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Connecticut Healthcare Benchmark Initiative Informational Hearing

June 23, 2026

Agenda

9:00 – 9:10	Welcome and Introductions
9:10 – 9:50	Healthcare Affordability in Connecticut: Highlights of the 2024 Cost Growth, Quality and Primary Care Benchmark Reports
9:50 – 10:45	Leveraging Federal Opportunities to Strengthen Primary Care
10:45 – 11:00	- Break -
11:00 – 11:35	Successful Value-Based Care Programs in Connecticut
11:35 – 12:00	Connecticut's Healthcare Benchmarks - 2026 Updates
12:00 – 12:15	Public Comment
12:15	Conclusion/Adjournment

Healthcare Affordability in Connecticut:

Highlights of the 2024 Cost Growth, Quality and Primary Care Benchmark Reports

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Cost Growth Benchmark: Context

Calendar Year	Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	*4.0%
2025	2.9%
2026-2027	2.8%
2028-2032	3.9%

*Modified from 2.9% to account for inflation

A target **annual rate-of-growth** for per person healthcare spending

Values are based on a blend of forecasted per capita potential gross state product and forecasted growth in median income

2026 to 2030 values were recommended by a Technical Team, and 2028+ were legislatively established

Cost Growth Benchmark Performance, 2024

Total healthcare expenditures for Connecticut residents in 2024: **$38 Billion**

Total healthcare expenditure growth from 2023: **7.9%**

Primary care spending as a percentage of total medical expenses: **4.6%**

Percent of Connecticut population covered by cost growth benchmark data: **84%**

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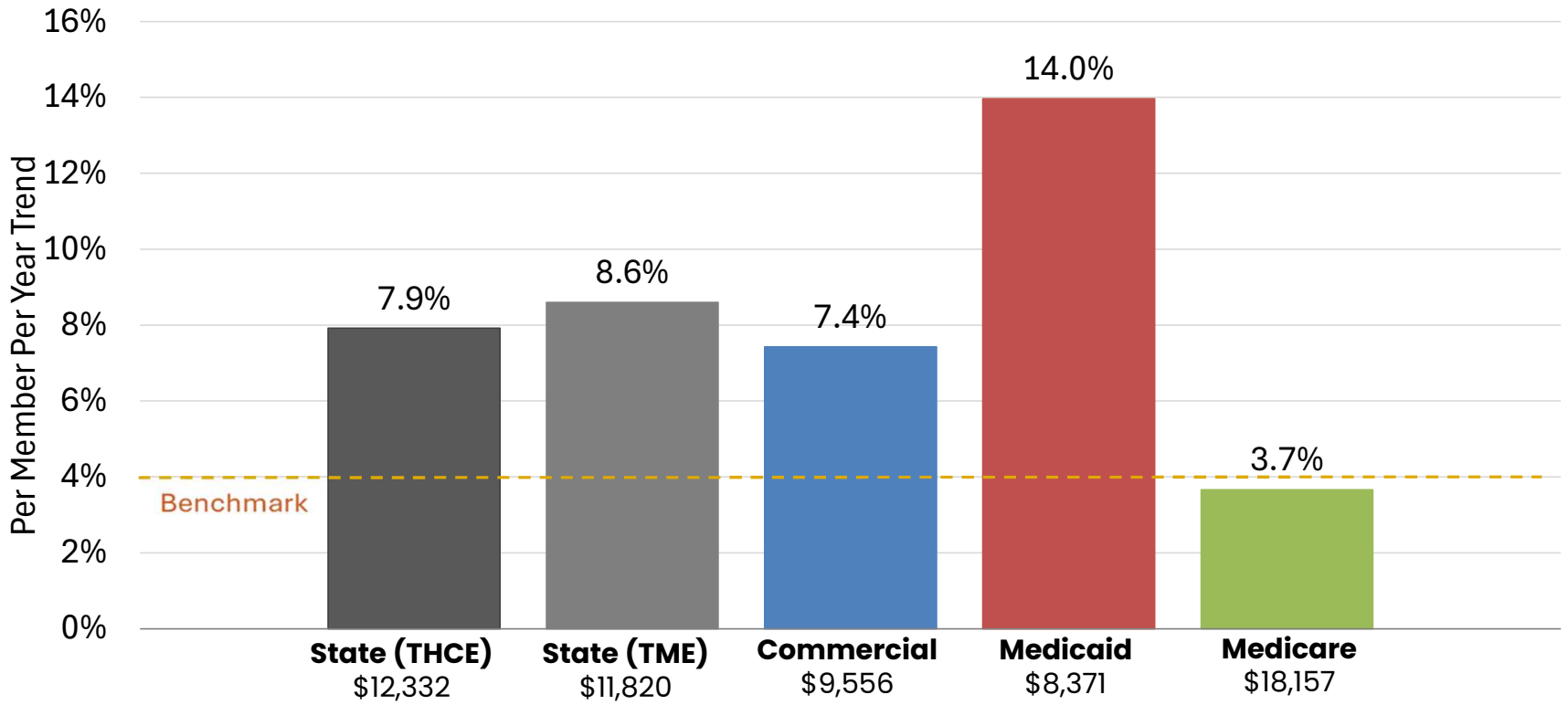
State and Market Per Capita Growth and Spending, 2023-2024



Notes: Commercial, Medicaid, and Medicare represent Total Medical Expense (TME). Data are not age/sex adjusted and data are reported net of pharmacy rebates

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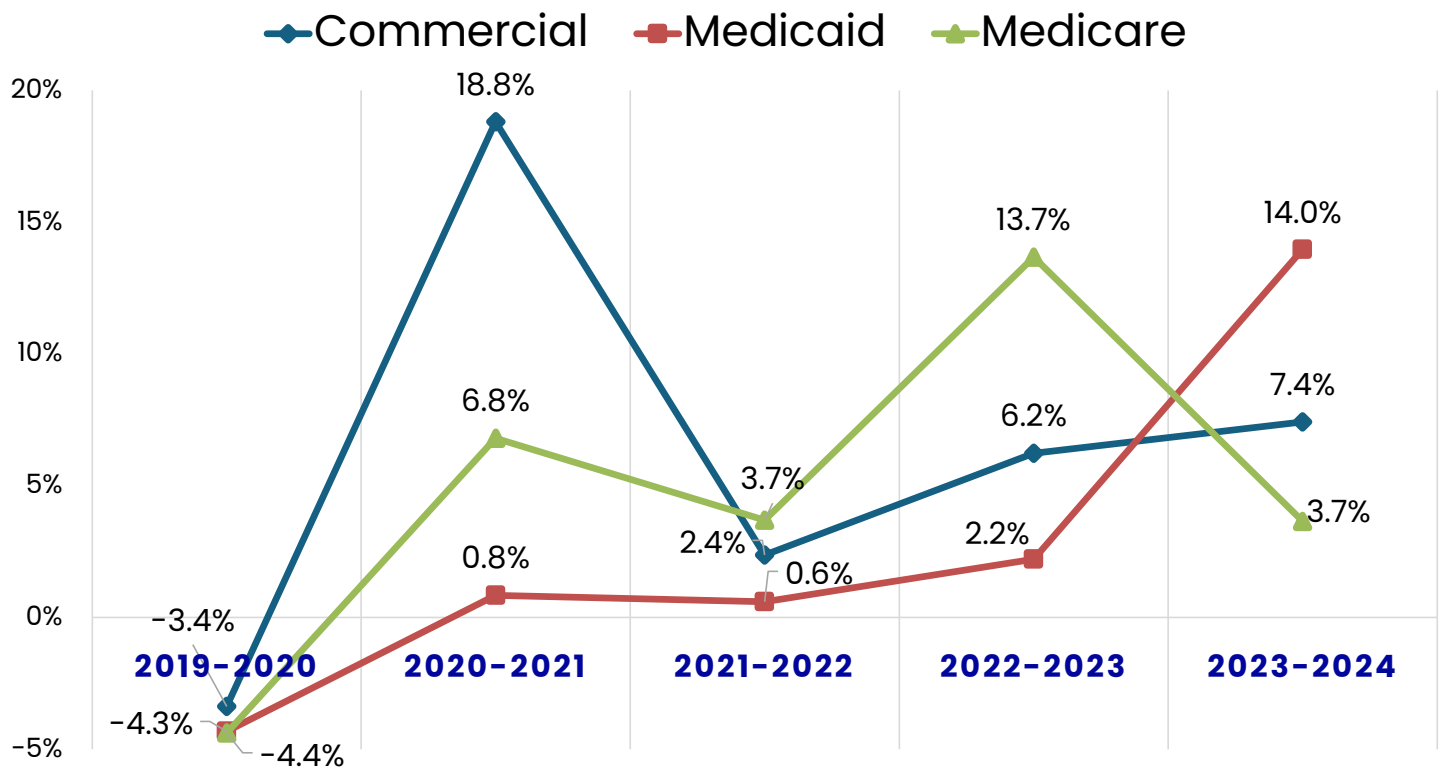
Year over Year Annual Per Capita TME Trend by Market, 2019-2024



Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates. Medicaid and Medicare include dual eligibles. Medicare market includes both Medicare Fee for Service and Medicare Advantage. Reporting period reflects the most accurate data available, including resubmissions.

