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U.S.

## Connecticut Moves Away From Private Insurers to Administer Medicaid Program

Most states pay private insurers to provide care under the program; Connecticut says it has saved money by reimbursing providers directly



Dr. Barbara Ziogas, a pediatrician in Farmington, Conn., talks to a patient earlier this month. Dr. Ziogas said Connecticut's new 'medical homes' system enables her to follow patients more closely. *PHOTO: ANDREW SULLIVAN FOR THE WALL STREET JOURNAL*

By **MELINDA BECK**

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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, physicians 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% and as a result fewer patients are using emergency rooms for routine care.

Some experts say Connecticut's experience shows there is no one-size-fits-all approach to managing care for a state's low-income and disabled residents—an often-challenging population.

“There's a lot of emphasis on innovation and testing new models right now,” said Julia Paradise, who studies Medicaid programs at the Kaiser Family Foundation, a nonprofit research group. “Connecticut illustrates that there is more than one way to run a Medicaid program that is high-performing.”

Currently, 41 states contract with private insurers to run some or all of their health programs for the poor, and many are increasing their role. Nationwide, 70% of the 73 million Medicaid enrollees are in private plans. Most states use “full-risk” managed-care contracts, where insurers get a monthly fee per assigned enrollee. If plan members' care costs less than the fees, the plans make money; if it costs more, the plans lose.

States have turned to managed care as a way to control spending, particularly those that expanded Medicaid under the Affordable Care Act. Health plans say they can provide better, more-coordinated care and save states money—some \$6.4 billion this year, according to an estimate prepared for the Association for Community Affiliated Plans, which represents nonprofit health plans in 26 states.

Other reports say managed care's record with Medicaid has been mixed. With some exceptions, a county-by-county study by the nonpartisan Urban Institute last year found no evidence that greater reliance on managed care cut costs, but it did increase the likelihood of ER visits, difficulty seeing specialists, and unmet need for prescription drugs.

Jeff Myers, CEO of Medicaid Health Plans of America, a trade group for insurers, said: “No one is saying that managed-care is perfect, but there is an overwhelming amount of data that suggests the fee-for-service model does not work,” referring to the traditional insurance method of paying doctors and hospitals per service.

Connecticut's verdict on managed care is different: “Been there, done that and it didn't

work,” says Robert Zavoski, a pediatrician and medical director for the Husky system.

Once known as “the insurance capital of the world,” Connecticut had 11 companies offering Medicaid managed-care plans in 1995, each with different rules and reimbursement rates. Industry consolidation, battles over rates and other disputes whittled that down to four by 2000—near the minimum required by federal law—which some observers say limited the state’s ability to bargain and enforce rules.

Patient advocates complained about denied services, delayed payments and inadequate provider networks. In a state-sponsored survey in 2006, only one in four callers posing as Husky patients was able to get an appointment with a network doctor; the others encountered erroneous listings or refusals to see Medicaid patients. State officials, meanwhile, were frustrated by the plans’ refusal to share data on costs and claims, prompting lengthy court battles.

“The phones were ringing off the hook with people saying they could not get care. We were losing providers, because they weren’t getting paid. But the state could not pull the trigger on penalties because there weren’t any other options,” said Ellen Andrews, director of the Connecticut Health Policy Project, a nonprofit advocacy group for patients.

In 2009, an audit by Milliman Inc. found Connecticut was overpaying the three remaining plans—run by Aetna Inc., UnitedHealth Group Inc. and Community Health Network of Connecticut, a nonprofit—by nearly \$50 million a year. Rather than continue sparring, Gov. Dannel Malloy, a newly elected Democrat, severed ties with the plans as of 2012.

Spokesmen for the three health plans declined to comment.

Connecticut calls its new system “managed fee-for-service.” A nonprofit administrator processes medical claims, but the state carries the financial risk. Patients have a 1-800 number to call with questions or to find providers. Reimbursement rates are the same across the state.

State officials say the streamlined system has trimmed administrative costs to just 5% of total costs, compared with 12% on average at Medicaid managed-care plans. And having data on all 750,000 Husky patients has helped target those with complex needs for additional support. That saved \$12 million on 12,000 patients last year, according to the state.

Mr. Myers, at Medicaid Health Plans of America, questions whether Connecticut will be able to sustain its cost savings. “That’s a challenge you see over and over in fee-for-service model,” he said.

And some experts say it is unlikely that 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.

He noted that Oklahoma, which quit Medicaid managed care in 2005, has called for proposals to privatize the program again. North Carolina, another holdout, is moving to managed care next year.

In Connecticut, officials said one key to Husky’s success are “medical homes,” whereby primary-care doctors are paid extra for coordinating patient care. To qualify, practices must hold slots open for Medicaid patients, use electronic medical records and offer off-hours coverage, so patients don’t have to use ERs by default.

More than 100 practices and 1,332 physicians have qualified. 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,” she said.



Dr. Ziogas examines a one-month-old baby earlier this month. Under the ‘medical homes’ system, primary-care doctors are paid extra for coordinating patient care. *PHOTO: ANDREW SULLIVAN FOR THE WALL STREET JOURNAL*

Patients say they have noticed a difference. Under the old system, Marlene Donahue, a foster mother to children with complex medical needs, said she would frequently take

her children three of whom were on feeding tubes, to specialists only to find that the required referral had gone astray. “There’s more communication now,” she said. “I can call Dr. Ziogas and talk about anything.”

The Centers for Medicare and Medicaid Services has proposed new rules to increase state oversight of Medicaid managed-care plans, including more scrutiny of provider networks and limits on administrative costs and profits. Health plans and patient advocates responded with nearly 900 comments. Final rules are expected later this year.

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