



Healthcare Update

October 13, 2026

Agenda



- Public Comment
- Financials (Rae-Ellen)
- Partnership (Bernie)
- High-level utilization (Rae-Ellen)
- Communications (Betsy)
- SOCT PCI 2025 Program Results (Sandra)



Public Comment

Financials



FY 2026-2027 Anticipated Year End Health Account Balances	
Budget Review 9.15.26	
Active Employee Healthcare Appropriation	
Projected Appropriation Balance:	\$ 421,691.56
Active Employee Healthcare FAD Accounts	
Projected Active Health FAD	\$ 16,231,923.48
Projected Active Rx FAD	\$ -36,439,260.98
Combined FAD Balances:	\$ -20,207,337.50
Retired Employee Healthcare Appropriation	
Projected Appropriation Balance:	\$ -59,905,712.79
Retired Employee Healthcare OPEB FAD Accounts	
Projected Retiree Health	\$ 226,206,604.32
Projected Retiree Rx	\$ -76,495,774.41
Combined FAD Balances:	\$ 149,710,829.91

Financials



FY 2026-2027 Anticipated Year End Health Account Balances		
State Partnership Plan FAD Account Balances		
	<i>FY Starting Balance</i>	<i>Projected FY End Balance</i>
SPP 1.0	\$ -10,339,258.11	\$ -12,449,779.25
SPP 2.0	\$ -45,840,581.49	\$ -32,715,387.03

Partnership



Partnership 2.0

- As of 10/1/26 we have 207 groups enrolled totaling approximately 32,000 employees and just under 75,000 members.
- There is one potential (returning) group that may be re-joining on 1/1/27
- On 10/28, Alex Humble from our office will be doing a presentation on partnership at the CCM (Connecticut Conference of Municipalities) convention

Partnership 1.0

- As of 10/1/26 there are 4 groups remaining totaling approximately 2,300 employees and 3,000 members.

Actives & Non-Medicare Retirees

All Plans

Claims Summary¹

	Total Cost (PMPM)	% of Total Cost	Current Trend
Medical	\$843.68	80%	▲ 3.3%
Inpatient Facility	\$158.41	15%	▼ 3.2%
Outpatient Facility	\$331.20	31%	▲ 4.6%
Professional Services	\$332.52	32%	▲ 5.5%
Ancillary	\$21.54	2%	▲ 3.0%
Pharmacy	\$211.64	20%	▲ 15.4%
Total Cost	\$1,055.32		▲ 5.6%