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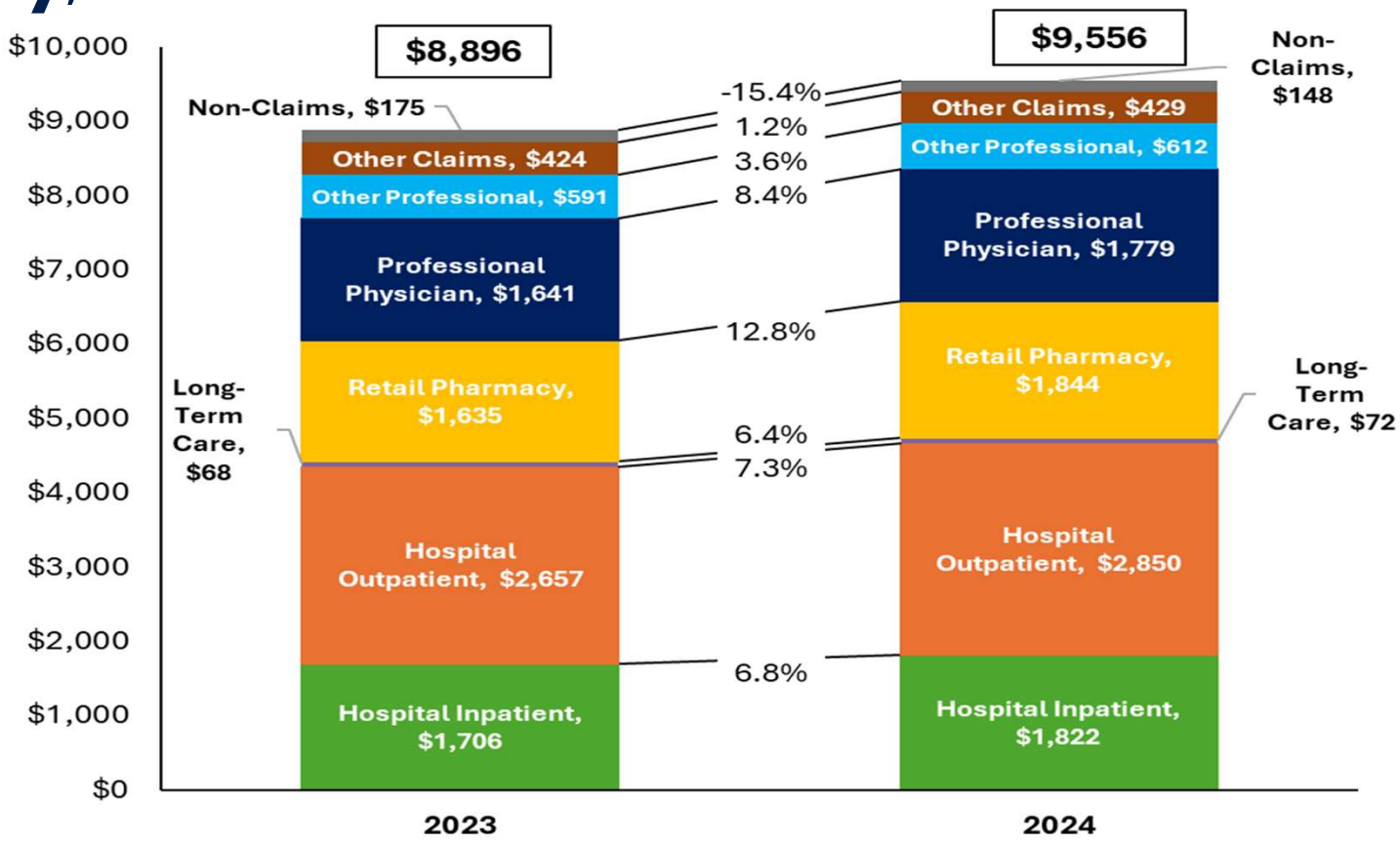
Per Capita Spending Growth and Total Spending, Statewide and by Market

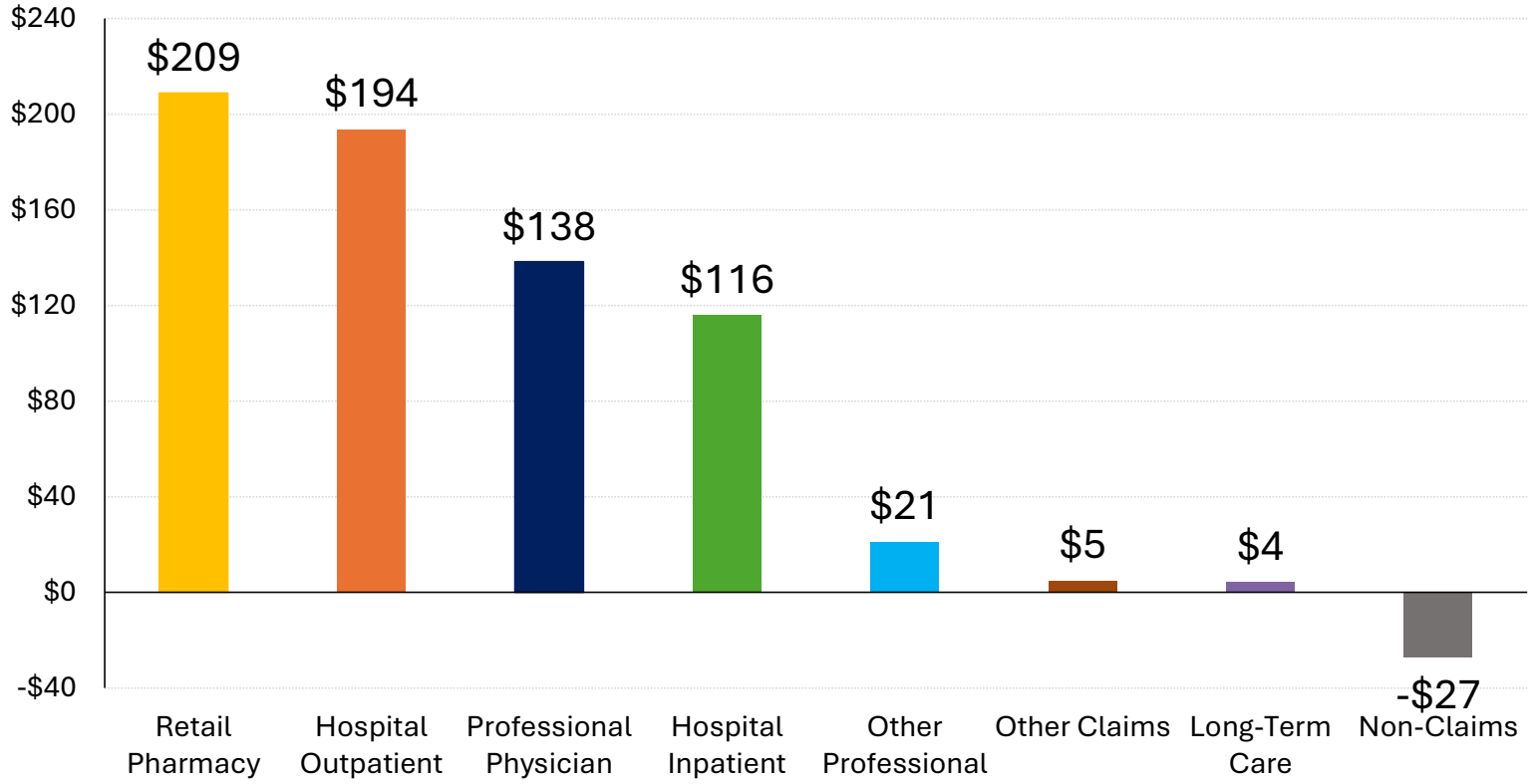
State or Market	Per Capita 2023–2024 Spending Growth	Per Capita 2024 Total Spending
Statewide THCE	7.9%	$12,332
Statewide TME	8.6%	$11,820
Commercial TME	7.4%	$9,556
Medicaid TME	14.0%	$8,371
Medicare TME	3.7%	$18,157
Benchmark Value	**4.0%**	

Commercial Market Per Capita TME by Service Category, 2023-2024



Notes: Data are not age/sex adjusted and data are reported net of pharmacy rebates.

Commercial Per Capita Contribution to TME Spending Growth by Service Category, 2023-2024



