HEALTHCARE COST
CONTAINMENT COMMITTEE

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STATE OF CONNECTICUT
HEALTHCARE POLICY & BENEFIT SERVICES DIVISION
OFFICE OF THE STATE COMPTROLLER

HEALTHCARE COST CONTAINMENT COMMITTEE MEETING MINUTES
August 11, 2025

Meeting Called to Order by **Josh Wojcik.**

Attendance:

Labor	State Comptroller Administrative Staff
Carl Chisem – CEUI	
Logan Place – SEBAC	Thomas Woodruff
	Josh Wojcik
	Presenters
	Bernie Slowik – OSC
	Rae-Ellen Roy - OSC
Management	Betsy Nosal -OSC
Gregory Messner	Sandra Czunas - OSC
Karen Nolen	Ariana Sisti - Quantum
	Consultants
Dept. of Insurance	Terry DeMattie, Segal
Paul Lombardo	

Public Comment:

No public comment.

Financials:

No financial report this month due to some technical difficulties. As a result, the report is not complete. After the meeting, Rae-Ellen will make the necessary corrections and share the report with the committee.

Partnership:

As of August 1st, we have 185 groups enrolled in Partnership 2.0, totaling approximately 29,000 employees and just over 60,000 members. In July, we held two quarterly update meetings, during which we reviewed the financials and discussed the 2024 HEP compliance.

We have one small group confirmed to join on October 1st, and a couple of other small groups are interested in joining this fall, which we are currently evaluating.

For Partnership 1.0, we have four groups remaining, which total approximately 2,300 employees and 3,000 members.

High-Level Utilization- Professional Services Drivers:

The 9.5% rate highlights the overall trends in professional services. The trend has continued to escalate and remains noticeably high, particularly for professional services.

Historically, it was common to see these rates at around 3% or 4%, but now they have significantly increased. Currently, the year-over-year trend stands at 9.5%, while the annualized two-year trend is at 6.9%. We focus on the two-year trend since year-to-year figures can be volatile.

The median was 5.4% in 2023, and in 2024, it rose to 8.3%. The two-year average is about 6.8%, which is very close to the 6.9% figure. Although the timings differ slightly, I want to emphasize that this is a significant trend.

It's essential to recognize that this increase isn't necessarily peaking; it may still be on the rise. Predicting how this will develop is challenging. The dynamics occurring in Connecticut are not isolated; they reflect broader industry trends. We'll delve into some specifics and showcase the drivers influencing these changes.

Much of this growth is driven by price inflation, as many practices actively seek ways to increase revenue in the current environment.

To clarify what we mean by professional services, this category typically includes office visits with your primary care physician (PCP) or specialists, preventive care, lab tests, and radiology services not performed in a hospital setting. Additionally, if you have a surgery or procedure in a hospital, the bills from the surgeon and the anesthesiologist are also included in this professional services category. Therefore, it encompasses a broad range of services.

Many details can often get overlooked in a high-level overview of healthcare trends. While some analyses may delve deeper into specific areas, it can be challenging to generalize too broadly. In the context of practicing medicine or running any business today, a key focus is likely on protecting revenue. Many providers are facing threats to their income from various factors such as increasing costs, tariffs, and general inflation. As a result, there is a concerted effort across the industry to find ways to maintain or increase revenue, whether through price adjustments or other strategies.

Notably, several areas are experiencing considerable movement, and this trend isn't restricted to specific locations. Major categories include primary care physician (PCP) visits, specialist visits, and psychiatric care. Additionally, office administration of drugs and various therapies is significant as well, with the latter being somewhat less expected. We will discuss these topics further, including professional fees, which vary by region.

We have a representation of the leading diagnosis categories explaining why patients seek these services. This section reflects broader trends rather than localized ones, particularly highlighting an increase in developmental disorders and anxiety-related conditions. This increased utilization emphasizes the growth in mental health services and treatments, especially concerning neurodevelopmental disorders like autism, which often involve ABA services and related interventions.

