Executive Summary: Utilization Management for Adult Members

On at least a quarterly basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the state for review. This summary focuses on the utilization management portion of these reports evidenced in the 4A series which reviews utilization statistics such as average length of stay (ALOS) and admissions per 1,000 (Admits/1,000) members. NOTE: A detailed description of the measures can be found at the end of this document.

Two changes from previous reports will be evident in the report this quarter, both occurring as a result of discussions with the State partners. First, results were graphed only for benefit groups that had a sufficiently large number of members receiving each level of care. This change made the graphs much easier to read and focused the discussion on benefit groups that warranted greater attention. Second, if the analysis for a level of care did not reveal results or trends that warranted discussion, then those results were removed from the body of the report. Those analyses can be found in an Appendix at the end of the main report. For this quarter, the only level of care that did not warrant discussion was Methadone Maintenance.

Inpatient Level of Care

Inpatient Admits/1000
Inpatient admits per 1,000 remained stable across most benefit groups and across quarters reported to date. The only significant exception in this quarter was for the ABD Single group. That group continues to have the highest penetration rate at 6.79/1,000, which is 10.7% higher than in the previous quarter, and 2.6% higher than the rate reported in Q2 2011. That increase reverses a trend from the previous two quarters in which the ABD Single rate dropped by approximately 7.5%, cumulatively. MLIA members have the second highest admits per 1,000 with a rate of 4.28 in Q4 2012. That group again accounted for the largest number of admissions, with 1,114 members admitted, compared to 636 ABD Single members. While some variation was found in the Admits/1000 rate for other benefit groups, the number of admissions was too low to warrant analysis.

Inpatient Days/1000
ABD Single members have the greatest number of inpatient days per 1,000 at 63.53, which is a 15.8% increase from the rate of 54.84/1,000 reported in Q4 2011 and a 22.4% increase from the rate reported in Q2 2011 (51.91). The complex and chronic nature of these members' circumstances can require longer time in care to stabilize than it does for other members, leading to more days at this level of care. In addition, members with chronic conditions can have fewer discharge options for follow-up care, including housing alternatives. As data is collected and analyzed over time, trends should become more apparent. Understanding the barriers to discharge will be critical as we continue to manage this LOC.

Inpatient days per 1,000 for the MLIA population remained relatively consistent between the most recent reporting periods, with only a slight increase from Q4 2011 to Q1 2012 (6.7%). The rate for that group has increased 15.8% since Q2 2011, however. Family Single days per 1,000 have risen by 21.1% across the four quarters, although that group did have a slight decrease between the last two quarters. Results for ABD Single members showed an increase during Q3 2011, but that rate fell back essentially to the baseline measured initially.

Average Length of Stay
The Average Length of Stay range across all benefit groups with more than 20 admits in Q1 2012 was from 8.03 to 9.16. That represents a significant increase over the past year, even though the results from Q1 2012 showed mixed increases and decreases, by benefit group. ABD Dual and Family Single ALOS decreased from Q1 2011 to Q4 2012, while the ALOS for MLIA and ABD Single increased during that same period.
By comparison, in Q2 2011, the same groups achieved a range of ALOS between 5.91 and 7.72 days. Four benefit groups (MLIA, ABD Single and Dual, and Family Single) accounted for 97.4% of the discharges during that time. All four groups recorded an increase in ALOS during the year, as shown in the table below.

<table>
<thead>
<tr>
<th>Benefit Group</th>
<th>Q2 2011</th>
<th>Q1 2012</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>MLIA</td>
<td>6.70</td>
<td>8.03</td>
<td>19.9%</td>
</tr>
<tr>
<td>Family Single</td>
<td>5.91</td>
<td>7.05</td>
<td>19.3%</td>
</tr>
<tr>
<td>ABD Single</td>
<td>7.72</td>
<td>9.16</td>
<td>18.7%</td>
</tr>
<tr>
<td>ABD Dual</td>
<td>7.51</td>
<td>8.47</td>
<td>12.8%</td>
</tr>
</tbody>
</table>

Conclusions – Inpatient Psychiatric Level of Care: For any new program, the first year’s data should be reviewed cautiously because results can be affected by factors such as seasonality. Typically, the first year’s data is viewed as a baseline for future comparisons. In this case, however, the increase in ALOS for the largest benefit groups is concerning and contrary to efforts to manage the utilization for this level of care. The relatively flat Admit/1,000 rates suggest that the demand for inpatient admissions is steady. But once members are admitted, they are staying longer than they did a year ago, as much as a day and a half, on average. This change will require more focused attention on managing this LOC, as well as the need to more fully examine any issues with discharge planning and/or gaps in community resources designed to meet the needs of these individuals.