Notes: Data are not age/sex-adjusted and are reported net of pharmacy rebates

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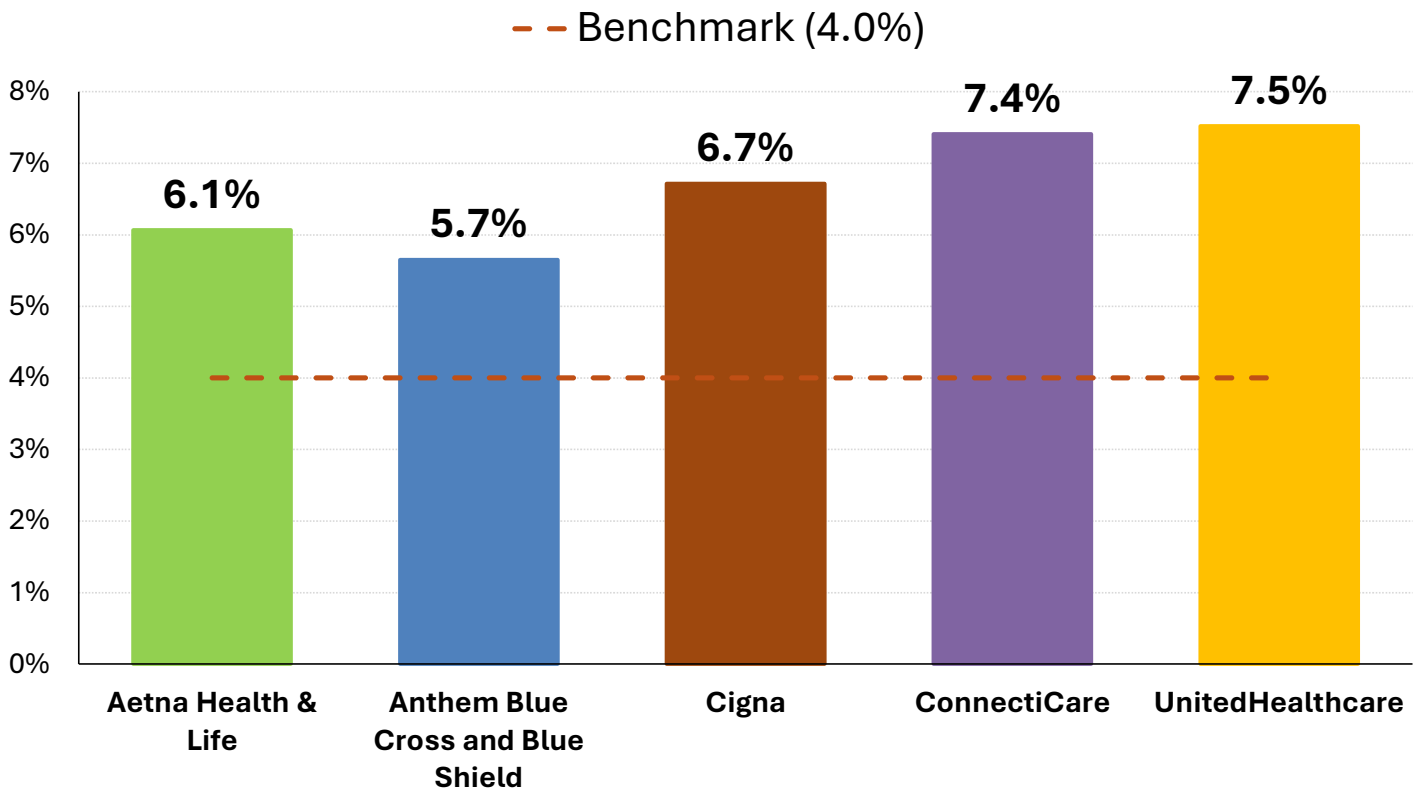
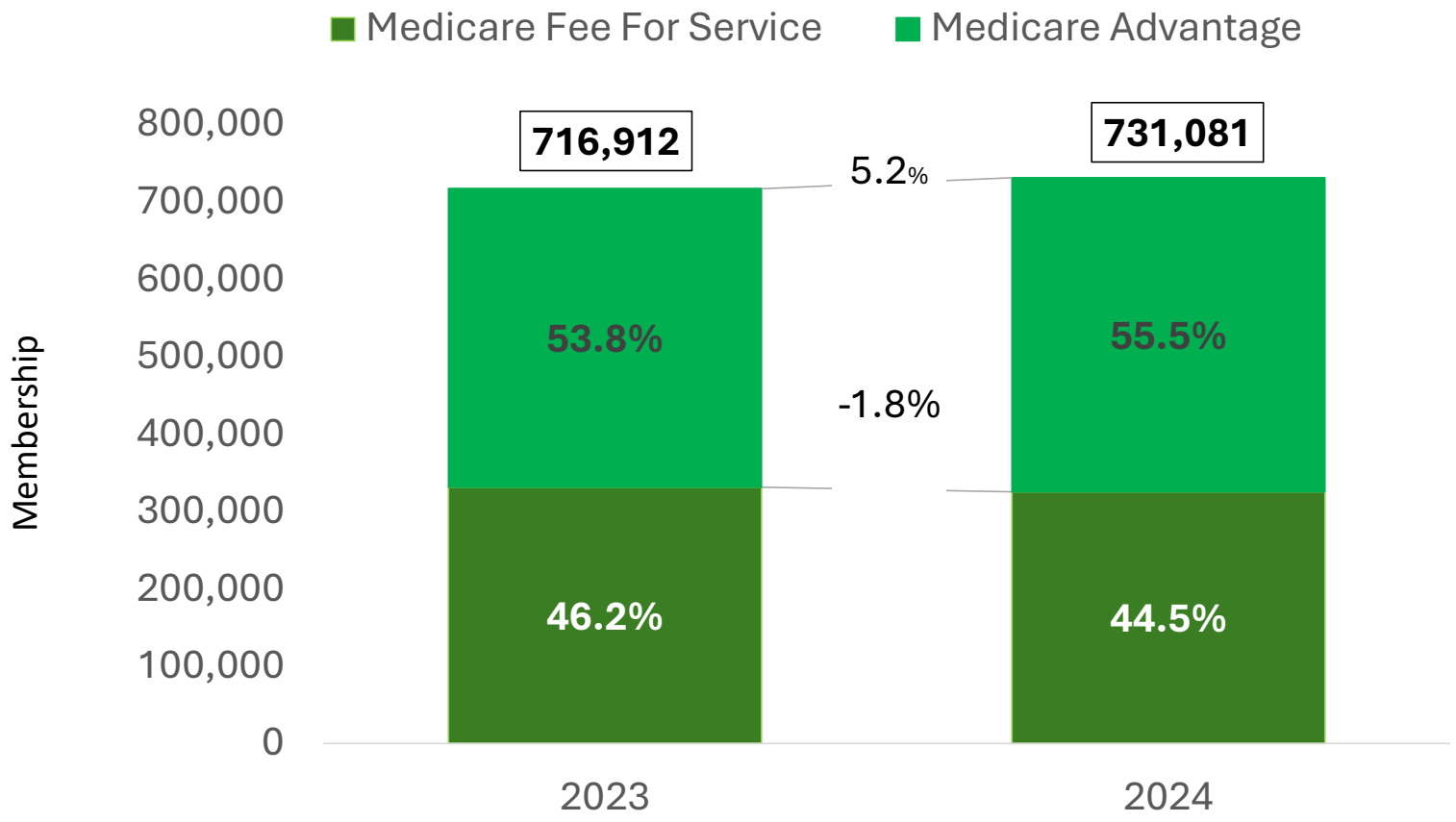
Commercial Market Per Capita TME Growth by Insurer, 2023-2024



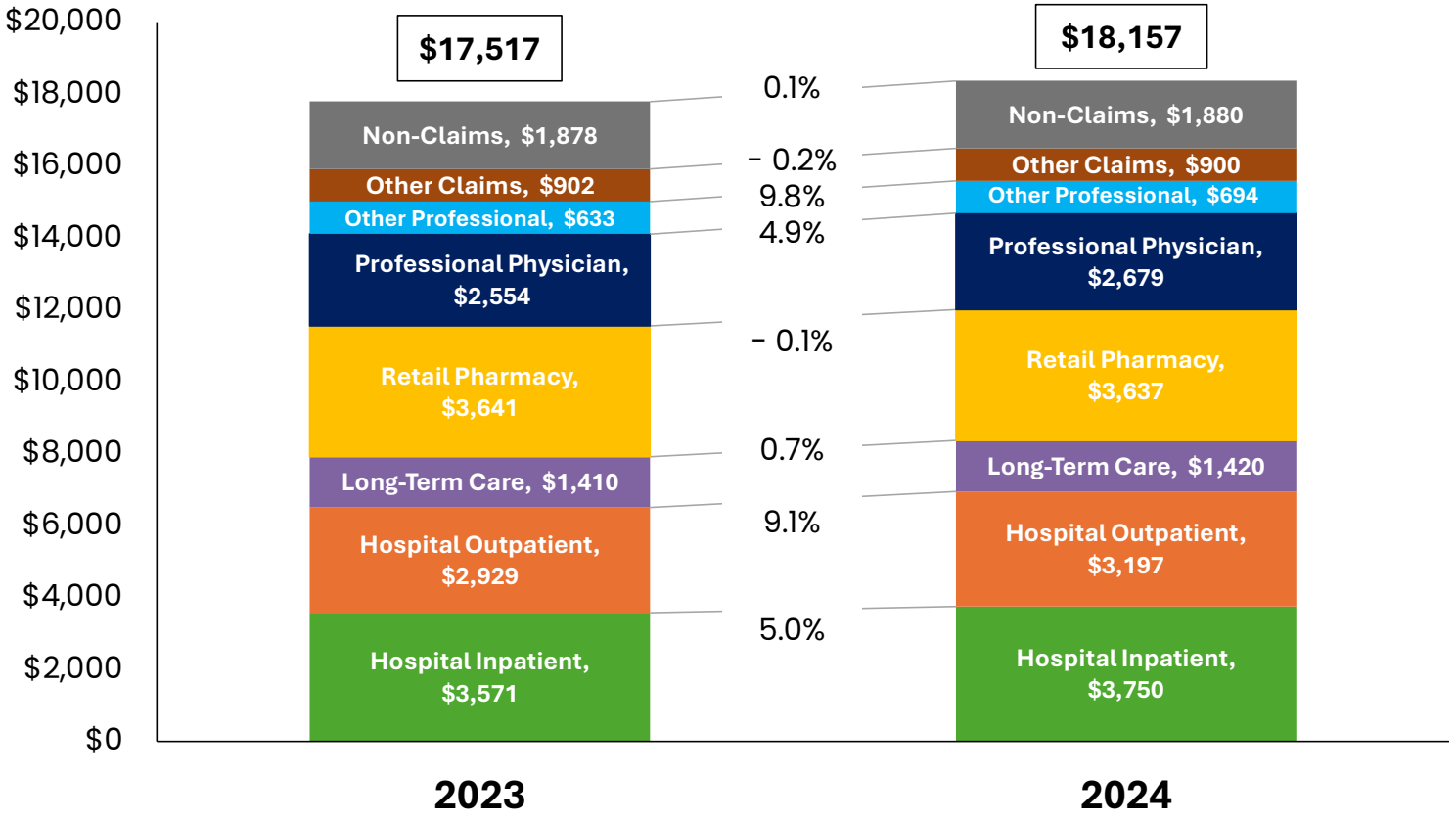
Notes: Performance data are truncated for outliers and age/sex adjusted