Primary care physician (PCP) and specialist visits, also known as evaluation and management. This refers to standard office visits where doctors evaluate and manage patient health without any specific procedures involved.

We see a two-year trend of a 9.6% increase and a one-year trend of 14%, which is quite significant. This increase is primarily driven by unit costs. As highlighted, the data shows a 2.1% increase in utilization and a 7.3% increase in unit costs. These changes are likely due to price increases. The mix of services and codes in this category is relatively stable, so it is a case of practices catching up to the price inflation seen earlier in hospitals, which felt these effects more acutely six months to a year ago.

Looking at the diagnosis codes, a broad range of treatments is being addressed. The top 10 PMPM changes show varying levels, with many codes exhibiting similar trends. While specific cases, such as acute respiratory events, may contribute to this, the overarching driver seems to be unit cost increases stemming from price inflation.

Next, let's consider therapies, which are more influenced by utilization. Over the past two years, we have seen an 8.7% increase in this area, reflecting a long-term trend across the industry. A significant contributor to this rise is the application of ABA for autism treatment, particularly among children. The diagnosis rates for autism have surged over the last five to ten years, accompanied by an increase in treatment options and the establishment of more clinics, leading to greater accessibility and awareness.

In the industry, we are witnessing a trend in therapies related to developmental and neurological disorders, which is primarily driving this utilization increase. The most common ABA code is at the forefront of this growth, but it is important to note that it also includes various other physical therapy codes. There has been a notable rise in codes not commonly seen in the past, such as neuromuscular reeducation and therapeutic activities, which indicate a shift in practices.

It's unclear if this trend is due to new patients seeking treatment for the first time or a general increase in the use of specific codes that are now more prevalent. Overall, we observe increased activity in the physical therapy space, with new techniques and treatments likely contributing to the rise in utilization.

In terms of office administrative drugs, this category includes various treatments, which could range from oncology infusions to less acute medications. There has been a significant long-term trend in this area. It's worth noting that the hospital-based pharmacy segment is also experiencing a similar upward trend.

One of the initial questions that arise with such trends is whether we are observing a shift from one care setting to another. At a high level, I don't see much evidence to suggest that this is happening. Both the office and hospital drugs are trending relatively high, and this area is characterized by a mix of utilization rates and unit costs.

The range of top diagnoses being treated is quite broad, and this sector tends to be volatile. Treatments classified as office or hospital drugs can vary significantly over time. It's important to remember that while we may see consistent trend numbers, treatment specifics can change dramatically from year to year.

Regarding professional fees, particularly in the New Haven area, we've observed a notable outlier. When someone visits the emergency room or is admitted to a hospital, a physician may or may not be able to bill separately for their services. Patients typically receive bills from the facility for the ER visit, the hospital charges, and potentially several physician fees.

Currently, this trend is primarily associated with ER visits, although it is also present in inpatient admissions. A significant driver of this trend is the increase in professional physician bills related to ER visits. This appears to reflect a greater proportion of ER visits incurring these professional fees compared to previous times rather than a simple increase in the overall number of ER visits.

Interestingly, we are observing three Tax Identification Numbers connected to this trend, rather than just one. This suggests that multiple practices in the area contribute to the increase in professional fees. Notably, this issue is specific to the New Haven area, as we do not see a similar pattern or level of PMPM charges in other parts of the state.

Question by Greg Messner:
I have a question about how to proceed with this information.

Answer by Josh Wojcik:
Yes, Greg. For a few of these items, I'd like to follow up with Anthem to understand what they might observe from a contractual standpoint. In certain areas, we suspect that price could be a significant factor. The service mix may affect the situation, but understanding their professional price increases over the last 12 months, especially regarding the ER piece, is essential. I would also like to gain better insight into whether there has been a shift from employed physicians covering the ER to external providers in the New Haven area, as this could drive up costs. So, we should look into that.

Additionally, regarding physical therapy, two years ago, PT was managed through Anthem and Carelon with tighter restrictions after the first eight visits. On the other hand, Quantum manages PT more significantly after 20 visits. This difference in management may contribute to increased

costs, so it would be beneficial to investigate this further. Overall, I believe there are several areas we can explore to gain a better understanding and see if any adjustments can be made.