Some efforts to address this issue have begun already. The bypass program is one of several strategies implemented to reduce Length of Stay and improve discharge planning/connect to community. In the upcoming year, an inpatient Provider and Analysis Reporting (PAR) program will begin, bringing the providers and VO together to support a collaborative focus on LOS and outcomes utilizing data measures. As root cause becomes more obvious, we will explore ways to impact system/facility opportunities to improve outcomes and to better understand and quantify significant barriers to discharge. We are continuing our ongoing efforts to partner with inpatient providers to insure that there are mutual expectations for LOS and quality of care. In addition, we will review the data in future quarters to determine if there are seasonal or other trends that might explain some of this variance.

Inpatient Detox – Hospital-based and Free Standing

Admits/1000

Only three benefit groups had as many as 10 admissions to hospital-based detox programs during Q1 of 2012. Those groups were MLIA (90 admissions), Family Single (19) and ABD Single (16). All three benefit groups had significantly fewer admissions than in the previous quarter, with correspondingly lower rates of Admits/1,000. For MLIA members, the rate decreased 42.6%, from 0.61 in Q4 ’11 to 0.35 in Q1 ’12, while the rate for ABD Single members decreased from 0.36 to 0.17 during that same time span, a drop of 52.8%. The rate for Family Single fell by 20%. Other benefit groups had very small numbers of admissions and were not graphed.

Admissions/1,000 to the Free Standing detox programs increased for both MLIA (up 2.4%) and Family Single (30.9%) populations, and fell slightly for ABD Single members (-2.3%). While not in direct proportion to the decrease in the Hospital-based programs, we have expected the Free Standing programs to experience an increase as a result of the efforts to divert members to the more appropriate level of detox services. Other benefit groups had much lower rates of Admits/1000 than the groups noted above. The large increase in Admits/1,000 for the Family Single group is not clearly understood at this time. We will monitor these benefit groups in the next quarter to identify any continuing trends.
**Days/1000**

As the Admits/1000 has decreased in Hospital-based programs, so has the Days/1,000 for all benefit groups. In Free Standing programs, the results have been more variable. Some benefit groups have had slightly increased rates of Days/1,000 and others have had slightly decreased rates. The Family Single group has had the greatest changes across both LOC’s, with an approximately 50% decrease in the hospital-based LOC and an approximately 24% increase in the Free Standing programs.

As with Admits/1000, and as the previous quarters have shown, the MLIA and ABD Single benefit groups record the highest rates of Days/1000 in both Hospital-based and Free Standing programs. Other benefit groups demonstrated greater variability between quarters, but the number of members involved in those results was very small.

**ALOS**

At the hospital level of care, the ALOS for MLIA and ABD Single members increased slightly Q4 ’11 to Q1 ’12. This change may be a result of the successful efforts to divert members from hospital to Free Standing detox when the acuity of a hospital admission is not warranted. The members admitted for hospital level of care therefore would have more complex conditions, and therefore would potentially require longer to detox safely.

At the Free Standing detox programs, the ALOS for both ABD Single and Family Single members decreased slightly from Q4 ’11 to Q1 ’12. MLIA members were relatively unchanged over the same period. The decrease in ALOS may again be the result of the focused management brought to this level of care over past quarters.

**Conclusions – Inpatient Detox Level of Care:** We believe the continued downward trend in admissions to hospital-based detox programs represents the focused management of these programs. Consistent efforts have been made to reduce unnecessary admissions to hospital-based programs and divert those admissions to Free Standing programs when the members do not need the higher level of medical management that the hospital-based programs provide.

In addition, several discussions have occurred with providers to address their use of pre-determined treatment protocols and the need to individualize treatment to each member. We will continue to individualize authorizations so that members receive the right service for the appropriate length of time. Following our ongoing discussions, some programs also have developed a more intensive focus on discharge planning and individualized care plans for these members. We expect to see continued movement in this ALOS over time.

**Partial Hospital**

**Admits/1000**

As explained last quarter, data from Q2 2011 has been excluded from this analysis because the results were misleading. In that quarter, registrations were created for members who were already in service before we assumed responsibility for authorizations. As a result, the Admits/1,000 rate was artificially inflated.