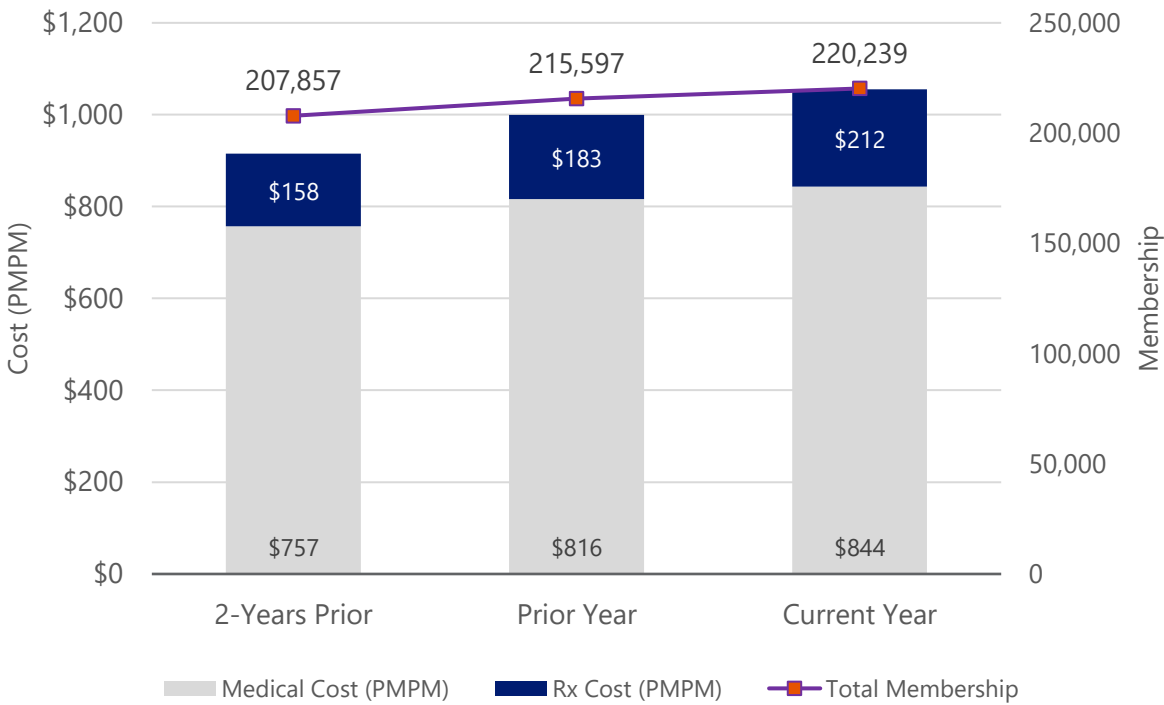
Drivers of Trend

Service Category	Current PMPM	Prior PMPM	Change
Pharmacy - Brand	\$83.80	\$70.74	▲ \$13.06
Pharmacy - Specialty	\$104.11	\$91.52	▲ \$12.60
Outpatient - Surgery	\$111.26	\$102.82	▲ \$8.44
Inpatient - Surgery	\$60.47	\$66.62	▼ \$6.15
Inpatient - Neonate	\$9.59	\$14.39	▼ \$4.80

Observations

- PMPM medical costs have increased 3.3% Year-over-Year (“YoY”) and accounted for 80% of total spend.
- PMPM Rx costs have increased 15.4% YoY and accounted for 20% of total spend.
- The second table above illustrates the top 5 drivers of trend. Pharmacy - Brand was the top driver of spend on a PMPM basis, increasing \$13.06 PMPM over last year.

Cost and Membership Summary



¹ Reflects medical and Rx paid claims through August 2026, PrudentRx claims through August 2026. Claims for the current period have been completed using a factor of 0.95



Care Compass All-user Email Impact: September



Email Topic	Audience	Reach	Open Rate	Total Clicks	CTOR
Wellbeing /Chronic Condition Seminars (June-July events)	State – Sept 1	32,508	20%	1,747	5%
	Personal – Sept 2	88,185	22%	1,717	2%
	SPP - Sept 2	20,262	24%	2,338	6%
Benefit Spotlight (Webinars)	State –Sept 16	32,267	10%	2,441	10%
	(State resend) Sept 21	16,566	11%	1,000	11%
	Personal –Sept 16	7,005	19%	1,790	6%
	(Per. resend) Sept 21	22,712	11%	378	6%
	SPP –Sept 16	60,264	14%	5,602	19%
	(SPP resend) Sept 21	6,444	11%	43	4%
Flu Shot	State – Sept 24	32,098	19%	902	4%
	Personal – Sept 24	87,918	11%	1,200	3%
	SPP - Sept 24	20,174	13%	2,340	11%

September & October 2026

Monthly Webinar Schedule

Healthy Living Program Workshops • HEP Chronic Condition Webinars • Well-being Webinars



WEBINAR SERIES

Join us live!