Communications Update:

Last month, we sent out four emails. One was the first registration for DPP, along with a reminder email. I combined the statistics from these emails, and overall, we are seeing great open rates across our audiences.

These rates are fairly typical but also strong. Our CTOR reflects the current interests of our employees. Our offerings clearly resonate with our audience, which is why we send a variety of emails each month directing them to Care Compass.

In the reminder email, we included a quote from a husband and wife who greatly benefited from the DPP program as state employees. This addition emphasized the program's value.

Regarding the Quantum Health portal, which serves as our members' personal portal, we highlighted the "Find a Provider" feature. This aligns with our email about the provider tool, emphasizing a personalized experience for users who log in. The portal defaults to the plan they are enrolled in, showcasing both program distinction providers and in-network providers.

On our landing page, we also feature a highlight of the month. For the current quarter, we are showcasing Virta, a diabetes program for participating state employees. This will soon change to feature our orthopedic solutions. As we move forward, we will also introduce our mental health solution, Lyra.

These initiatives are designed to help our members easily find and access the care they need when they need it.

This is a reminder that we have sliders available on the Care Compass. To illustrate our commitment to consistency, we launched these updates in July alongside the new plan year. Additionally, we have added an orange button featuring the Dependent Eligibility FAQ prominently. If you click to the next, you will find more information about dependent verification, including relevant forms if needed. The third button leads you to resources for assistance, which include your agency's benefits contacts or your designated care coordinator. We have created a new list for employees to easily locate their agency benefit contacts, as feedback from open enrollment indicated that some employees were unclear on who to reach out to, as many never received a follow-up from their contacts. The lookup tool on Care Compass has been designed to address this.

As mentioned, we initiated a program to distribute printed guidebooks in early January of 2025. These new guidebooks are shorter than our planners and include a New Hire Guide and a Transition to Retirement Guide, targeting two distinct populations. We launched this initiative in January, and 34 agencies reached out to order copies. We have since sent them updated versions to reflect the new plan year changes, increasing our outreach to 45 contacts.

Our goal is to expand this initiative to ensure that newly hired employees, those transitioning, or preparing for retirement, are equipped with the necessary information. Guidebook orders tend to fluctuate; some of this variability comes from our initial outreach and understanding of agency needs, as we encourage more agencies to request additional printed copies. As we continue to re-educate our agencies and promote awareness of these resources, we have someone available to distribute or send guidebooks when necessary. As a reminder, we have been sending out a new hire email for about a year, including a link to Care Compass. Within the Care Compass, a dedicated new hire page helps inform new employees right from the start. This resource will also be beneficial as we assist individuals transitioning into retirement.

Quantum Performance Report:

In 2024, we engaged with 66% of our membership, with partnership engagement at 67% and state engagement at 65%. This leads us to an overall engagement rate of 66% concerning real-time intercepts. Our model focuses on engaging with members before we receive claims; in fact, 88% of those eligible for real-time intercepts were engaged with us at the time of the intercept.

The member NPS for 2024 was 74, slightly higher than the previous year. For context, the industry average NPS is 30, indicating that we perform notably better.

Regarding vendor referrals, 85% of members enrolled in the Flyte program were referred by Quantum Health. This figure is based on mandatory surveys conducted with enrolled members. Similarly, 85% of those enrolled in the Upswing program were referred from Quantum Health. This percentage includes referrals made during phone conversations or when members clicked on the Upswing link through the member portal.

For the Virta program, 31% of enrolled members reported referrals from Quantum. This number is likely lower than the actual figure, as Virta does not require survey respondents to specify where they heard about the program.

We also categorize our interactions with members into several key areas. Over the past year, we revised how we classify these interactions:

1. Navigation and Steerage: This category includes performing in-network provider searches, providing referrals to different vendors, and offering prescription savings and cost transparency.

2. Decision Support: This involves benefits education and assisting members in choosing the right doctor or fully understanding their benefits.