The utilization rates in this LOC vary considerably between benefit groups, from no utilization at all for both LTC groups and HUSKY B to a rate of 2.70/1,000 for MLIA members. For the lowest utilizers, the rates have been relatively stable over time. For the groups with higher utilization, there has been more variability, and in some cases, an increased use of this LOC. For example, MLIA members had the highest penetration rate at 2.70 per 1,000, which is a 12.5% increase from Q4 2011. However, that rate is still just below the MLIA rate of 2.72 that was originally reported in Q3 2011. The rates for ABD Single and Family Single members increased by 13.3% and 19.4%, respectively, between Q4 2011 and Q1 2012. Despite these increases, these rates remain significantly lower than that for MLIA.
Conclusions – Partial Hospital: PHP’s are utilized as either a step-down from inpatient care or as a buffer to prevent hospitalizations, if possible. As we continue to target unnecessary hospitalizations, it is expected that some members will enter PHP instead. That type of diversion would be considered a good use of PHP services. At this time, the increases in Admission Rates are not well understood, but PHP services still are utilized by a very small number of members, only 1,102 individuals across all benefit groups in Q1 2012. As we continue to focus on higher levels of care, attention to PHP might take on greater significance, especially as part of care coordination that addresses employment, housing, and other areas of need.

Intensive Outpatient

Admits/1000
As explained last quarter, data from Q2 2011 has been excluded from this analysis because the results were misleading. In that quarter, registrations were created for members who were already in service before we assumed responsibility for authorizations. As a result, the Admits/1,000 rate was artificially inflated.

Over the past three quarters, the rate at which adult Medicaid members have utilized Intensive Outpatient services has been relatively stable across all benefit groups. The greatest increases in Admits/1,000 have been in the Family Single and Dual groups, but those increases are only approximately 5%, and represent less than 65 members. MLIA members continue to use IOP services at a higher rate than other adult Medicaid members.

Conclusions – Intensive Outpatient: IOP admissions are essentially stable across the three quarters that are reported. This LOC has been identified for greater study during 2012, and we are beginning the process of developing Provider Analysis and Reporting standards. Given the large number of utilizers (3,569 new admissions in Q1), this added attention is warranted. We will continue to gather data in an effort to track and trend activity going forward. Once trends are highlighted, tailored interventions can be implemented.

Outpatient-Level Services: Ambulatory Detox, Methadone Maintenance and Outpatient

Admits/1000
Note: All Ambulatory Detox, Methadone Maintenance and Outpatient LOC’s were registered on the web during the second quarter of 2011 and were not subject to pre-certification for the first year. As a result, there has been no opportunity to manage or influence those admission rates.

While the overall rate of admissions in ambulatory detox remains very low overall (0.31/1,000), results from Q1 2012 for MLIA did show an increase of over 30%. The reason(s) for this increase are unclear. Fewer than 125 members were authorized for this LOC across all benefit groups. Given the very small number of admissions, it is possible that the change is insignificant. We will continue to monitor this LOC to determine if a trend does exist.

Methadone Maintenance results were insignificant, and are graphed in the Appendix.

The Admits/1000 rate in Outpatient services increased for all benefit groups, except LTC Dual. The largest increases occurred in the Family Dual (55.5%), Charter Oak (35.7%) and ABD Single (34.5%) groups, although Family Single (18.4%) and MLIA (17.2%) groups also registered double-digit increases in the admission rate. This LOC accounted for almost 18,000 admissions in Q1 2012, an increase of 14.9% compared to Q3 2011.

Conclusions – Outpatient Levels of Care: Multiple factors may contribute to the increases in admissions described above, but the overall cause is unclear at this time. One likely factor is the overall increase in membership during 2011. While the “per 1000” means of measurement takes membership
growth into consideration, when the growth in utilizers outstrips the growth in membership, admits per 1000 will increase. This increase in penetration rate of outpatient services may point to pent up need for services among new Medicaid members. The Outpatient LOC appropriately tends to be the most widely used because most members do not need more intensive services. Increases in membership might be expected to drive this admission rate because less distressed members would be admitted here.

Utilization management of outpatient services has not been a primary focus to date, but this increasing admission rate may warrant discussions about implementation of some management strategies. As discussed in the last quarterly report, the magnitude of utilization here might warrant a review of the authorization parameters that currently allow automatic authorization for a year at a time, with no clinical review. Methadone Maintenance results were insignificant, and are graphed in the Appendix.

