Connecticut's Medicaid Transition

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Interim Report for the New Mexico Legislature

November 2025

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Medicaid Delivery Models

- MCO: Capitated, risk-based contracts
- FFS: Direct payment per service
- ASO: Managed FFS — combines oversight with transparency

- Connecticut diverged from the national trend by adopting an ASO model in 2012.

Why Connecticut Changed Course

- Access barriers (2006 Mercer 'secret shopper' survey)
- MCO overpayments (2009 Milliman audit)
- Accountability failures and transparency issues
- Bipartisan legislative frustration with system opacity

Behavioral Health Carve-Out (2006)

- Established ASO model viability for complex behavioral health care
- Resolved harmful MCO financial incentives ('warehousing' of children)
- Established operational roadmap for later reform

Building Political Will

- Governor Malloy's 2011 commitment
- Strong legislative and advocate support
- CMS cooperation

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Provider Support and Alignment

- Providers frustrated by MCO payment delays and prior authorizations
- ASO model pays claims in ~2 weeks
- Simplified administration → increased provider participation (+14.6% PCPs, +11.4% specialists)

Implementation Strategy

- Leveraged existing FFS infrastructure
- Contracted with nonprofit CHNCT as ASO
- Cost-based contract with 7.5% performance withhold
- Extensive stakeholder outreach ensured smooth transition

How the ASO Model Works

- DSS administers Medicaid, contracts ASOs for support
- ASOs handle care coordination, utilization, and data
- Three ASOs: CHNCT (medical), CTBHP (behavioral), CTDHP (dental)
- Payments: state → provider (statewide fee schedule)

Financial Outcomes: Medicaid Expenditure Growth

- **Annual Percentage Change in Medicaid Expenditure (State Funds)**

Year	Connecticut	USA Average
2007-2008	8.6	3.2
2008-2009	26.2	-3
2009-2010	-7.1	-5
2010-2011	11.9	20.3
2011-2012	5.2	14
2012-2013	2.9	8.1
2013-2014	-39.1	4.4
2014-2015	-7.5	5.5
2015-2016	3.3	3.2
2016-2017	4.7	5.7
2017-2018	19.5	5.3
2018-2019	-3.3	1.7
2019-2020	2.4	0.5
2020-2021	1.8	0.2
2021-2022	2.2	5.4
2022-2023	7.8	14.7

Provider Payment Challenges

- No physician fee increases since 2007
- Specialist rates = 57.5% of Medicare
- CT average Medicaid rate $163 (among lowest nationally)
- Fiscal control v. network adequacy tension

Access and Quality Improvements

- PCP participation +14.6%, specialists +11.4%
- EPSDT screening ↑ from 52% → 64%
- Pediatric checkups: 73% vs. 54% national avg
- Improved early-stage cancer diagnoses & survival post-2012

Transparency and Accountability

- Medicaid Oversight Council meetings public (CT-N)
- Unified DSS data system
- FOIA access restored
- Performance-linked payments (7.5% withheld quarterly)
  - Should the incentive to develop innovative cost control strategies be higher?

Ongoing Challenges

- Frozen provider rates
- Limited subspecialty access
- Behavioral health and care coordination gaps

Lessons for New Mexico

- Evidence-driven policymaking
- Transparency as a cost-control mechanism
- Engage providers early
- Sustainable rates critical for long-term success

Next Steps

- Complete additional CT interviews (Nov–Dec 2025)
- Develop NM stakeholder interview guide
- Assess ASO feasibility in NM Medicaid context