3. The Solution: is resolving issues like incorrect copay charges or denied claims.

4. Care Coordination and Clinical Support: This encompasses authorizations, personal care guidance, nurse management, post-discharge calls (to check on members after surgeries), and medication reconciliation.

These categories help us better serve our members and address their needs effectively.

This overview illustrates what our real-time intercept model looks like in practice. We have a specific member who has been diagnosed with stage five chronic kidney disease and needs a kidney transplant.

January 2024 marks the first time we engaged with the member, following the obtaining of authorization for the kidney transplant. In August 2024, we began receiving claims that included the diagnosis of chronic kidney disease stage five.

This timeline shows an eight-month gap between when we identified the member as needing assistance and when a traditional carrier model would have recognized the need. During these eight months, we conducted 55 interactions between the member and Quantum. This level of engagement demonstrates how effectively we supported the member when she may have otherwise gone unnoticed without the authorization we secured in January.

As of May or June 2025, the last point on the graph, the member remains on the transplant waitlist. If she had already undergone the procedure, that would be reflected here, but it hasn't occurred yet; hence, we only noted the month.

Here are some highlights of our interventions and interactions with this member: For navigation, we noticed the member was initially taking a 30-day supply of her medication, paying a $5 monthly copay. We successfully switched her to a 90-day supply, which alleviated the burden of needing to pick up her prescription each month and saved her some money. In terms of solutions we offered, we provided the member with a variety of community resources. We mailed her a cookbook with dialysis-friendly recipes and offered resources for financial assistance, transportation, and post-operative care, especially because she mentioned she lacked a strong support system. We wanted to ensure she had help beyond her standard benefits.

Additionally, we assisted her with claims advocacy. She was incorrectly billed for services processed out of network when they should have been in network. For example, a mammogram and an ultrasound were initially classified as out of network. Still, we corrected this to reflect in-network status because the provider and facility were both in our network.

She was also mistakenly billed copays for visiting a value tier one provider, where the charge should have been $0. We successfully rectified this issue for her. Moreover, there was an instance where lab work was sent to a non-covered service facility, resulting in a 20% coinsurance charge. The tests conducted at Quest were billed under Hartford Healthcare, so we filled out the necessary site of service waiver, which eliminated any financial responsibility for her.

On the clinical support side, we continued to monitor her status on the kidney transplant waitlist, backdated the office authorization for her kidney evaluation, assisted with code authorizations, and regularly checked her status.

In summary, this real-case example illustrates how we have supported one of our members in various ways throughout her healthcare journey, thus alleviating many burdens she may have faced.

Question by Lara Manzione:
All the steps you took to help that member sound great. They also seem like things that could apply to any member or patient like ensuring they're on the right 30-day versus 90-day prescription and confirming that Tier 1 services have no copay. Is there a way to systematize or expand these efforts beyond focusing on just one patient?

Answer by Ariana Sisti:
Yes, we have a stratification model that categorizes members based on their conditions. Those requiring higher levels of care and support are classified as high-engagement members, and we work our way down from there. Whether for cancer or a less serious condition, we try to engage with as many members as possible through outreach. If members call in with similar questions, we're always available to assist them as well. Does that answer your question?

Question by Lara Manzione:
Your focus seems to be primarily on high-acuity patients, which makes sense. The basics like ensuring that eligible individuals fill a 90-day prescription instead of a 30-day one are small but can lead to significant savings for the patient, member, and plan. Additionally, ensuring that Tier 1 providers are available at no copay for specific services is important. Is there a way to explore similar opportunities and do a bit more data digging to identify these savings for all members, not just those with high acuity?

Answer by Ariana Sisti:
We can definitely look into that. I'm not sure if there's currently a system in place for stratification beyond high-acuity patients, but I can investigate whether we can incorporate that as an additional task when we review claims and ensure that everything is processed correctly, even for members who aren't stratified or who might not notice it on their own.

This report covers the last six months of 2024. We processed approximately 84,000 authorizations during this period, with an approval rate of 94%. For in-network authorizations, the approval rate was even higher at 97%.

