Sean explained that while his office can help overturn many denials, the rapid appeal process in skilled nursing facilities creates significant pressure on patients who must decide whether to follow discharge recommendations or risk financial hardship by staying longer. The discussion also covered concerns about vertical integration in healthcare, where insurance companies own medical practices, though no specific Connecticut laws were identified addressing this issue. Bill Halsey (DSS) and Brittany Kane (DSS) then outlined their three-pillar approach to supporting dually eligible members, including work on DSNP contracts, data collection, and coordination with the Rural Health Transformation team's PACE program implementation.

## Dually Eligible Population Data Review

Bill presented data on the dually eligible population for quarter four of 2025, focusing on full duals (210,000 members) with 46% on traditional Medicare and 54% on Medicare Advantage. The presentation covered demographic information including age distribution, showing Medicare Advantage has a higher presence among 65-74 year olds, and healthcare utilization patterns with 86% accessing pharmacy services and 53% using outpatient clinic services. The data breakdown showed how services are paid for between Medicaid and Medicare, with Medicaid waiver services being fully covered by Medicaid, and identified areas for further investigation regarding differences between waiver and non-waiver populations.

## Nursing Facility Utilization Disparities

The team discussed differences in nursing facility utilization between Medicaid waiver recipients and non-recipients, noting a significant disparity in long-stay facility usage (26% vs 4%). Deb Migneault suggested further analysis of the non-waiver group and proposed examining trajectories over time to identify potential intervention opportunities. Susan Johnson raised questions about the criteria for Medicaid nursing facility level of care, which Deb acknowledged needed clarification but provided limited details about the specific functional and ADL requirements.

## Nursing Home Level of Care Criteria

The meeting focused on level of care criteria for nursing homes and the PACE program. Bill confirmed that participants need to meet nursing home level of care criteria, and Deb agreed that the same criteria applies to the PACE program. Matt Barrett suggested exploring a connection between housing instability and longer nursing facility stays, which Bill said could be an interesting predictive tool despite potential inconsistencies in housing instability coding. Steven Colangelo raised concerns about self-reported level of care in Connecticut, which Matt and Bill clarified is not accurate, as a third-party vendor called ASCEND is used for level of care screening. The discussion also covered Medicare Advantage claims data limitations, with Deb explaining that while crossover claims data is available, it's only partial and cannot provide an accurate representation of full utilization.

## Complex Care Data Analysis Meeting

The meeting focused on analyzing data related to complex care, particularly long-term nursing facility stays and pharmacy utilization. Bill and Deb discussed challenges in obtaining CMS data, with Deb confirming UConn's efforts to work with CMS to develop a process for data sharing. Steven emphasized the importance of using Medicare Advantage diagnosis details to identify complex care needs and suggested potential care coordination improvements, while Matt and Mairead Painter provided insights on nursing home level of care approvals and the Ascend process. The group agreed to further investigate long stays in nursing facilities and pharmacy differences, with Bill committing to provide more detailed data on these areas.

## Medicare Enrollment Process Overview

Laura Crews presented on the Medicare enrollment process and upcoming enrollment periods, explaining the different enrollment windows including the initial enrollment period for new Medicare beneficiaries and the annual enrollment period from October 15th to December 7th for current Medicare participants. She highlighted the importance of the Medicare & You handbook and annual notice of change documents that will be sent to beneficiaries, noting that premium increases are already being reported with some drug plan premiums rising from around \$155 to \$240 per month. Laura also discussed the Medicare Savings Program and special enrollment periods available to qualifying beneficiaries.

## Medicare Advantage and Savings Updates

Laura presented important information about Medicare Advantage plan non-renewals and the Medicare Savings Program. She explained that clients should watch for non-renewal notices by October 2nd and enroll in new coverage by December to maintain January 1st coverage. Laura detailed the three levels of the Medicare Savings Program in Connecticut, which provides assistance with Medicare Part B premiums and cost-sharing, with no asset requirements. The discussion revealed that only about 40-50% of eligible individuals in Connecticut know about or apply for the

Medicare Savings Program, leading to discussions about improving outreach and addressing potential confusion between Medicare Savings Program and Medicare Advantage plans.

