

# June 12, 2026 MAPOC (Full Council) Zoom Meeting

## Meeting summary

### Quick recap

The MAPOC (Full Council) meeting focused on the presentation of Connecticut's Rural Health Transformation Program (RHTP), a \$154 million federal grant aimed at improving rural health access and outcomes. Dan Sinclair, Project Director for the Rural Health Transformation Program at the Connecticut Department of Social Services, presented the program's structure, which includes five strategic goals covering prevention, sustainable access, workforce development, innovative care models, and technological innovation across 30 projects implemented by 11 state agencies. Quad-Chair Senator Saud Anwar raised concerns about maintaining equivalent training levels for healthcare workers in rural areas compared to urban areas, while other legislators inquired about community health workers, value-based payments, school-based health centers, and broadband access challenges in rural communities. The discussion highlighted the program's aggressive timeline requiring all contracts to be executed by August 2026 and funds to be spent by September 2027, with ongoing coordination between state agencies and plans for public engagement through regional collaboratives and webinars.

### Next steps

Commissioner Andrea Barton Reeves

- [Ensure ongoing monitoring and evaluation of Rural Health Transformation Program projects and be prepared to recommend continuation or expansion of successful pilots to legislature as appropriate.](#)

### Collaboration

- [Daniel Sinclair/\(RHTP team\): Share detailed budget information and program narrative link for the Rural Health Transformation Program with interested council members and the public.](#)
- [DC Easha Canada/Mark Raymond \(Office of the CIO\): Follow up with Chief Information Officer to determine current status and future plans for state broadband strategy, especially as it relates to healthcare access in rural areas.](#)
- [Shantelle Varrs/Rep. Susan Johnson/Casey Anthony \(DSS/Complex Care Subcommittee\): Provide detailed information to Representative Johnson on the standards of care and distinctions between Medicaid skilled nursing facilities, intermediate care facilities, and home care, including discharge planning processes.](#)
- [Shantelle/Briana Mitchell/Team \(DSS Finance\): Provide further analysis and data on reasons for disproportionate decline in HUSKY A and D enrollment, including impact of PHE unwinding, income eligibility changes, and potential policy drivers.](#)

- [Shantelle/DC Peter Hadler/Team \(DSS\): Provide breakdown of Medicaid costs for dually eligible \(Medicare/Medicaid\) members, comparing traditional Medicare and Medicare Advantage, and clarify inclusion/exclusion of Medicare Savings Program \(MSP\) populations.](#)
- [Shantelle/Team \(DSS\): Bring back information on the feasibility and process for combining state data linkages across 11 identified agencies to support HR1 community engagement/exemption determinations.](#)
- [Shantelle/Team \(DSS\): Continue to evaluate and update medical frailty definition and process in light of new CMS IFR guidance, and report back on operational approach for HR1 compliance, including use of self-attestation and claims data.](#)
- [Shantelle/Team \(DSS\): Share updated HR1-related data, tools, and outreach materials via \[portal.ct.gov/dss-hr1\]\(http://portal.ct.gov/dss-hr1\) and collect/apply feedback from stakeholders for ongoing improvements.](#)
- [Daniel Sinclair/Julie Virgil \(RHTP\): Continue active coordination with OHS/OPM and other agencies during the transition of data/technology responsibilities to ensure continuity and progress on rural health data/technology initiatives.](#)
- [Shantelle/Sussan Johnson/Steven Colangelo \(DSS/Complex Care Subcommittee\): Provide analysis of cost differences between dual eligible members in traditional Medicare versus Medicare Advantage plans and share with committee as data becomes available.](#)
- [Shantelle/Team \(DSS\): Pull together and share information on the impact of HR1 implementation on HUSKY D enrollment, including categories of service utilization changes, for future council sessions.](#)
- [Shantelle/Team \(DSS\): Continue deeper analysis of why HUSKY A and D enrollment is declining, including policy impacts and income eligibility changes, and report findings to the council.](#)
- [Shantelle/Team \(DSS\): Provide information on the administrative and clinical distinctions between types of long-term care facilities \(skilled nursing, intermediate care, home care\) and their impact on Medicaid cost and discharge planning, as requested by Representative Johnson.](#)
- [Daniel/Andrea/Julie \(RHTP/Commissioner\): Continue robust public engagement, including regional visits and webinars, and promote email distribution list for ongoing updates and feedback on the Rural Health Transformation Program.](#)
- [Shantelle/Team \(DSS\): Monitor and report on the impact of pharmacy cost trends, including GLP-1s and declining rebates, and continue to explore options for managing these costs, including multi-state purchasing efforts.](#)
- [Shantelle/Team \(DSS\): Continue to update and iterate the HR1 prescreener and toolkit based on stakeholder feedback and new federal guidance and widely share relevant URLs and resources.](#)
- [Shantelle/Team \(DSS\): Continue to monitor and report on the efficiency and outcomes of Connecticut's Medicaid program, including administrative costs and per-member-per-month trends, and provide comparative data with other states as available.](#)
- [Shantelle/Team \(DSS\): Continue to evaluate the impact of HR1 work requirements and community engagement rules, including the effect of new IFR guidance, and provide regular updates to the council.](#)
- [Shantelle/Team \(DSS\): Provide information on the use of self-attestation for medical frailty and other exemptions in 2027, and plans for documentation requirements in 2028 and beyond, as HR1 implementation proceeds.](#)