**Mental Health Group Homes**

*Admits/1000*  
A total of 34 members were admitted to MHG’s during Q1 2012 compared to 31 members in Q4 2011. We expect that number of admissions to be fairly stable across all quarters going forward. While Q1 2012 produced a 67% increase in admissions for ABD Dual members, that increase was countered by a nearly 44% decrease in admissions for ABD Single members. Neither change is thought to be significant.

*Days/1,000*  
Days/1,000 rates were essentially unchanged during the most recent quarter, compared to Q4 2011. That stability is expected, given that the available beds typically are filled throughout the entire quarter. In the future we might expect the Days/1,000 rates to vary slightly if more members from a particular benefit group are placed, but there likely would be a reciprocal change in the rate for the other group(s) because the total number of beds is capped.

*ALOS*  
The ALOS increased for all benefit groups during Q1 2012. That increase was expected because it reflects the long-term nature of these placements. We have registered members in this level of care for only one year, less time than they typically remain in this level of care. The ALOS will continue to increase until it reflects the actual time members remain in this LOC.

**Conclusions – Mental Health Group Homes:** The conclusion for this LOC remains the same as it did in the last quarter: This LOC has been identified by DMHAS as a transitional living program for members who require 24-hour supports before moving to less restrictive care. It has become a more permanent housing alternative, however, and many members stay in this LOC for extended periods, up to several years in duration. Utilization management efforts are unlikely to have an impact until more housing alternatives exist.

**Home Health Services**

*NOTE:* The current analysis reviews initial authorizations for Skilled Nursing Visits (SNV) only. The previous analysis included both SNV and Medication Administration (MAD) services, resulting in each admission being counted twice, once for SNV and once for MAD. As a result of correcting this methodology, the scale of Admits/1000 was reduced by half. The previous quarterly data was also adjusted for consistency, and this method will be used going forward.

*Admits/1,000*
New admissions to HH services have declined due to the bulk of admissions being transferred from DSS during the second and third quarters of 2011. While many authorizations were given by DSS for durations of 6–12 months, most of them have been assumed by CT BHP by this time. It is expected that we will see a high level of stability beginning with Q2 of 2012 because the transferring authorizations will have been incorporated by that time.

**Conclusions – Home Health Services:** After the high volume of authorization requests were absorbed into the system during 2011, it appears that the number of Admits/1,000 will remain relatively stable going forward because it now reflects only members who are newly prescribed Home Health services. However, this volume could vary based on two factors that may affect the Home Health industry in the future. First, as we continue to shape services toward Recovery principles and practices, existing members will require fewer services, possibly opening slots for additional referrals. Second, the recent legislation regarding nurse delegation may lead to some medication administration services being performed by Home Health Aides and other paraprofessionals, thereby allowing greater availability by nurses. That change also could allow an increase in new referrals. We will monitor both factors going forward.

**RECOMMENDATIONS:**

While we now have four quarters of data to be considered for analysis, we also must recognize that some factors may not be known. One example of such a factor would be seasonality and its possible influence on the Admits/1,000 or ALOS. (For example, in cold weather, members might be more likely to remain in shelters or residential programs, thereby limiting the options available to inpatient programs looking for discharge alternatives.

Below is an update to the recommendations made to the Departments on the annual review:

**Inpatient Recommendations --**

1. **Review and update the inpatient bypass program for adult members and facilities.** The Adult bypass program has recently been reviewed and amended for 2012. Additional metrics regarding discharge information has been added to the parameters as well as new inclusion/exclusion timelines so that programs may move in and out of the program bi-annually instead of annually.

2. **Resume consultations with inpatient programs for members with extended stays.** This activity, in cooperation with the hospitals and our physicians here at CT BHP, garnered little in the way of improvement or value-added service. It was therefore suspended at the end of Q1 2012. In conjunction with the bypass program, however, this consultation might bring added benefit.

3. **Discuss and possibly develop additional outcome measures for inpatient LOC.** Ongoing discussions continue regarding outcome measures with our provider partners at many levels of care including the inpatient programs. The dialogue with providers regarding the concept of measuring “outcomes” and what that will look like is ongoing.

4. **Consistent with the proposed new model for Intensive Care Management (ICM), develop procedures to work face-to-face with members and their support systems to enhance discharge planning and facilitate time in community.** The enhanced ICM procedures are expected to begin within the next quarter.