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**Attendees:** David Kaplan, Michael Taylor, Mairead Painter, CT State Long Term Care Ombudsman, Steven Anthony Colangelo, Tracy Wodatch, Claire Volain-Bureau of Aging, Rep. Susan Johnson, Rep. Anne Hughes, Bill Halsey, Brittany Kane, Laura Crews, Deb Migneault, Carleen Zambetti, Kate Parker-Reilly, Matt Barrett, Melanie Lambert, Michael Beentz, Kathy Holt, Sean King

## Key Outcomes

The committee reviewed resources for navigating **Explanation of Benefits (EOB)** statements and analyzed the impact of **Medicare Advantage** plans on dually eligible members. Key findings highlight a high-resolution rate (70-80%) for cases handled by the **Office of the Healthcare Advocate (OHA)**, though the office is currently operating beyond its capacity due to increased volume. The meeting also emphasized the importance of the upcoming **Annual Enrollment Period** and the underutilization of the **Medicare Savings Program (MSP)**.

## Healthcare Advocacy & EOB Navigation

- **EOB Education:** The OHA developed a fact sheet to help consumers understand that an EOB is not a bill and to clarify terms like **allowed charges**, **provider write-offs**, and **cost sharing**.
- **Consumer Rights:** OHA provides free services to ensure access to medically necessary care and assists in appealing insurance denials.
- **Case Volume:** OHA has seen a 25-30% increase in volume over the last few years, compounded by a legislative change requiring denial letters to prominently feature OHA contact information on the first page.

## Medicare Advantage Analysis

- **Caseload Trends:** Approximately 9% of OHA's overall caseload relates to Medicare Advantage plans.
- **Complexity:** Two-thirds of Medicare Advantage complaints are "core cases" involving complex issues like **prior authorization denials** or skilled nursing facility stay denials.
- **Resolution Rate:** OHA achieves a favorable resolution in 70-80% of its complaints.
- **Systemic Risks:** Concerns were raised regarding **vertical integration**, where insurance companies own provider practices, potentially creating conflicts of interest during the denial and appeal process.

## Dually Eligible Population Data

- **Population Split:** Of the full dually eligible members, 46% use traditional Medicare and 54% use Medicare Advantage plans.
- **Nursing Facility Utilization:** Data shows a significant difference in long-stay nursing facility utilization (over 90 days): 4% for those on a **Medicaid HCBS waiver** versus 26% for those not on a waiver.

- **Data Gaps:** The department lacks full encounter and claims data for Medicare Advantage plans, relying instead on partial crossover claims.

## Medicare Enrollment & Savings Programs

- **Annual Enrollment Period:** Runs from **October 15 to December 7**; beneficiaries are urged to review their **Annual Notice of Change (ANOC)** to avoid unexpected premium spikes.
- **Medicare Savings Program (MSP):** A critical benefit that pays Part B premiums and can cover deductibles/co-pays; however, an estimated 40% of eligible individuals in Connecticut are not enrolled.
- **Low Income Subsidy (LIS):** Enrollment in MSP or Medicaid automatically qualifies beneficiaries for "Extra Help" with prescription drug costs.

## Action Items

- **Bill/DSS:** Provide the committee with the specific **level of care criteria** used for Medicaid nursing facility eligibility.
- **Bill/DSS:** Conduct a deeper data dive into the drivers of **long-stay nursing facility utilization** and isolate **pharmacy data** for further analysis.
- **Complex Care Committee:** Consider increasing the capacity/funding of the OHA as a legislative priority.

### Sean King - OHA

[https://portal.ct.gov/oha/news-and-publications/annual-reports/annual-reports?language=en\\_US](https://portal.ct.gov/oha/news-and-publications/annual-reports/annual-reports?language=en_US)

### Melanie Lambert

For full duals, I would say cost-sharing for covered prescription drugs is not significantly different between Medicare Advantage and traditional Medicare enrollees with Part D due to the Low-Income Subsidy which reduces Part D premiums to zero for "benchmark" standalone Part D plans. Copays would be the same for covered drugs whether in Medicare Advantage or standalone Part D for all duals.

### Claire Volain-Bureau of Aging

<https://portal.ct.gov/ads-choices>