We completed 2,300 concurrent reviews, which means we authorized several inpatient days for hospitalized members. Each day thereafter, we ensure that their continued stay is medically necessary and that they are not staying longer than required.

Additionally, we conducted 924 physician reviews and had 28 provider redirections. The low number of redirections is primarily due to the out-of-network benefits available through the plan.

The top three non-certifications were for hereditary breast cancer, related disorders, and unlisted molecular pathology tests, along with other genetic testing. These issues are common within our overall book of business, so there is nothing unusual about these top non-certifications for the state population.

In terms of approved authorizations, the most common were for diagnostic colonoscopy, therapeutic exercises, and physical therapy.

Regarding non-certifications, the family history of breast cancer was linked to the top two non-certifications. We had 22 appeals that were overturned with additional information provided, alongside 29 member-initiated appeals and 135 provider-initiated appeals. The only two authorization requests that had more than one appeal were for sleep apnea and prostate testing. Typically, when we receive more clinical information, we find that the appeals for the top non-certification reasons can be overturned.

SOCT Primary Care Initiative 2024 Program Results:

The 2024 program results and ongoing activities within the Primary Care Initiative (PCI) are the focus of this overview. Many participants on the call are familiar with the program, which is currently in its second year of a three-year contract cycle. Although there have been some changes, the overall structure remains consistent.

The primary objective of the PCI is to improve health outcomes for our planned membership while also managing cost trends. Below are some key components of the program, with a strong emphasis on quality and alignment with the Office of Health Strategy Primary Care Roadmap. Supporting documentation has been included in the appendix for further reference.

One of our key goals is to create a reimbursement structure that aligns quality patient outcomes with long-term costs. This alignment will connect incentives for provider groups with those of payers, ultimately enhancing overall quality reporting. We also aim to establish a forum for receiving feedback to improve the program continuously.

The program consists of several key components. First, there is a medical cost performance component, where each provider group must meet or exceed a specified medical cost trend to qualify for shared savings. They may have to return funds to the state if they exceed their cost target.

Second, the quality performance measures align directly with the OHS quality measures. In 2024, the number of quality measures has increased compared to last year. Provider groups can earn points for quality when they show year-over-year improvement in their performance. Additionally, they can earn extra quality points if they rank in the top quartile of performers, which qualifies them for what is known as a quality bonus.

There is also an excess pool, which adds a competitive aspect to the program. Provider groups can see their ranking in terms of earning quality bonus dollars and how they stack up concerning quality-enhanced care coordination.

An additional care coordination fee is paid on a PMPM basis for the attributed population. Primary care groups are encouraged to reinvest these funds into several key activities.

Lastly, we have the PCI dedicated team. Our internal team at OSC includes me, Tom Woodruff, and Stephanie Kraig, under the direction of Josh Wojcik. We have also developed enhanced reporting that was not available before the PCI.

We have three additional groups compared to last year: our collaborative health systems, Day Kimball, and Stanford. The list includes the average attributed member population and the care coordination fee payments directly tied to PMPM rates.

Many factors are taken into account regarding the quality bonus to measure quality and assess how each group performs, determining their ability to earn this bonus. Any unachieved quality metrics contribute to an excess quality bonus, which is accessible to top-quartile groups. This year, three provider groups, Northeast Medical Group, Pro Health, and UConn, earn those excess quality dollars.

The following column outlines total shared savings and losses, and the total earnings on the right. A key takeaway is that, despite operating in a challenging environment with rising trends, some groups performed exceptionally well. Notably, Privia and Pro Health excelled last year in the program. Kudos to these groups for their creative strategies in making referrals to high-value, high-performing providers and taking proactive steps to ensure their success in this program.

A critical component of this program is the feedback we receive from providers. We ask providers to report back to us on how they are improving their primary care services, expanding their teams, and reinvesting the care coordination fee payments.

Many responses indicated that a significant portion of these funds has been allocated to hiring additional staff to manage transitions of care, perform medication reconciliation, and facilitate home health care. This is particularly important because we know that hospital discharges can be challenging; if a patient isn't followed up on properly, it can lead to complications.