## Summary

Rural Health Transformation Program Overview

[Rural Health Transformation Program](#)

The MAPOC (Full Council) meeting began with introductions, where Dan Sinclair, the Project Director for the Rural Health Transformation Program at the Connecticut Department of Social Services, introduced himself and his team members Julie Vigil and Margaret Ostafin. Dan presented an overview of the Rural Health Transformation Program (RHTP), which received \$154 million in initial funding and aims to improve rural health access and outcomes through 30 projects across 11 state agencies. The program has five strategic goals including prevention, sustainable access, workforce development, innovative care, and technological innovation, with a focus on Northeast and Northwest Connecticut. The team is working to implement projects by August 2026 and has been conducting public engagement activities including site visits and webinars.

### Rural Healthcare Training Quality Standards

Senator Anwar raised concerns about ensuring equivalent training levels for healthcare personnel in rural areas, emphasizing the importance of maintaining high-quality care standards. Daniel and Julie clarified that their program aims to improve health access and outcomes in rural areas without compromising care quality, and Andrea confirmed that ensuring high-quality care in rural areas is a foundational value of the application. Senator Lesser inquired about community health workers and SNAP service changes, though these topics were not fully addressed in the transcript.

### Community Health Initiatives Update

Daniel provided updates on two key initiatives: the Community Health Worker Project, which will support postpartum mothers through home visits for services and mental care, and the SNAP waiver program, where Mehul Dalal explained they have flexibility in implementing junk food restrictions. Rep. Johnson raised concerns about healthcare access coordination during the transition of functions from the Office of Health Strategy to the Department of Public Health and Office of Healthcare Advocate, which Daniel assured was being managed through weekly coordination meetings. The discussion concluded with questions about funding opportunities for the 30 projects, with Daniel noting that while there have been some current procurements, detailed information is available in the program narrative.

### State Grant Program Planning Meeting

The meeting focused on discussing a \$154 million grant program with 30 projects across the state. Daniel and Julie emphasized the importance of sustainability in program design and mentioned that cost share could be explored in areas like the integrated care network to cover services not covered by Medicaid. The discussion addressed concerns about breaking down silos between providers and collecting data to inform workforce development. Mark raised questions about funding requirements and timelines, with Daniel explaining that contracts must be executed by the end of August and budget becomes locked by October, with 11 months to expend resources by September 2027. Karen Siegel and Commissioner Barton-Reeves highlighted the need for ongoing monitoring and evaluation, with the Commissioner noting they would use practices from ARPA funding to identify successful projects for potential continuation in the state budget.

## Rural Hospital Support Program Planning

Senator Anwar asked about using funds to support financially insecure rural hospitals, and Daniel confirmed this was a priority focus area, working with four rural hospitals to help right-size operations and expand services. The discussion covered the five-year structure of the grant, with the Commissioner explaining that projects would be evaluated annually, and additional investments could be considered based on success rather than waiting until year five. Margaret Ostafin and Mehul Dalal explained that value-based payment initiatives would be explored, particularly through the AHEAD model and coordination with CMS, with year one focusing on landscape analysis and planning. Andrea encouraged continued engagement through the program's 22-person advisory committee rather than direct engagement with leadership.

## School-Based Health Center Expansion Discussion

The discussion focused on school-based health centers, with participants clarifying that the current RHTP program does not plan to invest in expanding school-based health centers beyond behavioral health services, particularly in rural areas where such centers are not currently present. Margaret explained that technical assistance will be provided to hospitals to address sustainability and service line planning. Representative Johnson highlighted challenges in rural areas including transportation access and the need for special education services, while Ellen Andrews noted concerns about value-based purchasing implementation in Connecticut. The conversation concluded with a discussion about broadband access, where Daniel acknowledged it's not explicitly authorized for spending under the grant but suggested that technological advances like wearable technology and telehealth could help address some access challenges.