**Inpatient Detox Recommendations --**

1. **Focus utilization management efforts on shaping provider practices in three areas.** First, as we have seen in the data for this quarter, there are some preliminary indications that cases are being managed more effectively. Evidence includes the decrease in the hospital-level admissions and the increase in the Free Standing programs. This indicates to us that we are clarifying with providers the level of medical management necessary for a hospital-based detox admission.
Second, we have entered into a dialogue with the detox providers that is intended to reduce the automatic use of standard detox protocols, rather than on individualizing care. This discussion will be an ongoing endeavor with the provider community. Third, we will continue to focus on discharge planning to produce successful outcomes and prevent unnecessary admissions to other levels of care. All providers are aware that providing discharge information to us in a timely manner is necessary for our ability to assist members in connecting to care. In addition, clinical staff have been recommending that providers connect members with contact information for the Connecticut Community for Addiction Recovery (CCAR) prior to discharge. We propose monitoring those contacts as part of the discharge planning process to enhance connection to the community.

**Partial Hospital and IOP Recommendations --**
1. **Track and trend PHP utilization to determine areas for future discussion.** Efforts in 2012 will continue to focus on studying Partial Hospital service utilization and admissions to develop suggestions for ongoing discussion. The review of IOP services is ongoing and has already resulted in changed authorization parameters implemented in February. Further analysis is being conducted at this time in conjunction with a 2012 Performance Target.

**Outpatient Recommendations (Ambulatory Detox, Methadone Maintenance, Outpatient LOC) --**
1. **Track and trend Outpatient services.** All outpatient LOC is web registered and has lengthy time frames for concurrent reviews. As a result, there are few opportunities to manage utilization meaningfully. Of note, National ValueOptions currently is engaged in an effort to determine opportunities related to UM for outpatient services. We will track activities closely in this arena and share information and activities with our State partners as they become available. Ongoing review will assist in determining if there are targets for future consideration. Update: These efforts are continuing locally and at VO National.

**Mental Health Group Home Recommendations --**
1. **Continue to monitor ALOS.** Ongoing analysis of this LOC would allow for discussions about what kinds of residential options would supplement the existing service system. This is not at present a focus of our efforts because of the expectations that members will have extended stays in group homes.

**Home Health Recommendations --**
1. **Continue with utilization management activities outlined in Performance Target deliverable of January 3, 2012.** Those activities include implementation of a PARs program (by July 15), development of draft clinical review guidelines for medication administration (by July 15), education and consultation with home health prescribers (by September 30), and other measures.
DEFINITIONS OF THE MEASUREMENTS USED IN
THE QUARTERLY REPORTS

Inpatient Admit/1000

This report is based on the number of admissions during the reporting period. If a member is admitted more than once, they are counted more than once. The count is NOT un-duplicated. The count of admissions is the numerator for the calculation of admits/1000.

Inpatient Days/1000

This measure is based on the number of inpatient days used during the reporting quarter. The report first determines the number of cases during the quarter. The case count includes any member who was authorized for care during the reporting period, whether they were admitted during that quarter or not. As a result, the number of cases in the table included with the graph will NOT necessarily match the number of admissions in the table attached to the Inpatient Admits/1000 section. The number of cases will always be at least as large as the number of admissions and usually is larger because of the members who were admitted prior to the reporting period who are still in the hospital and accruing inpatient days.

Inpatient Average Length Of Stay (ALOS)

The Length of Stay calculation is based upon only those members who were discharged during the reporting period. The measure includes all days accrued by that member from the beginning of their stay, including days from previous reporting periods if applicable. The count of members discharged will not match the number of members admitted during the quarter nor will it match the number of cases during the quarter.

Counts or measures that change from previous quarters

Any of the counts that are the basis for one of the measures described above included in a quarterly report may change in the next quarterly report. For example, the number of admissions reported for the 1st quarter of the year may change when the 1st quarter admissions are reported in the 2nd quarter report. This may occur for several reasons:

1. Temp members are not included in utilization reports. If a member admitted in Quarter 1 as a Temp member obtains retrospective eligibility during Quarter 2, the Quarter 1 admission will be added to the Quarter 1 data.
2. Stays that are retrospectively authorized will be added retrospectively.
3. Stays that were denied and then overturned on appeal will be added retrospectively.