

Connecticut Bucks the Trend on Managing Medicaid

By MELINDA BECK

At a time when most states are paying private insurers to provide health care for their Medicaid recipients, Connecticut says it has saved money and improved care by going the opposite way.

In 2012, Connecticut fired the companies that were running Husky, as its Medicaid system is known, and returned to a more traditional “fee for service” arrangement where the state reimburses doctors and hospitals directly.

State officials, doctors and patient advocates have welcomed the move: Average cost per patient, per month, is down from \$718 in mid-2012 to \$670 last year, according to state data. The number of doctors willing to treat Medicaid patients is up 7%, meaning fewer patients are using emergency rooms for routine care.

Now, 41 states contract with private insurers to run some or all of their health programs for the poor. Nationwide, 70% of 73 million Medicaid enrollees are in private plans. Most states use managed care, where insurers get a monthly fee per enrollee. If plan members’ care costs less than the fees, the plans make money; if it costs more, they lose.

States have turned to managed care to control spending. Health plans say they can provide better, more-coordinated care and save states money—



Connecticut pediatrician Barbara Ziogas with a patient and his mother. The state's Medicaid program no longer uses private insurers.

\$6.4 billion this year, according to an estimate prepared for the Association for Community Affiliated Plans, which represents nonprofit plans.

Connecticut had 11 firms offering managed-care plans in 1995, each with different rules and reimbursement rates. In-

dustry consolidation and battles over rates whittled that down to four by 2000, which some observers say limited the state's ability to bargain.

Patient advocates complained of denied services and delayed payments. State officials were frustrated by the

plans' refusal to share data.

In 2009, an audit found Connecticut was overpaying the three remaining plans—run by Aetna Inc., United-Health Group Inc. and Community Health Network of Connecticut—by nearly \$50 million a year. Then-Gov. Dan-

iel Malloy cut ties with the plans as of 2012. Plan spokesmen declined to comment.

Under Connecticut's new system, a nonprofit administrator processes claims, but the state bears the financial risk. Patients have a 1-800 number to call with questions.

Reimbursement rates are the same across the state.

State officials say the system has trimmed administrative costs to just 5% of total costs, compared with 12% on average at managed-care plans. And having data on all 750,000 Husky patients has helped target those with complex needs for extra support.

Jeff Myers, CEO of Medicaid Health Plans of America, a trade group, questions whether Connecticut can sustain its savings. “That’s a challenge you see over and over in fee-for-service model,” he said.

And some experts say it is unlikely Connecticut's experience will spark a wider return to fee-for-service. “Most other states have found it's easier to go the managed-care route,” says Matt Salo, executive director of the National Association of Medicaid Directors.

In Connecticut, officials said one key to Husky's success are “medical homes,” whereby primary-care doctors are paid extra for coordinating care. To qualify, practices must hold slots open for Medicaid patients, use electronic records and offer off-hours coverage.

Barbara Ziogas, a pediatrician in Farmington, said the new system enables her to follow patients more closely: “Now, if I've sent someone to a specialist, we get the specialist's notes back and can update their records—and if they didn't go, we find out why.”

ANDREW SULLIVAN FOR THE WALL STREET JOURNAL