- Benefits & HEP Portal
- Flexible Spending Accounts
- Dental Benefits
- Healthy Living Programs



Flu Shots are 100% Covered

Protect yourself, your family and your community



Quantum Health Portal Registrations

Total Registered: 121, 630 lives as of Sept 2026

Audience	Status	Registered	Percentage of eligible
State + NM Retiree	Employee	54,807	81.5%
	Spouse	20,396	68.9%
	Dependent	8,992	16.6%
SPP	Employee	23,301	68.6%
	Spouse	9,973	60.6%
	Dependent	4,161	15.5%

- Quantum's online portal and app re-launched in January 2026.
- Quantum launched an email campaign in January 2026 (sample to the right) to promote registration
- Care Compass emails, HEP compliance, and education letters and emails continued to point to the benefits portal registration and use
- In September, our office collaborated with Quantum on a webinar to educate on the portal features and uses.



Register or Log In



SAY HELLO
to a better benefits experience

HEALTH ENHANCEMENT PROGRAM (HEP)
BY THE STATE OF CONNECTICUT, ADMINISTERED BY QUANTUM HEALTH.

It's easier than ever to manage HEP and your benefits

Download the Quantum Health app to confirm your 2025 Health Enhancement Program (HEP) compliance – and access your healthcare benefit information. If you have an existing Quantum Health account, you'll need to update your log in information to take advantage of recent security enhancements. This one-time process should take just a few minutes.

Download the App

The new app makes it easier to stay on track of your Health Enhancement Program (HEP) compliance with:

- **A compliance meter:** From your homepage, view your progress in a clear and straightforward way.
- **Dependent visibility:** See compliance details for children under age 18.

- **A clearer checklist:** Review and track requirements in one place.

Watch for more information next month on when the portal is updated with 2026 HEP information!

Have questions?
Your Quantum Health Care Coordinators are here to help you navigate healthcare and address your benefits questions and concerns.



(833) 740-3258
Monday-Friday, 8:30 a.m.-10 p.m. ET



carecompass.quantum-health.com
Chat, schedule a call or send a secure message anytime.



Download the Quantum Health app



State of CT Primary Care Initiative 2025 Program Results



October 2026

Objective of State of CT Health Plan **Primary Care Initiative**

To improve care coordination and health outcomes for state employee health plan participants by:

- providing additional resources to participating advanced primary care groups to allowing for additional investments in 11 key functions as identified by the state's Primary Care Road Map;
- creating a reimbursement structure with accountability for improving health care quality, patient outcomes, and sustainable long-term costs; and
- improve overall quality reporting and provide feedback on areas needing improvement using the CT Quality Council endorsed Quality Measures

The payment model is designed to better align incentives of the state as a payer and providers to achieve the above objectives; creating a partnership in which each entity can use the tools at its disposal to work toward common objectives.



SOCT PRIMARY CARE INITIATIVE: PROGRAM STRUCTURE OVERVIEW

- **Medical Cost Performance**
 - Potential to earn shared savings
- **Quality Performance Measures**
 - Align with CT OHS 2025 quality measures
 - Earned points for quality
 - Excess quality bonus
- **Enhanced Care Coordination**
 - Enhanced care coordination fee payments
 - Reinvest in primary care / care coordination activities
- **Dedicated PCI team supports**
- **Enhanced Reporting**



Overview of 2025 SOCT Primary Care Initiative program results



State of CT Primary Care Initiative Performance:

- Quality & Cost
- Care Coordination Fee payment & investment



Opportunities for Program Improvement:

- Improvements in data: collection, reporting, analytics
- Risk adjusting



Potential Solutions:

- Improvements in data collection and reporting
- Pharmacy data



What's next for SOCT PCI?

- New Vendor
- Inclusion of pharmacy experience
- Improved reporting

SOCT PCI 2025 QUALITY MEASURES:



2025 SOCT PCI Quality Measure

Adolescent Immunization: Combo 2
All Cause Readmission
Asthma Medication Ratio - Adult
Asthma Medication Ratio - Pediatric
Breast Cancer Screening
Cervical Cancer Screening
Child and Adolescent Well-Care Visits Age 3-21
Chlamydia Screening - Adult & Pediatric
Colorectal Cancer Screening
Controlling Blood Pressure
Developmental Screening in First 3 Years of Life
Diabetes Glycemic Control ≤ 9
F/U After ED Visit for Mental Illness - 7 Day - Adult
F/U After ED Visit for Mental Illness - 7 Day Pediatric
Kidney Health Evaluation for Patients with Diabetes
Screening for Depression and Follow Up - Adult / Pediatric
Well Child Visits 1st 30m , 0 - 15 M
Well Child visits 1st 30m, 15 - 30 m