Membership by Medicare Plan Type, 2023-2024



Note: Dual eligible members are included. Medicare FFS includes Part A and B

Medicare Per Capita TME by Service Category, 2023-2024



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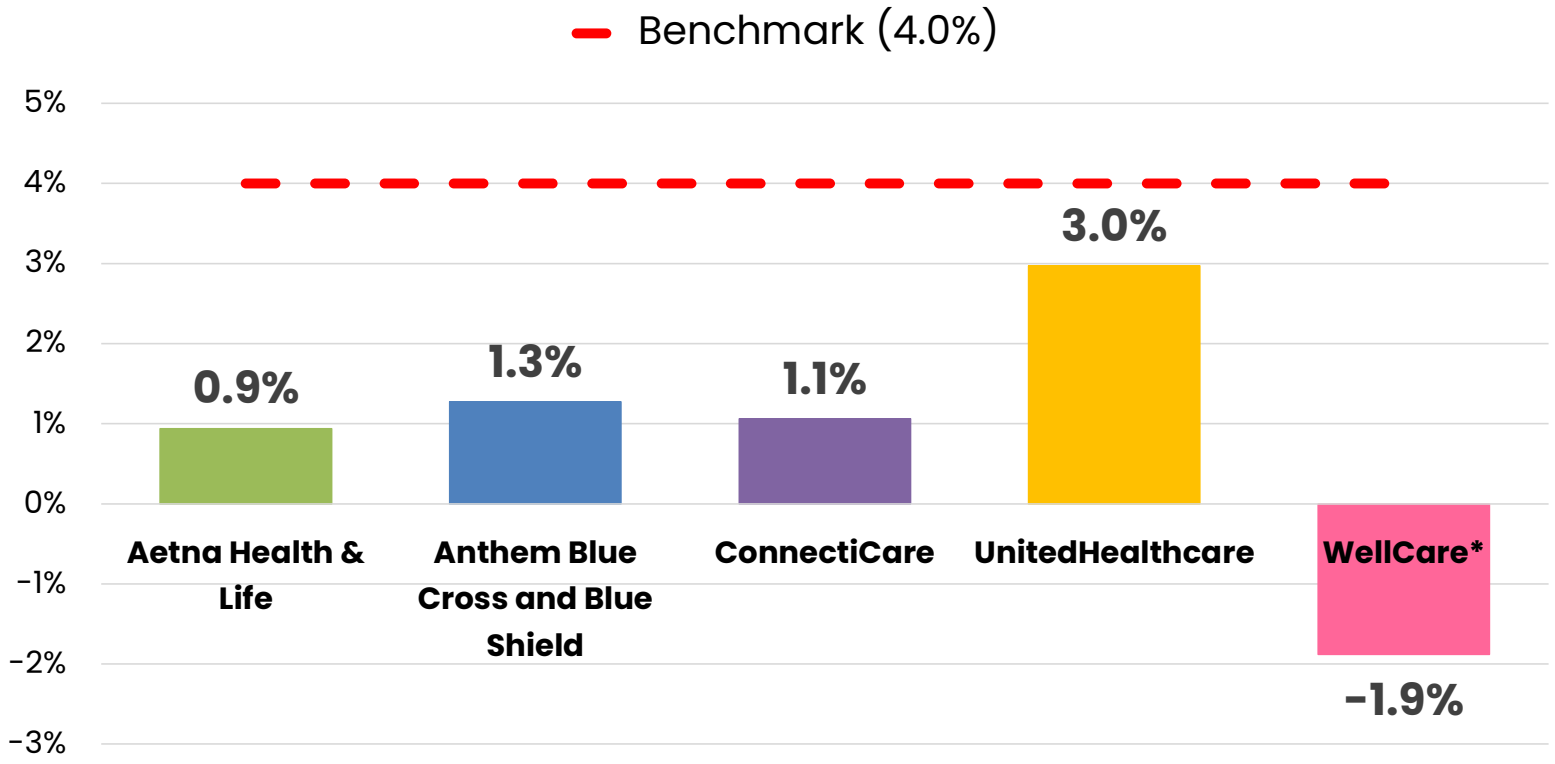
Medicare Advantage Per Capita TME Growth by Insurer, 2023-2024



Notes: Performance data are age/sex adjusted and truncated for outliers with the exception of *WellCare which was unable to truncate spending or provide standard deviations. Additionally, WellCare did not include member cost sharing in their reported spending

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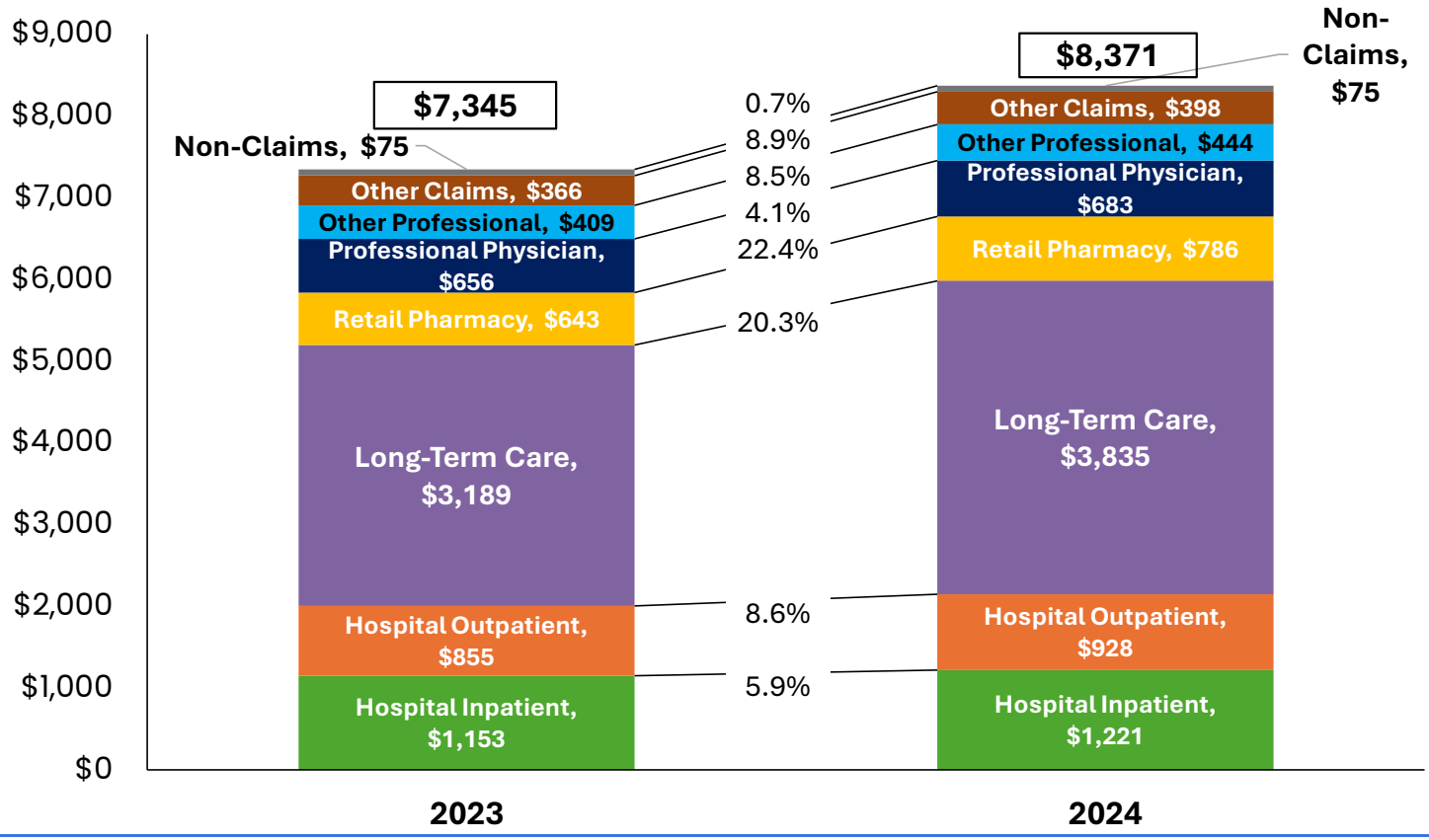
Medicaid Per Capita TME by Service Category, 2023–2024



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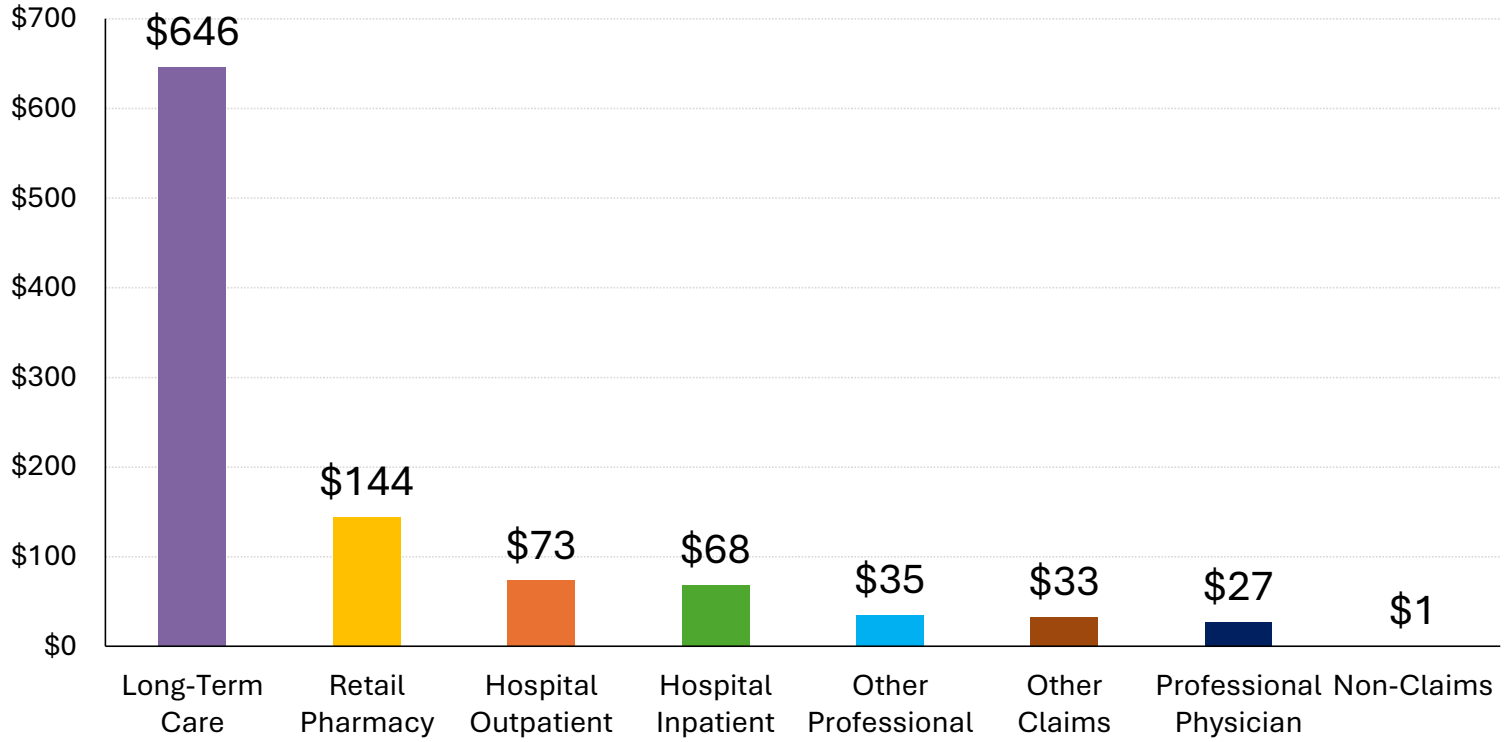
Medicaid Per Capita Contribution to TME Spending Growth by Service Category, 2023–2024