Quantum is handling its part, and provider groups follow up with their assigned patient populations. We track these movements with real-time admission, discharge, and transfer alerts. We have also expanded call center support, and numerous groups are embedding behavioral health clinicians to address mental health needs.

As we look at rising costs and increased utilization in behavioral health, we recognize an urgent demand for these services. Provider groups have indicated this need and are being evaluated on the quality of the care they provide in these areas. Consequently, they need to have effective referral systems for behavioral health providers.

In examining specific improvements, one of the most significant areas we noticed was an enhancement in patient access and satisfaction. Medication reconciliation following hospital discharge is critical, yet we currently lack a quality metric for this process. Most of us have experienced the routine of updating our medication lists at doctor's visits, and it's vital to ensure this is done accurately, especially after a hospital discharge or medication changes. This understanding helps patients manage their medications effectively.

We have also made strides in improving access to behavioral health services and providing better visibility into patient care outside the organization. Our program has enhanced our ability to inform provider groups about where their patients seek care beyond their facilities. Previously, we didn't have this insight, but providers can gain more information with data from the carrier, the administrator, and the use of Connie. This presents opportunities for bringing care back into their own networks.

Additionally, we are assisting patients in accessing care by connecting them with community support services and improving both patient and staff satisfaction.

A key aspect of this is increasing the number of clinical and support staff, which has been essential for extending appointment hours and creating more opportunities for telehealth services.

Furthermore, we have established teams to support the Patient-Centered Initiative, which did not exist prior to its implementation. These teams meet regularly with provider groups and administrators to advance the program. Investments are also being made to address physician burnout, a significant issue in primary care. Many resources have been dedicated to physician wellness programs, improving workflows within the office, and developing pre-visit face sheets. These face sheets ensure that primary care providers come into appointments equipped with all necessary information, maximizing their time with patients.

Some provider groups have implemented 20-minute time slots to allow providers to catch up on paperwork, make calls, address care gaps, and review reports. Additionally, some organizations are using grand rounds to raise awareness and discuss provider burnout. To balance workloads, certain groups are adjusting panel sizes according to risk, ensuring that no clinician is overloaded with patients who have a high disease burden compared to their peers.

Regarding new technologies, we have noted the importance of Social Determinants of Health SDOH. Many provider groups are collecting this information in various ways, and we know that Connie is involved in this effort. Investment has been made in care coordination fee dollars to support these initiatives and create necessary linkages.

For example, some groups utilize crisis centers for acute behavioral health needs, while others use Connie to gather SDOH data. One group has purchased Unit us as a resource directory to enhance connections with community support services. Finally, additional tools are being implemented across inpatient and outpatient settings as part of their AMR investment.

Data is always a priority for our team since our reporting focuses on current utilization, cost trends, and gaps in care. However, we are aware that some gaps in data exist, and we are working diligently to address them.

Provider groups have raised concerns regarding attribution and roster management. These issues, particularly related to physician accountability, remain challenging, and we are actively addressing them. Additionally, some groups have pointed out that the cost opportunities presented may not always be actionable. Understanding their concerns is crucial; for instance, a

patient with complex behavioral health needs might require inpatient care without any alternatives. Ultimately, it is the clinician's responsibility to make that decision.

The reporting we provide serves as a baseline and offers recommendations, but the decision on patient care rests with the clinician. We are continually improving our reporting capabilities and ensuring that data flows effectively into the tools we use.

One challenge we face is capturing the necessary information to address quality data gaps. Sometimes, what appear to be gaps in care or quality are actually due to the lack of measurable data. We have implemented several measures to enhance our data collection in this area.

Behavioral health services are always needed, and many provider groups have established processes for making referrals and scheduling appointments for their targeted populations. Some groups require additional support, and we take their feedback seriously as we work on addressing these social determinants of health. Collecting this information effectively remains a challenge, and we are committed to ongoing improvement.

Providers have also inquired whether this SDOH information is used in risk scoring. We are exploring this relevant issue further.