Link to [HCBI Quality Benchmarks](#)

2025 Quality Measure Scoring

SOCT PCI groups receive a composite quality score that represents the percentage of the \$3 PMPM bonus each group is eligible to receive.

- Composite Score Calculations for each measure:
 - Meeting the benchmark: 1 point
 - Showing year over year improvement on the measure: 1 pt.
 - Percentile rank on measure: up to 2 pts.
- Scores are normalized as a percentage of total available points for each measure (pts/maximum pts) to determine a final score for each measure
- A minimum of 30 cases for each measure will be required for the measure to be scored and scores for all applicable measures are averaged
- The resultant average percentage is the final composite score and is multiplied by the \$3 (the maximum base bonus) to determine final base bonus

EXCESS QUALITY BONUS

A quality bonus approximately equal to \$3 PMPM will be paid for performance on quality measures from the Office of Health Strategy's standard measure set.

Unrealized bonus funds to be equally distributed to groups meeting highest quartile of quality scores as additional bonus payment.

SOCT PCI Care Coordination Care Delivery Requirements:

1. Care delivery is centered around what matters to the patient, developing trusted relationships with patients, making them feel heard and listened to, and instilling person-centered practices from the front desk to post-visit follow-up.
2. Care delivery is team-based, with the practice team consisting of a range of clinicians and non-clinicians, working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.
3. Practice teams formally designate a lead clinician for each patient. That person fosters a continuous, longitudinal relationship. A lead clinician is a designated medical professional within a practice team who holds lead responsibility for an individual patient relationship e.g., a physician or APRN.
4. Practice teams coordinate care for its patients between visits and across the continuum of care. To support such work, the practice team includes a) qualified, embedded clinical care management personnel to support patients with chronic conditions and disabilities and patients experiencing transitions of care, and b) embedded non-clinical care coordination personnel to connect all patients with community supports to address social factors that influence health, and work with families and other caregivers. “Embedded” refers to staff who are dedicated to specific practices. They may be physically located full or part-time at the practice site or should the practice site not afford sufficient physical space, physically located elsewhere.*
5. Behavioral health is integrated into the practice team through a) mental health clinicians who are members of the practice and provide assessment, brief treatment and referral, and b) through screening and referral for substance use treatment.*

6. Practice teams deliver “planned care” at every visit, including reviewing the patient’s medical record prior to the visit and addressing all identified issues during the visit.
7. Care is easily accessible and prompt, using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is accessible to persons with disabilities and is culturally and linguistically competent.
8. Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.
9. Practices engage and support patients in healthy living and in management of chronic conditions.
10. The practice team utilizes patient information in conjunction with data from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform targeted quality and equity improvement activity, including design and implementation of quality improvement plans.
11. The practice team identifies social factors that influence the health of its patients and is knowledgeable about community resources that can address social needs.