## Rural Health Services Discussion

The meeting focused on discussing rural health services and Medicaid financial trends. Senator Anwar raised concerns about broadband access gaps affecting specialty services and proposed including broadband infrastructure in a strategic plan. The discussion covered EMS service challenges, with the Senator highlighting response time disparities between urban and rural areas, and Daniel explained how mobile integrated health pilots would help bring services closer to people while avoiding emergency room visits. The group also discussed the integration of community health workers and CNAs as part of the Rural Health Initiative, with Amy sharing insights about the Bridge Project in Bridgeport. The conversation ended with a brief introduction to a financial presentation on Medicaid program trends by Shantelle Varrs and Brianna Mitchell.

## Connecticut Medicaid Cost Trends Overview

Brianna Mitchell, Assistant Chief over Budget for Department of Social Services, presented an overview of Connecticut Medicaid trends, expenditures, and cost drivers. She highlighted that projected gross spending in Medicaid for fiscal year 26 is \$9.3 billion, with hospital expenditures being the largest share at 27%, followed by nursing homes and long-term care facilities at 18%. The

presentation also discussed per member per month (PMPM) cost trends, showing increases across all HUSKY groups despite declining overall enrollment, particularly driven by higher-cost services and pharmacy expenses. Key cost drivers identified included increased utilization, enrollment growth in home and community-based services, and rising healthcare costs associated with specialty drugs, with pharmacy costs being particularly impacted by lower rebate revenue and new high-cost drugs.

### Medicaid Expenditure Analysis Meeting

The meeting focused on analyzing Medicaid expenditure trends and outcomes across different service categories. Shantelle explained that while comparisons with other states are limited due to different operating models, the department is working to analyze outcomes data and will provide additional information on service categories impacted by HR-1. The discussion revealed that increased expenditures in home care are primarily driven by enrollment growth rather than acuity or utilization changes, while pharmacy costs are concerning. Rep. Johnson raised questions about long-term care facility categories and discharge planning, which Shantelle agreed to address by providing more detailed information about standards of care for Medicaid skilled nursing facilities and intermediate care facilities.

KFF detail on Medicaid enrollment including at state level [Medicaid Enrollment and Unwinding Tracker | KFF](#)

### Connecticut Medicaid Program Efficiency

Sheldon Toubman highlighted that Connecticut's Medicaid program has very low administrative costs of 2.7%, significantly lower than the 13% average in managed care states and performs above median for national quality measures. The discussion revealed that HUSKY A and D enrollment has been declining due to changes in eligible populations, with Husky A participants typically experiencing more income changes than HUSKY C participants, and some decline attributed to the unwinding of public health emergency policies. The meeting participants noted that other states are increasingly interested in Connecticut's administrative services organization model due to its cost efficiency and member-focused approach.

### HUSKY A Enrollment and Pharmacy Costs

The meeting focused on discussing changes in HUSKY A enrollment and pharmacy costs. Deputy Commissioner Peter Hadler explained that the decline in enrollment could be attributed to several factors including the unwinding of the public health emergency, national trends showing declining Medicaid enrollment, and changes in federal administrative approaches. The group discussed concerns about rising pharmacy costs, particularly for GLP-1 drugs, with Andrea noting that while these drugs offer benefits for patients with conditions like diabetes and hypertension, the high costs make coverage challenging. The discussion also covered questions about distinguishing between Medicare Advantage and traditional Medicare costs in HUSKY C, with Steven Colangelo confirming that the Department could provide data on this if needed.

## [Connecticut Enrollment and Spending for Dual-Eligible Individuals](#)

### HR-1 Medicaid Work Requirements Update

Peter Hadler, Deputy Commissioner at DSS, provided an update on the implementation of HR-1 work requirements in Connecticut's Medicaid program, focusing on medical frailty definitions and community engagement rules. The analysis identified approximately 57,000 people who might qualify for medical frailty exemptions under the original definition, though the new interim final rule released on June 1st introduced more restrictive requirements, including a requirement that medical conditions significantly impair an individual's ability to work. The department is also working on leveraging state data to inform eligibility determinations and has launched an HR-1 toolkit and Medicaid work requirements pre-screener tool to help clients understand their potential compliance status.