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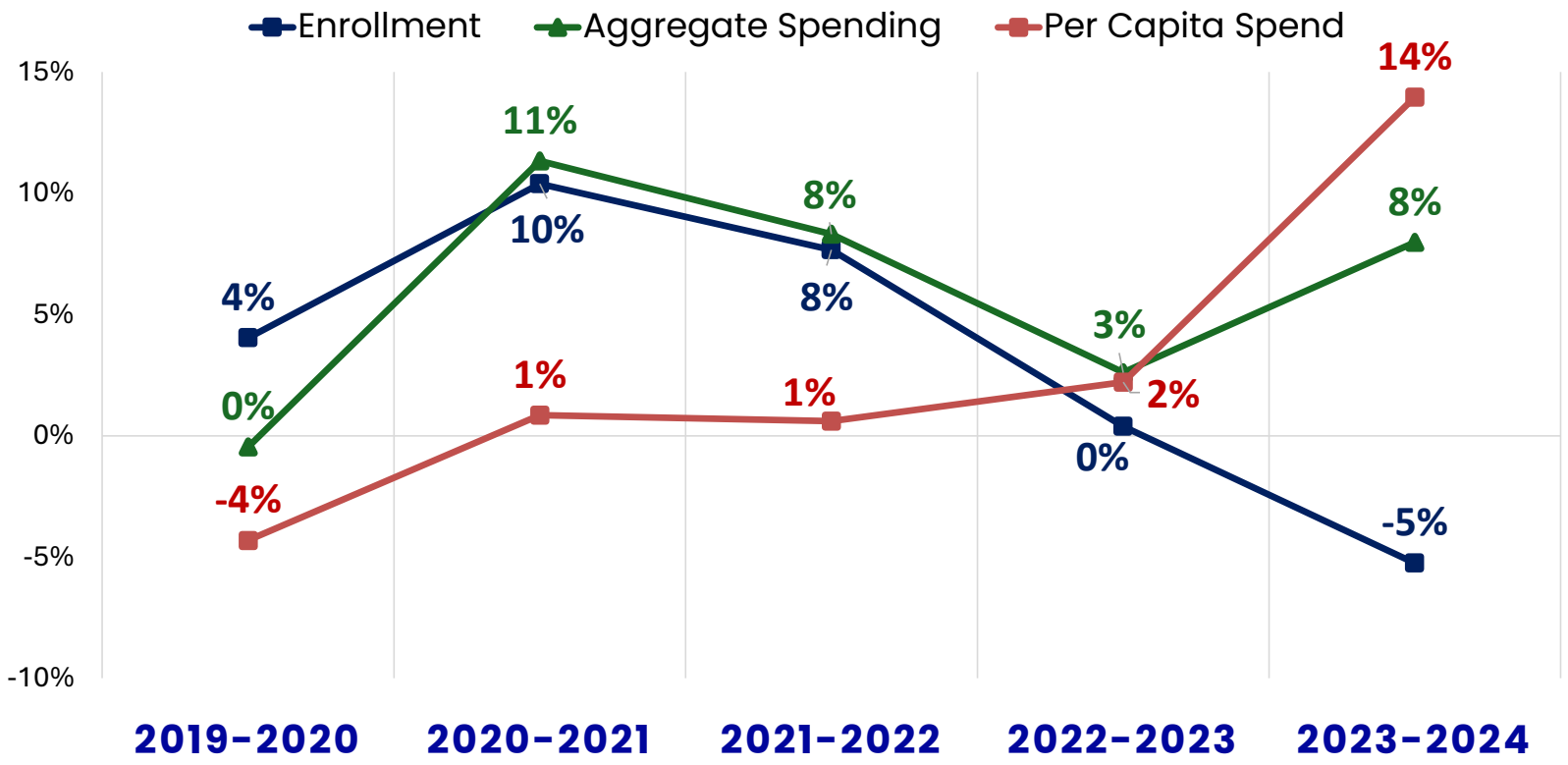
Medicaid Year over Year Annual Trends in Enrollment and Spending, 2019-2024



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Advanced Network Per Capita TME Performance Trends by Market and Type, 2023-2024

Market	Advanced Network Type	# of ANs*	# of ANs Meeting Benchmark	2024 Mbr Mos	Per Capita TME Trend
Commercial	**All**	**16**	**2**	**8,798,692**	**6.7%**
	Hospital Affiliated	11	2	5,501,983	6.7%
	Non-Hospital Affiliated	5	0	3,296,709	6.7%
Medicare Advantage	**All**	**12**	**4**	**3,182,280**	**3.5%**
	Hospital Affiliated	8	3	1,859,069	3.3%
	Non-Hospital Affiliated	4	1	1,323,211	3.9%
Medicaid	**All**	**26**	**2**	**6,280,275**	**9.0%**
	Hospital Affiliated	10	1	2,255,620	8.8%
	Non-Hospital Affiliated	4	0	1,879,308	9.9%
	FQHC	12	1	2,145,347	8.3%

*Analysis limited to Advanced Networks meeting the minimum threshold of 60,000 member months in each reporting year. Unattributed lives and spending are excluded

Healthcare Affordability and Accessibility Challenges

- Over 70% of Healthcare Value Hub's 2025 Healthcare Snapshot for Connecticut survey respondents believe the healthcare system is unaffordable

- 61% of those surveyed delayed or went without care over the last twelve months due to cost

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The High Cost of Avoidable Emergency Department Visits

- Delayed or forgone care can result in more ED use and worse health outcomes

- In Connecticut in 2024:
  - over **500,000** visits
  - and **$818 million** in payments made for potentially avoidable ED visits

- These were for health conditions that could have been more effectively managed in a primary care setting, and at less cost to the system

- Opportunity for the state to lower healthcare spending by increasing primary care access?

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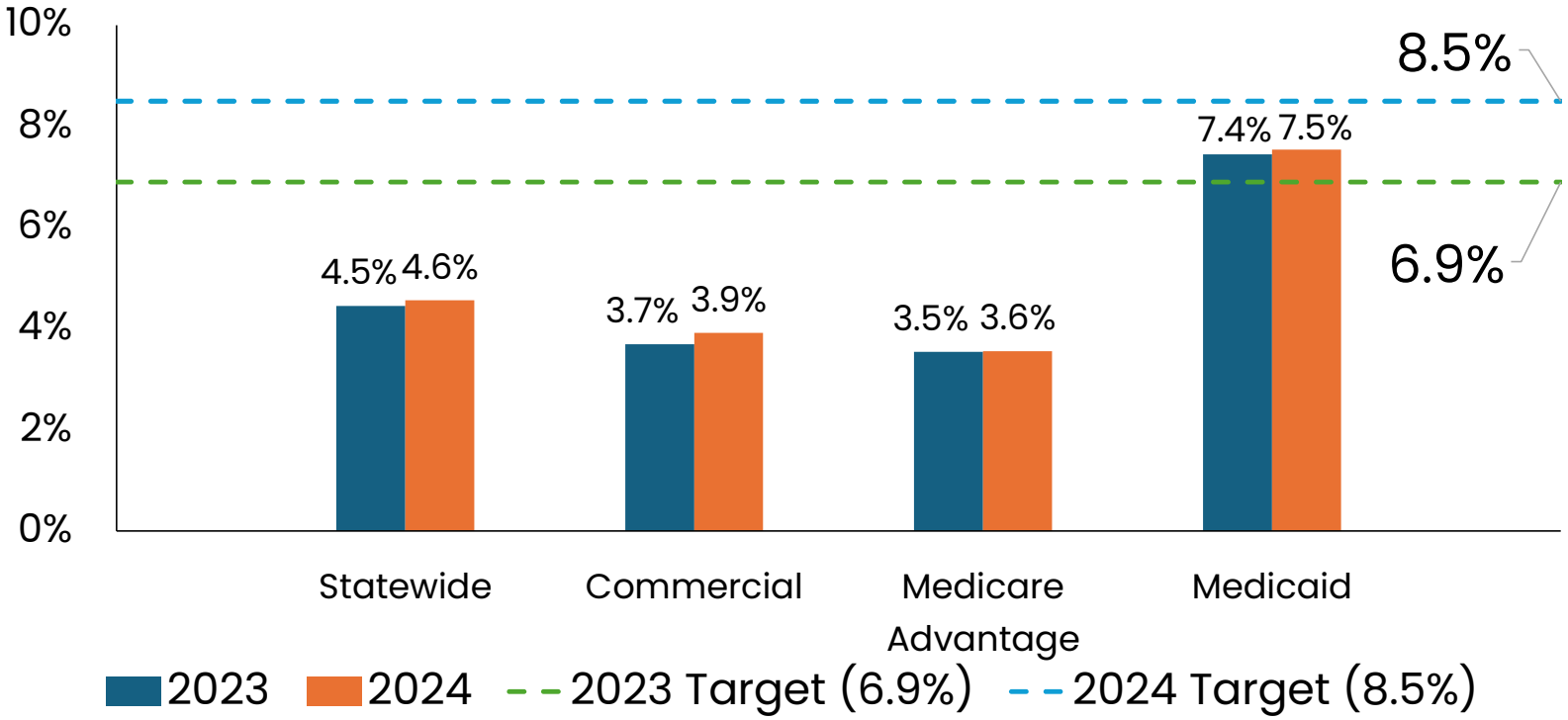
Primary Care Spending as Percentage of TME v. the Primary Care Spending Target, for the State and by Market



Note: Data exclude long-term care spending

Aggregate Primary Care Spending Trends, by Market

Market	Aggregate Primary Care Spending 2023	Aggregate Primary Care Spending 2024	Trend
Statewide	$1,066,316,562	$1,171,268,607	9.8%
Commercial	$452,715,111	$518,775,761	14.6%
Medicare Advantage	$234,206,567	$255,362,161	9.0%
Medicaid	$379,394,884	$397,130,685	4.7%

Per Member Per Month Primary Care Spending Trends, by Market

Market	PMPM Primary Care Spending 2023	PMPM Primary Care Spending 2024	Trend
Statewide	$32	$36	11.3%
Commercial	$27	$31	13.9%
Medicare Advantage	$51	$52	3.6%
Medicaid	$26	$29	10.5%

Note: Includes non-claims primary care payments

Quality Benchmark Performance, 2024

In 2021, the Quality Council recommended seven quality benchmark measures and values for phased implementation from 2022-2025.

