Connecticut's Move from Capitated Managed Care to an Administrative Services Model

Briefing for the Colorado Commission on Medicaid · November 2026

Why the Commission asked

Docket line 92 proposes ending capitated managed care for behavioral health and paying for it fee-for-service or through an administrative-services contract. On November 10th, the Commission tabled the line so behavioral and physical health could be weighed together on November 18th. Additionally, Commission members agreed any evaluation should not presume a pilot. Connecticut is the state most often cited as having left capitated Medicaid managed care, so it is the closest real example of the model line 92 describes.

Bottom line

Since January 2012, Connecticut has run all of Medicaid and CHIP (HUSKY Health) as a self-insured, "managed fee-for-service" program: the state pays providers directly and holds the financial risk, and contractors are paid only to administer. Per-member costs fell after the change, and the program's administrative share is low. Two caveats apply. First, the 2012 switch coincided with a federal primary care rate increase and new medical homes, and no study has separated the effect of each, so the savings cannot be credited to the model alone. Second, costs have risen since 2020, largely because of a 2019 hospital settlement that increased hospital payments.

- **Behavioral health** moved first, to an administrative services organization (ASO) in 2006; dental also runs through a separate ASO (NASHP).
- **A 2024 independent review for the state** found per-enrollee spending about 14% below the Northeastern average and did not recommend returning to comprehensive managed care (Connecticut Hospital Association summary).
- **For Colorado**, Connecticut is the clearest working example of line 92's model, with one large difference: Colorado's physical health program already pays most providers fee-for-service; the open question here is behavioral health, where capitation also carries state-directed payments.

What changed and when

Connecticut contracted with capitated plans from 1996 to 2011, moved behavioral health to an ASO first, and moved all medical care to a self-insured ASO model in January 2012 (Stateline; NASHP).

Year	Milestone
1996	Medicaid moves to capitated managed care plans
2006	Behavioral health moves to an administrative services organization
2008	Plans operate without financial risk; the state actuary reports lower medical costs
2012	All medical care moves to a self-insured ASO model (January)

Year	Milestone
2024	Independent review for the state does not recommend returning to managed care
2025	Senate passes a bill requiring legislative approval before any return to managed care

How the model works today

The state holds the risk and pays every claim through its own claims system; contractors run care management, customer service, and utilization review for a fee. In the Governor's 2011 announcement, the state would "no longer pay outside firms to assume the financial risk" and would instead pay providers directly (Office of the Governor, 2011).

Function	Capitated managed care (Colorado behavioral health today)	Connecticut's ASO model
Who holds financial risk	The plan, paid a fixed amount per member per month	The state
Who pays claims	The plan	The state, through its Medicaid claims system (NASHP)
Who coordinates care	The plan	Contracted ASOs: Community Health Network of Connecticut for medical care, Beacon Health Options (now Carelon) for behavioral health, BeneCare for dental (Managed Healthcare Executive)
How contractors are paid	Capitation, with a medical loss ratio	Administrative fee; state law allows incentive payments tied to targets (C.G.S. 17b-261m)
Primary care role	Varies by plan	Person-centered medical homes, paid enhanced rates, launched with the 2012 change (NASHP)

Connecticut's statute requires every ASO contract to include a provision to reduce inappropriate emergency department use (C.G.S. 17b-261m).

Results

The evidence points to lower costs and administrative spending after 2012, but most of it is descriptive, and supporters and skeptics read it differently.

Finding	Figure	Source
Cost per member per month after the change	$718 (2012), $646 (2013), $605 (2015 low), $648 (2020)	Managed Healthcare Executive
Per-enrollee spending trend, 2010–14	Down 5.7%, the largest reduction of any state in a Health Affairs comparison	CT Department of Social Services
Spending per enrollee, 2019	$8,405, against a $8,436 national median, in a high-cost state	Managed Healthcare Executive
Spending per enrollee, 2024 review	About 14% below the Northeastern average	CHA summary

Finding	Figure	Source
Administrative share of spending	3.8%, against an estimated 9.4% in managed care states (2024 review)	CHA summary
Quality	Above the national median on about 70% of adult and child measures; below the median on 53% of acute and chronic condition measures	CHA summary
Before the full switch	In 2008, when plans carried no risk, medical costs fell $2.78 per member per month (state actuary comparison, as reported by a Connecticut health policy advocate)	CT Health Notes

Limits of the evidence

- **Attribution.** The 2012 change coincided with the federal Medicaid primary care rate increase of 2013–14 and new medical homes; no study separates their effects (Managed Healthcare Executive).
- **Costs are rising again.** Spending has grown since 2020, largely from a 2019 hospital settlement that cut hospital user fees and raised payments by $871.5 million through 2026 (Managed Healthcare Executive).
- **Quality is mixed.** The 2024 review recommended new care management within the current system to reduce avoidable hospital use, and a look at rising drug costs (CHA summary).
- **Disputed review.** Some Medicaid advocates questioned the independence of the firm chosen for the 2024 review (InsuranceNewsNet).
- **Continuing debate.** A 2025 bill to require legislative approval before any return to managed care passed the Connecticut Senate in May 2025; final passage could not be confirmed (OLR bill analysis; bill status).

What it would mean for Colorado

Connecticut shows the model can run statewide for more than a decade; it does not show what Colorado would save, because Colorado's starting point is different.

- **Physical health is already close.** Colorado's Accountable Care Collaborative pays most physical health care fee-for-service, with the RAEs paid per member for care coordination; capitation is concentrated in behavioral health ($1.567 billion total funds and $375 million General Fund in FY 2025-26, per HCPF in the docket).
- **State-directed payments.** HCPF has told the Commission that ending behavioral health capitation would also end the state-directed payments that run through it. Connecticut has no capitation, so it offers no example of replacing them.
- **Risk returns to the state.** Under an ASO, overspending lands on the General Fund rather than a plan's capitation rate; Connecticut pairs this with its own claims data and reporting.
- **What Colorado would need to know first** (the questions for line 92): the administrative saving at constant use, which line 92 asks HCPF to cost; which federal financing depends on managed care; and how network, care coordination, and crisis functions would be contracted.

Connecticut's medical ASO contract is procured competitively; its 2021 request for proposals gives a template for scope and term (CT DSS RFP).

Sources

- Office of the Governor, "Malloy, Wyman streamline administration of health care services" (February 2011)
- Connecticut General Statutes 17b-261m, administrative services organization (2012)
- NASHP, Connecticut profile and Connecticut medical homes
- Stateline, "Connecticut revisits old-school Medicaid financing" (April 2012)
- Managed Healthcare Executive, "Connecticut Bucks the Medicaid Managed Care Trend" (January 2023)
- CT Department of Social Services, "Connecticut Medicaid Best in Nation for Curbing Per-Enrollee Cost Trend" (July 2017)
- Connecticut Hospital Association, summary of the DSS Medicaid landscape analysis (December 2024)
- CT Health Notes, ASO and HMO cost comparison (January 2011)
- InsuranceNewsNet, advocates on the 2024 review
- OLR bill analysis, sSB 985 (2025) and bill status
- CT DSS, Medical ASO request for proposals (2021)
- Colorado figures: Commission docket (HCPF, FY 2025-26) and the November 10 record of decisions.