Source: CT OHS Primary Care Roadmap

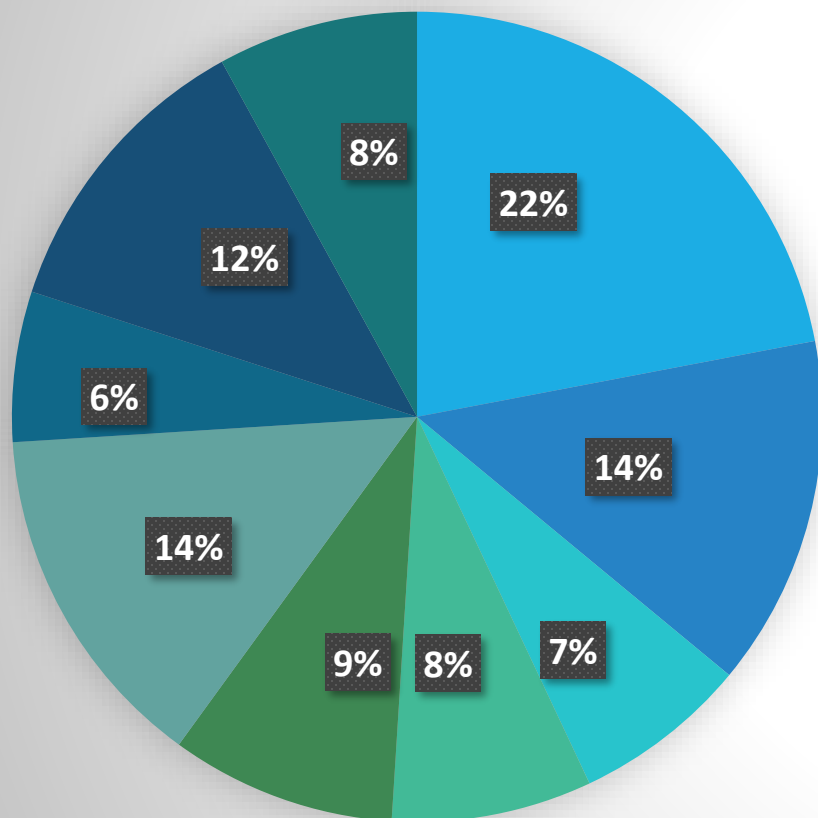
2025 SOCT PCI Care Coordination Investment

SOCT PCI Provider groups invested enhanced CCF payments to support activities including:

- Expansion of care teams or the addition of dedicated staff
- Improving access to and use of patient data through the Connie statewide HIE
- Employing new technology to improve workflows that support primary care providers
- Increased patient access to appointment availability
- Enhancing medication reconciliation processes
- Improving SDOH assessment and linkages to appropriate wrap around services

SOCT PCI – Provider Reporting on Primary Care Investment

SOCT PCI
Care Coordination Fee Investments



- Improve patient access to care and patient satisfaction: 22%
- Provide additional resources for patients post discharge from hospital: 14%
- Improve medication reconciliation/adherence: 7%
- Improve access and quality of behavioral health services: 8%
- Improve line of sight to patient care outside of organization: 9%
- Technology Improvements: 14%
- Improvements in assisting patients with accessing care : 6%
- Improve Physician / Staff satisfaction: 12%
- Other: 8%

Top Three Categories of Primary Care Investment

Improve patient access to care and patient satisfaction - 22%:

- Embedding of behavioral health clinicians and social workers to managing patients with behavioral health needs, psychosocial needs and substance use disorders.
- Development of behavioral health case management program to address care transitions for patients post behavioral health and substance use disorder discharge.
- Increased collaboration with community-based counseling and therapy services.

Provide additional resources for patients post discharge from hospital - 14%:

- Increased availability of appointments
- Expansion of care teams or the addition of dedicated staff
- Improved processes for medication reconciliation
- Enhanced linkages to wrap around services, needs identified through SDOH assessments
- Expansion of telehealth resulting in decrease of no-show rates

Technology Improvements - 14%:

- Adoption of care management platforms to facilitate and improve care coordination workflows and monitor patient outcomes
- Expanded use of AI scribes which helps reduce administrative burden on providers