2024 is the first year for which OHS is reporting on performance for the "Phase 2" quality benchmarks.

2024 Quality Benchmark Values by Market

Quality Benchmark Measure	Commercial	Medicare Advantage	Medicaid
Asthma Medication Ratio (Ages 5-18)	83%	N/A	70%
Asthma Medication Ratio (Ages 19-64)	82%	N/A	67%
Child and Adolescent Well-Care Visits	80%	N/A	66%
Controlling High Blood Pressure	65%	77%	65%
Follow-Up After ED Visit for Mental Illness (7-day)	64%	N/A	60%
Follow-Up After Hospitalization for Mental Illness (7-day)	67%	N/A	53%
Glycemic Status: Poor Control (>9.0%)	Reporting only	Reporting only	Reporting only

2024 Quality Benchmark Values, continued
Obesity Equity Benchmark

- The Quality Council also recommended assessing *statewide* performance starting in 2024 on an **Obesity Equity Measure**
- The measure tracks disparities in obesity between the Black and white non-Hispanic populations
- A value >1 indicates that the Black obesity rate is greater than the white rate

Quality Benchmark Measure	2024 Benchmark Value
Obesity Equity Measure	1.42

Phase 1 Quality Benchmark Results by Market, 2024

Quality Benchmark Measure	Commercial Target Value	Commercial Performance	Medicaid Target Value	Medicaid Performance	Medicare Advantage Target Value	Medicare Advantage Performance
Asthma Medication Ratio (ages 5-18)	83%	Not met (72%)	70%	Not met (52%)	NA	NA
Asthma Medication Ratio (ages 19-64)	82%	Not met (78%)	67%	Not met (63%)	NA	NA
Controlling High Blood Pressure	65%	Met (70%)	65%	Met (70%)	77%	Met (80%)

*Lower performance is better for *Glycemic Status Poor Control*.

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Phase 2 Quality Benchmark Results by Market, 2024

Quality Benchmark Measure	Commercial Target Value	Commercial Performance	Medicaid Target Value	Medicaid Performance
Child and Adolescent Well-care Visits	80%	Not met (78%)	66%	Met (68%)
Follow-Up After ED Visit for Mental Illness (7-day)	64%	Not met (60%)	60%	Not met (52%)
Follow-Up After Hospitalization for Mental Illness (7-day)	67%	Not Met (62%)	53%	Not Met (47%)

Statewide Quality Benchmark Results, 2024

Quality Benchmark Measure	Statewide	
	Target Value	Performance
Obesity Equity Ratio	1.42	Met (1.42)
Obesity Rate: Three-year rolling average obesity rate for the Black, non-Hispanic population (lower percentage indicates a lower obesity rate)	37%	Not Met (40%)

Commercial and Medicare Advantage Performance by Insurer, 2024

Quality Benchmark Measure & Market	Benchmark	Aetna	Anthem	Cigna	ConnectiCare	UHC	WellCare
Asthma Medication Ratio (ages 5-18)							
Commercial	83%	Not met (72%)	Not met (70%)	Not met (75%)	Not met (68%)	Not met (73%)	NA
Asthma Medication Ratio (ages 19-64)							
Commercial	82%	Met (83%)	Not met (76%)	Not met (79%)	Not met (80%)	Not met (71%)	NA
Child and Adolescent Well-Care Visits							
Commercial	80%	Met (80%)	Not met (73%)	Met (82%)	Not met (75%)	Not met (79%)	NA

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Commercial and Medicare Advantage Performance by Insurer, 2024 continued

Quality Benchmark Measure & Market	Benchmark	Aetna	Anthem	Cigna	ConnectiCare	UHC	WellCare
Controlling High Blood Pressure							
Commercial	65%	Met (69%)	Met (70%)	Met (70%)	Not met (65%)	Met (73%)	NA
Medicare Advantage	77%	Met (81%)	Not met (75%)	NA	Met (87%)	Met (80%)	Not met (68%)
Follow-Up After ED Visit for Mental Illness (7-day)							
Commercial	64%	Not met (59%)	Not met (62%)	Not met (58%)	Not met (63%)	Not met (59%)	NA
Follow-Up After Hospitalization for Mental Illness (7-day)							
Commercial	67%	Not met (65%)	Not met (61%)	Not met (64%)	Not met (53%)	Not met (62%)	NA

Leveraging Federal Opportunities to Strengthen Primary Care:

Rural Health Transformation Program and Achieving Healthcare Efficiency through Accountable Design (AHEAD)

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LEVERAGING FEDERAL OPPORTUNITIES TO STRENGTHEN PRIMARY CARE

HEALTHCARE BENCHMARK INFORMATIONAL HEARING

June 23, 2026

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Overview of Rural Health Transformation Program (RHTP)

New federal grant to states from Public Law 119-21, also known as H.R. 1 or One Big Beautiful Bill Act

$50 billion nationally over 5 years—to transform care and improve health outcomes in rural communities

Grant application was prepared in a short, 7-week deadline, with strict criteria. DSS submitted grant application to CMS on 11/4/2025

All 50 states applied and were approved. CT received ~$154 million in year 1 of 5 (CMS recalculates each year)

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Initiative Alignment Within 30 Projects Across 10 Sister Agencies

POPULATION HEALTH OUTCOMES

Outdoor recreation, ACCESS Mental Health expansion, nurse home visiting, mobile clinic pilot, exercise for older adults, non-traditional farming.

WORKFORCE

Rural residency expansion, interstate licensure compact, certified nurse aide training, rural provider incentives, AHEC workforce pipeline.

DATA & TECHNOLOGY

Bridging the digital divide, integrated care network, Connie HIE enhancements, predictive analytics, consumer AI-powered care management.

CARE TRANSFORMATION & STABILITY

Behavioral health crisis stabilization, mobile integrated health, rural hospital right-sizing, PACE, school-based behavioral health, community navigators.

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DPH	Interstate Licensure Compact Support	Implement and manage interstate licensure compacts to streamline cross-state licensing and expand rural healthcare workforce, with DPH staff overseeing enrollment, processing, and rural facility outreach.
	Mobile Integrated Health Pilot	Pilot Mobile Integrated Health program for in-home preventive/chronic/post-acute care, including follow-up, disease/medication management, behavioral health support, and community links to reduce hospitalizations and improve health outcomes for women/children.
DSS	ACCESS Mental Health ASD Service Access	Expand specialized ASD (autism spectrum disorder) consultation/support to build competencies in pediatrics, family medicine, behavioral health, and crisis care for timely, community-based expert guidance.
	ACCESS Mental Health Enhanced School-Based Mental Health Care	Strengthen school-based health centers' capacity for complex student behavioral health needs through ACCESS Mental Health for Youth – School Expansion, providing staff psychiatric consultation, guidance, and referrals to expand access and competency.
	Integrated Care Network	Establish Integrated Care Networks linking rural hospitals, Federally Qualified Health Centers (FQHCs), long-term care, Emergency Medical Services (EMS), and community organizations to improve prevention, chronic care, and access, with a TA vendor guiding feasibility/recruitment and organizations implementing state-approved plans.
	Improving Primary, Maternal, Behavioral, and Dental Health through Direct Investment and Value-Based Payments (VBP)	Support rural primary care, maternal, behavioral health, and dental providers' practice transformation via National Committee for Quality Assurance Patient-Centered Medical Home (NCQA PCMH) certification, Electronic Health Records (EHR)/telehealth adoption, and Administrative Services Organizations (ASO) technical assistance for value-based care readiness, with consultant/advisory council advancing sustainable payment models.
	Program of All-Inclusive Care for the Elderly (PACE)	Establish regional PACE hub for integrated primary/behavioral/long-term care for dually eligible rural older adults, reducing hospitalizations and supporting aging in place via scalable urban-rural model
	Rural Hospital Transformation & Rural Health Facility Right-Sizing and Infrastructure	Help rural/rural-serving hospitals achieve financial stability, efficiency, and value-based care readiness via multi-year technical assistance, planning, and grants, with vendor guiding state-approved modernization prioritizing independent, university-affiliated, chronic disease, and Tribe-operated facilities.
	Care Coordination Support for Primary Care Practices	Develop performance tracking for primary care in coordinated care models, with ASOs providing data/support for small practices and Medicaid PCMH providers earning per-member-per-month payments to coordinate across social/behavioral/dental partners, improving rural outcomes.
	Regional Collaboratives	Create regional coordination anchors to align Rural Health Transformation Program initiatives, foster state/local collaboration, and improve service integration by convening leaders to coordinate efforts, reduce duplication, gather input, and secure funding for sustained health/social services.