Here are some key observations from the program. Despite an overall positive trend, certain groups have performed particularly well, making significant investments to enhance their outcomes. Some of these groups have even incentivized their physicians to effectively close gaps in care.

Regarding attribution, we have made changes since the program's inception. Unlike the standard methodology, we are freezing attribution as of October, allowing provider groups to have a defined population set. While some individuals may fall off this list, those changes will not be added midstream, as it may be too late in the year for those individuals to impact their wellness visits. This freeze on attribution seems reasonable at this time.

In terms of access to pharmacy claims data, Anthem is not our PBM; CVS is. We have made considerable efforts to integrate our PBM data into our reporting tools. As a result, we can now analyze medical and pharmacy claims data through the PCMS tool. Additionally, we have engaged TrudataRX, which will serve as our formulary manager, providing support in the pharmacy area and developing network-level reporting specific to the attributed population of provider groups.

We continually gather feedback from meetings with provider groups to guide our program improvements.

Next, let's discuss opportunities for improvement. Data is at the heart of many of these challenges. We have worked diligently to enhance access to data regarding quality measures, care coordination, attribution, and measuring health outcomes. While measuring health outcomes is inherently challenging, we are progressing in our efforts.

We aim to improve the actionability and usability of claims data, which traditionally focuses on financial transactions. Supplemental data feeds have been introduced to bolster our data collection efforts. This initiative was not in place prior to our primary care initiative program, but we advocated for its inclusion. The administrator collaborated with each provider group to create supplemental data feeds, offering additional clinical data necessary to close some quality measure gaps.

We use standard metrics for quality measures, but there have been challenges. We typically see a six-month claims lag, which can render data unactionable for provider groups. We continually seek ways to expedite this process and provide more timely reporting.

We have heard about some struggles with specific quality measures, such as the Asthma Medication Ratio. One challenge arose when a medication related to this measure was removed from the formulary, leading to confusion. Although the Quality Council will retire this measure, we have invited provider groups to participate in discussions and voice their concerns, which has been beneficial.

There are complexities associated with coding, particularly with metrics like the depression screening and follow-up care plan. Capturing this follow-up care in coding can be intricate. We continue collaborating with provider groups to seek additional clinical data for more accurate coding. Furthermore, we have an immunization metric, but the necessary data is not fully accessible. We are considering approaches to enhance data availability in this area.

We are currently engaged in ongoing activities for the PCI program. Our plan includes meeting with top performers to learn their best practices, which we hope to apply at the programmatic level to increase the use of Connie broadly. Currently, we are receiving lab results data from Connie, which has been extremely beneficial. In particular, we have seen an improvement of nearly 8 or 9% in A1C levels, closing significant quality gaps that previously existed due to a lack of data.

We continue enhancing our data access and actively seek additional data sources, specifically ADT feeds from Connie. This will ensure that all provider groups can access critical data, such as ADT feeds and CCDs, which provide structured clinical information.

To support our initiatives, we have established working groups that meet quarterly. These groups focus on various aspects, including a pediatric quality measure working group, a pharmacy data collection, reporting, and analysis group, a risk adjustment working group, and a behavioral health working group. Participation is open to all PCI participants, and our administrator, OSC, attends these meetings. They have proven to be very helpful in guiding the program in a positive direction by incorporating feedback from the provider groups and exploring sensible solutions.

We are in the early stages of addressing contracting, which will begin in 2026. Notable changes will include incorporating prescription data into the total cost of care, an area we have not previously included due to a lack of data access through the tools provided by the administrator. However, we will soon have this data available, and we are reviewing our reporting processes to

better utilize the tools while also being prepared to implement creative reporting solutions if necessary.

On July 25th, an RFP was issued for the administration of the PCI program. I mentioned the immunization data earlier; we are exploring a potential solution involving CT Wiz, which serves as a repository for immunization data. The goal is to have this repository integrated with Connie so that the immunization data can flow through our existing feed to the administrator. We are continuing to work towards this integration.