SOCT Primary Care Initiative 2025 Final Program Results

SOCT Primary Care Initiative Organization	Attributed Members	2025 Care Coordination Fee Payments	2025 Quality Bonus	2025 Excess Quality Bonus	Total Savings /(Loss) Payments Due	Total 2025 PCI Earnings
Aledade	6,481	\$1,390,917	\$78,596		(\$40,549.58)	\$1,428,963
Universal Amer Corp / CHS	4,119	\$1,023,125	\$52,145		(\$18,296.47)	\$1,056,974
CT Children's Care Network	11,974	\$2,214,259	\$287,561		\$242,112.78	\$2,743,933
Day Kimball Medical Group	1,127	\$222,528	\$21,862		(\$21,579.12)	\$222,810
Northeast Medical Group	13,175	\$3,530,434	\$294,025	\$415,102	(\$709,274.38)	\$3,530,287
Privia Quality Network - CT Adult	21,040	\$4,276,914	\$158,262		(\$522,281.53)	\$3,912,894
Privia Quality Network - CT Pedi			\$208,183		\$68,694.17	\$276,877
ProHealth Physicians - Adult	19,778	\$4,717,944	\$345,371	\$380,481	\$497,873.56	\$5,941,670
ProHealth Physicians - Pedi			\$206,398	\$333,944		\$540,341
Prospect Health Services	5,043	\$1,314,558				\$1,314,558
SoNE	5,506	\$1,395,444	\$95,577		(\$247,414.57)	\$1,243,606
Stamford Health Medical Group	3,153	\$756,491	\$51,963		\$154,861.89	\$963,316
Starling Physicians	6,220	\$1,410,785	\$155,192	\$191,873	(\$246,787.65)	\$1,511,063
Trinity Health of New England	5,317	\$1,193,518	\$88,480		(\$41,510.03)	\$1,240,488
University Physicians - UCONN	7,028	\$1,906,258	\$157,452		(\$384,177.91)	\$1,679,532
Value Care Alliance	5,780	\$1,667,155	\$117,446		(\$291,299.08)	\$1,493,303
Western CT Health Network	3,706	\$1,064,133	\$41,527		\$194,346.89	\$1,300,007
Yale Medical	1,853	\$509,683	\$41,274	\$51,229	(\$164,787.35)	\$437,399
Total:	121,299	\$28,594,146	\$2,401,313	\$1,372,630	(\$1,755,788.55)	\$30,838,021

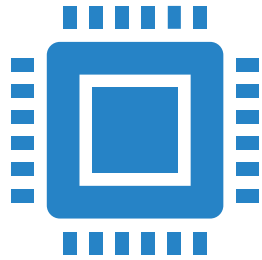
2025 Achievements in SOCT PCI

- Collaboration with SOCT PCI provider groups
- Increased investments in primary care to around 8.9% as a percent of total medical spent for SOCT health plan in 2025
- Improved data collection and quality measure with the integration of CT Connie and provider supplemental data
- SOCT PCI provider groups have invested CCF payments to improve care access and quality for their patients

Opportunities for Improvement

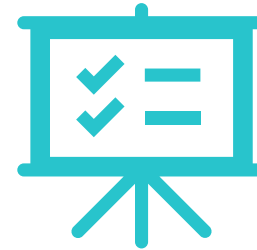
- Improve processes for collecting and reporting supplemental clinical data and integrating with EHRs, Connie, and state registries (CT Wiz Immunization Registry)
- Improve timeliness of actionable reports on cost and quality, necessary for provider groups to identify where early engagement of patients will result in improved outcomes and cost savings
- Align quality metrics with operational feasibility, involving frontline providers in measure selection and implementation planning.
- Strengthen administrator responsiveness and accountability for resolving issues related to data, claims, and technology.
- Continue investments in Care Coordination Fee funding to support care coordination staffing and technology to strengthen access, quality, provider engagement, and financial sustainability.

Ongoing work in SOCT PCI:



New PCI Administrator for January 1, 2027 go-live: Vera+Castlight

- Enhanced data analytics and reporting
- Integrated approach with increased administrative accountability



2027-2029 Program design to explore opportunities that:

- Increase transparency
- Improve alignment of quality measures
- Engage PCI Provider organizations in Workgroups, soliciting their feedback, used to further improve the PCI





Questions and Comments



Adjourn