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Achieving Healthcare Efficiency through Accountable Design (AHEAD)

01

Multi-Payer Demonstration

CMS model shifting from fee-for-service to value-based care through hospital global budgets, primary care transformation and investments, and aligning statewide population health goals.

02

Timeline & Funding

Runs 2024-2035, launching in 2028, with up to $12 million over five years to build data, policy, and payment infrastructure.

03

Participation Requirements

Voluntary for hospitals and payers. Must enroll hospitals totaling 30% Medicare Fee-for-service revenue (by 2030) and one commercial payer (by 2029).

Connecticut joins five states, including Rhode Island, Vermont, Maryland, Hawaii, and New York.

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AHEAD Model Components

HOSPITAL GLOBAL BUDGETS PAYMENT MODEL

PRIMARY CARE AHEAD

POPULATION HEALTH ACCOUNTABILITY PLAN

GEO AHEAD

CHOICE & COMPETITION

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AHEAD Model Components

AHEAD Model Component	Description
Primary Care Transformation Primary Care AHEAD and Medicaid Advanced Primary Care	• Voluntary participation by independent and hospital owned-practices and FQHCs in advanced primary care offering practice alignment for whole-person care including behavioral health integration, health promotion activities, and care coordination. • Practices receive an enhanced per member per month payment (a statewide average of ~$17) for Medicare FFS beneficiaries with an optional transition to partial or full capitated payments.

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Primary Care AHEAD

A Medicare Fee-For-Service Advanced Primary Care Model

Alternative Payment

- PC AHEAD payment pathways support practices in care transformation
- Practices can choose from 4 pathways that range from FFS plus an enhanced payment to full capitation
- Pathway progression is voluntary for practices

Care Transformation Requirements (CTRs)

- PC AHEAD directs care transformation through CTRs within 3 domains:
  - Behavioral Health Integration
  - Specialty Care Coordination
  - Health Promotion Activities

Quality Based Adjustment Domains

- Primary Care quality measures will be chosen from 4 domains:
  - Prevention and Wellness
  - Chronic Conditions
  - Health Care Utilization
  - Behavioral Health

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Federally Required Disclaimers

"This project is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $154,249,105.53 in Budget Period 1 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government."

"Connecticut AHEAD is supported by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $12 million with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government."

Discussion

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Break

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Successful Value-Based Care Programs in Connecticut (and Adoption of Alternative Payment Models)

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Value-Based Care (VBC)

- What is **Value-Based Care**?
  - Health care that is delivered with the aim of achieving clear measurable objectives that represent value for a patient.
  - Those objectives, and corresponding performance measures, may focus upon quality of care, quality outcomes, access to care, health equity, patient experience and cost efficiency.
- **Alternative Payment Models** (APMs) are designed to create financial incentives for health care providers to deliver VBC.

Alternative Payment Models

- APMs tie payments to demonstrated high-value care. They are an intended alternative to fee-for-service payment models that reward greater service volume.
- OHS monitors overall APM adoption in the state, pursuant to Conn. Gen. Statutes § 19a754a(b)(8)(F).
- APM adoption aligns with the Healthcare Benchmark Initiative's goals of lowering healthcare spending, promoting primary care access, and improving patient and population health outcomes.

2024 APM data showed that advanced APM adoption differed by market

- Advanced APMs (Categories 3B-4C) have the highest level of risk sharing tied to quality and patient outcomes.
- The 2024 analysis of APM adoption found that….
  - In the **commercial market**, Connecticut **caught up to and surpassed national adoption** of advanced APMs in 2024.
    - This increase was driven by adoption of Category 3B models.
  - In the **Medicare Advantage** market, Connecticut continued to see **lower adoption** of advanced APMs than nationally.

APM Adoption in Connecticut's Commercial Market

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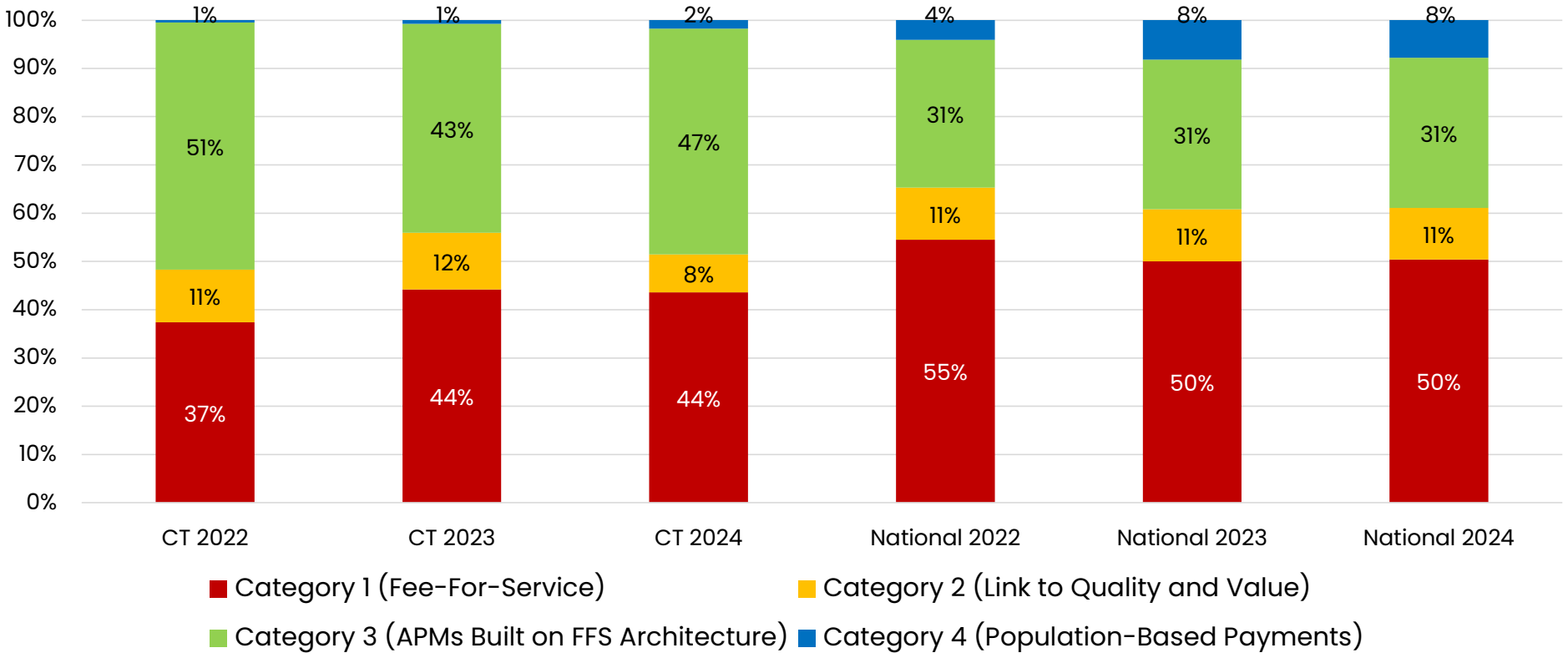
Commercial APM Adoption, Connecticut vs. National, 2022-2024



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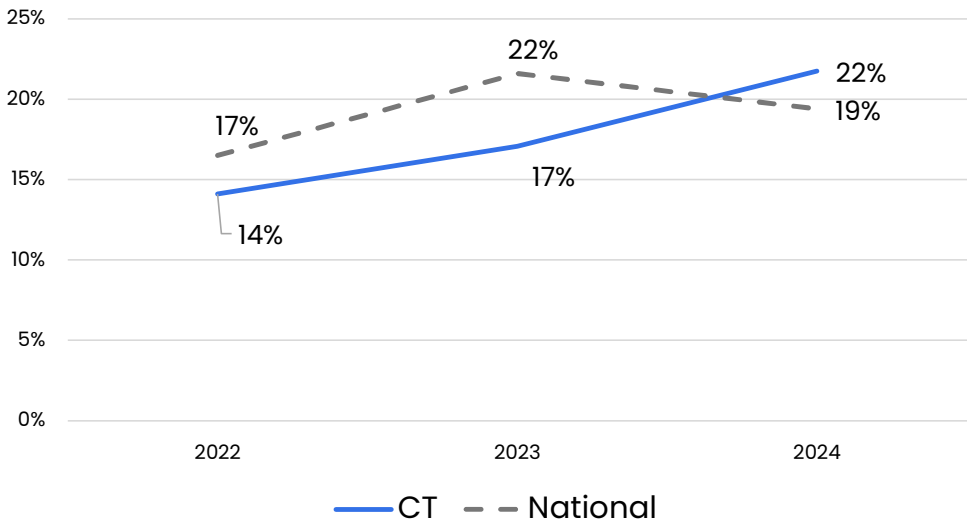
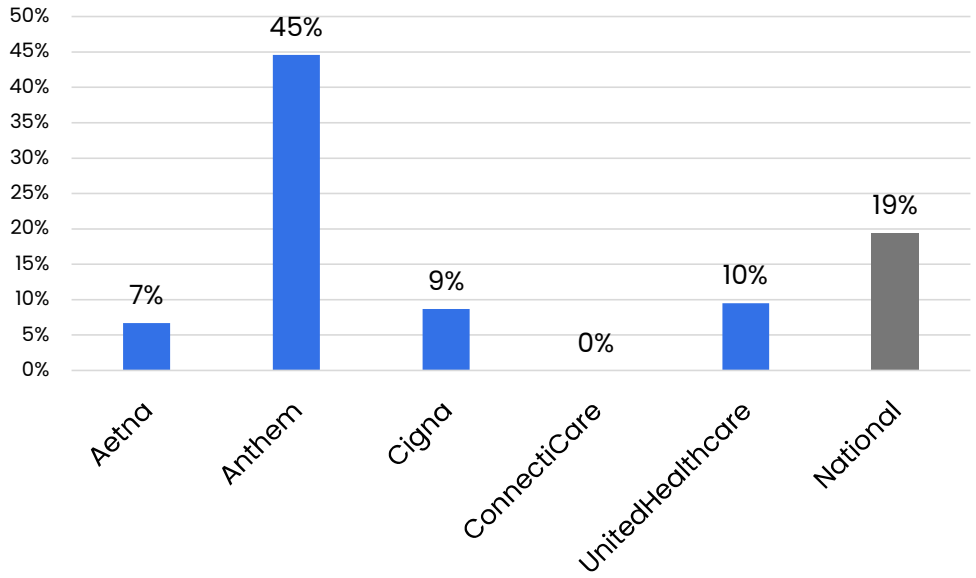
Commercial Market Adoption of Advanced APMs, 2024