In 2024, we focused on the percentage of primary care spending as part of the total medical expenses. We are actively working on improving our reporting and analysis regarding this matter, and we need to understand our progress toward this target.

As part of the Office of Health Strategy initiative, we aim to increase primary care spending to 10% by 2025. At this moment, we are still assessing how close we are to achieving this goal.

The target for 2023 was set at 6.9%, but the statewide performance stood at only 4.5%. However, it's noteworthy that the state employee health plan, represented on the far right of the graph, exceeded its target. We are making progress in increasing spending in primary care and are well on our way to meeting our goals.

DEVA Audit Update:

This update provides an overview of the DEVA audit and our current position. Since this is a closed population, there may not be many more updates in the future, but overall, the results have been positive.

PDA, Part D Advisors completed a death audit for us by utilizing various resources to identify our enrolled population. As of early May, they had found that 456 individuals had death records on file, either with Social Security or through obituaries. After further review, we confirmed that 407 of these individuals were indeed members of our health plan and had been deceased for at least a month, with many having passed away even longer ago.

Importantly, 156 of these deaths had not been reported to us. While we did receive notifications from some of our employees or retirees regarding these deaths, we were unaware of the passing of 156 individuals. Among them, 13 were from the active population: 7 were active employees, 4 were spouses, and 2 were children. These deaths were not recent, and it appears that some families believed they had reported the passing of their dependents to their agencies, but had not.

We were able to remove these individuals from coverage retroactively to the time of death, or as early as possible. Additionally, we identified 143 retirees from the matches provided. Among those, 19 were confirmed retirees, with 5 having passed away more than three months prior. Notably, one optionee annuitant died in 2022 but has continued to receive a monthly pension check since then. We have coordinated with payroll to recover approximately $60,000 annually that had been directly deposited into that individual's bank account.

The remaining retirees identified were non-pension retirees who were not eligible for Medicare, so we did not receive any notifications from Aetna through Social Security. These retirees were enrolled in medical coverage, either from out-of-area plans or at the point of enrollment. While these individuals incurred no costs, it was a financial burden for us.

We also identified 122 spouses (again, not on Medicare) and 2 children in this audit. These spouses were enrolled in the commercial plan, and we had no other means to identify their deaths.

As a result of this death audit, we removed a number of individuals from coverage, which allowed us to recover approximately 2,100 member months of coverage. This equated to $773,000 returned to the general fund, representing the employer's share of premiums that have now been reallocated. Some of these adjustments are still processing and will appear in upcoming paychecks.

Looking forward, had these individuals remained on coverage without our notification, we would have faced an annual cost of approximately $738,000 each subsequent year. We plan to conduct this death audit quarterly moving forward. While we don't anticipate finding as many matches in the future, thanks to improved reporting from employees regarding their dependent statuses and collecting information on those who had been deceased for several months, we will continue this process to capture any individuals who have not notified us otherwise.

We are now moving on to the dependent audit. As you know, we rolled out this initiative in waves, communicating with the population in four or five phases, organized alphabetically. Here are the results from the first month of activity, focusing on the initial wave of individuals.

We received reports from 30 members who requested the removal of specific individuals from their coverage. Many individuals were unaware that these dependents were still on their plans. Of the 30 reported, 14 were active dependents, and 16 were retirees. Some removals were due to divorces, while others involved adult children or spouses who already had their own coverage.

These individuals have been removed from coverage effective July 1 of this year. As a result, we anticipate saving approximately $115,000 in general fund state shares by eliminating coverage for those who no longer require it. Although this change may not significantly impact the overall family-size contracts, which remain family-size contracts, the savings are beneficial because we will not be covering individuals who are not utilizing services.

We will continue to provide monthly updates as more results come in. Additionally, we will share statistics regarding the number of individuals who have successfully reported their dependents and submitted the necessary verifications in the coming months.

Joshua Wojcik – Invited other questions or comments from committee members and the public. There were no additional questions or comments; call for a motion to adjourn.

Motion to Adjourn was made by Greg Messner and seconded by Dan Livingston.

The meeting was adjourned.