Commercial Advanced APM Adoption (Categories 3B-4C), Connecticut vs. National, 2022-2024



Commercial Advanced APM Adoption (Categories 3B-4C) by Payer, 2024



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APM Adoption in the Medicare Advantage Market

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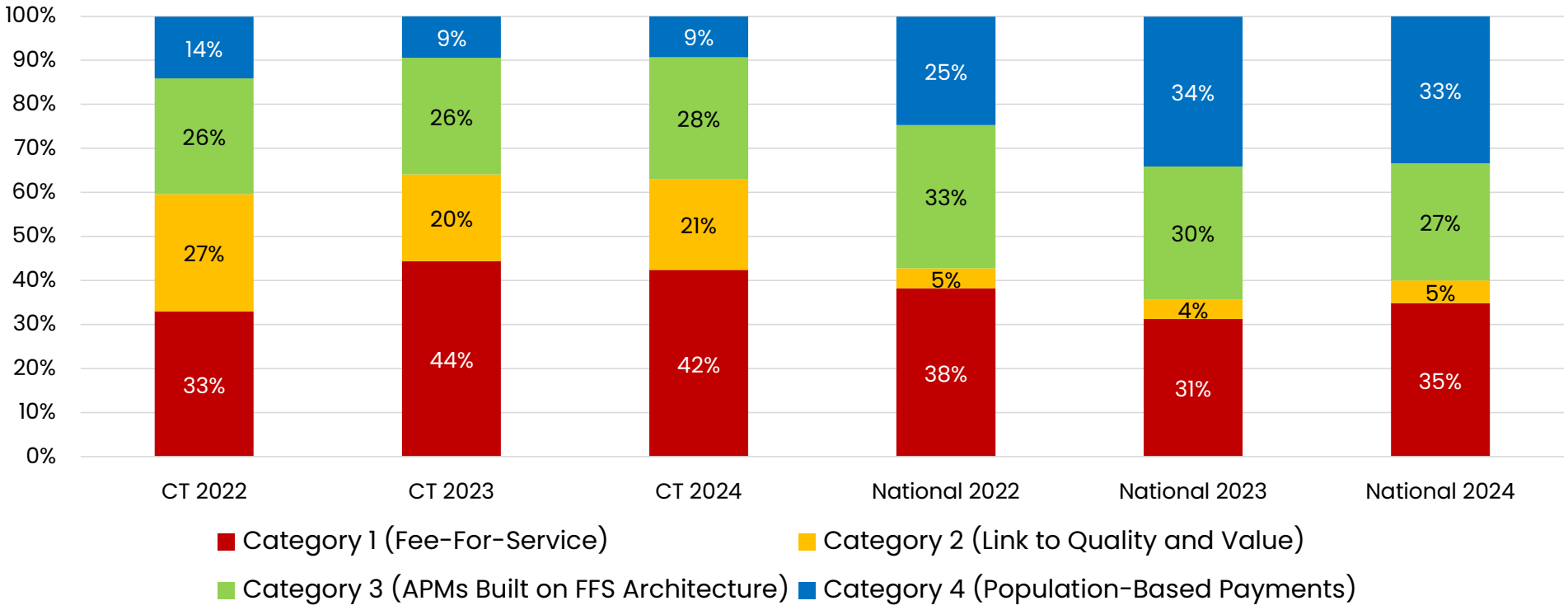
Medicare Advantage APM Adoption, Connecticut vs. National, 2022-2024



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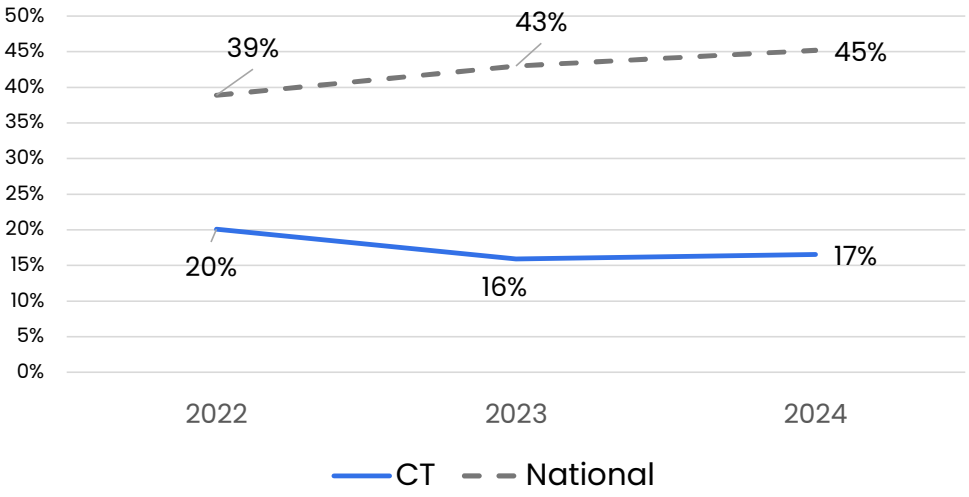
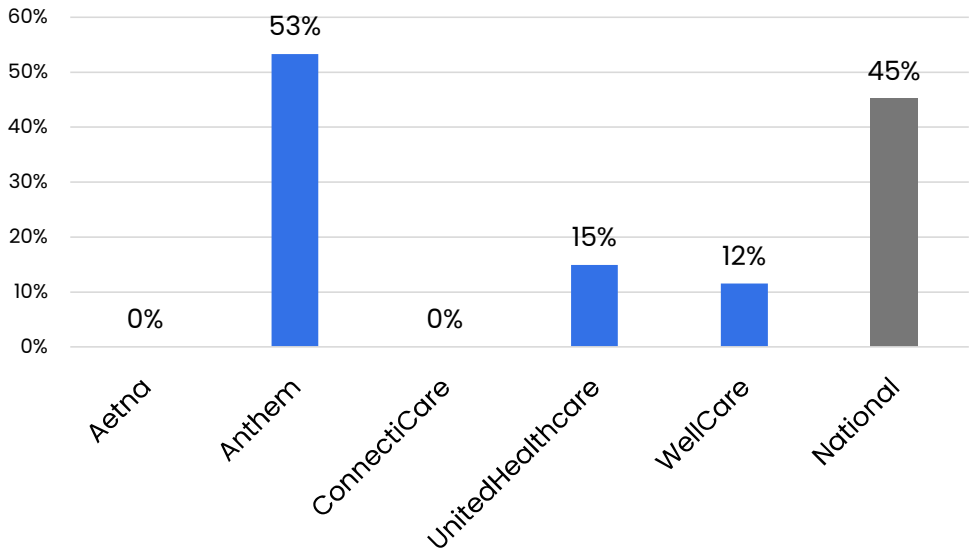
Medicare Advantage Market Adoption of Advanced APMs, 2024

Medicare Advantage **Advanced** APM Adoption (Categories 3B-4C), Connecticut vs. National, 2022-2024



Medicare Advantage **Advanced** APM Adoption (Categories 3B-4C) by Payer, 2024



CONNECTICUT Health Strategy

Discussion

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Connecticut's Healthcare Benchmarks – 2026 Updates:

Changes based on PA 26-68, §§ 364 – 369, as amended by PA 26-76

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Changes to the Healthcare Benchmark Initiative, Cost Growth

Cost Growth Benchmark

- Sets the 2028 – 2032 Cost Growth Benchmark at 3.9%
- Sets the 2033 and future Cost Growth Benchmark at 20% median household income plus 80% of the greater of growth in (1) PGSP or (2) employment cost index for private industry workers, New England
- Over the next couple of years:
  - Measured and assessed in aggregate across all applicable markets
  - Incorporates clinical risk and certain other factors

Changes to the Healthcare Benchmark Initiative, Hospital Payment Growth

NEW Hospital Payment Growth Benchmark

- Requires OPM to establish a market basket methodology to assess hospital payment growth
- Creates a Hospital Payment Growth Benchmark equal to the Cost Growth Benchmark
- Incorporates clinical risk and certain other factors
- Begin development in 2027

Changes to the Healthcare Benchmark Initiative, Accountability

Assessment

- Providers and Hospitals exceeding the Benchmark may be required to file a Cost Growth Plan
- Failure to file or follow the plan can result in a required community investment project valued at between $100,000 (for small hospitals) and $400,000 (for large hospitals).
- Begins 2028/2029

Changes to Process of Identifying Significant Contributors to Healthcare Cost Growth

- By July 1, 2028, establish a revised methodology for identifying significant contributors utilizing APCD data, incorporating (as practical) changes in clinical risk.

- Upon the request, OPM will make available the APCD data set and analytic files used to make the determination, provided the entity receives approval from the all-payer claims database release committee.

Data Releases

The APCD Data Release Committee must establish an expedited process for these requests by January 1, 2027.

- APCD requests must be approved within 10 days, with a Data Use Agreement sent within 5 days of approval. Data must then be provided 10 days after receiving the approved Data Use Agreement.

- Identified entities shall be exempt from payment of a data release fee.

Challenges

- The secretary shall consider any timely challenge submitted by an identified entity.
- In making and publicly presenting a cost-driver assessment, the secretary shall use the revised methodology and examine the contribution of material changes in clinical risk and payment methodologies.

Changes to Primary Care Spending Target

- Beginning 2031, requires new market specific primary care spending targets
- Targets can increase by up to 5 percentage points over a 5-year period and must aim towards a reference value that accounts for primary care access needs, workforce capacity, health equity

Public Comment

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Conclusions/Adjournment

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