UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2 of 2019: January-June 2019 - Submitted August 29, 2019

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A Beacon Health Options-CT Dashboard

This report was created by Beacon Health Options on behalf of the CT Behavioral Health Partnership. However the opinions, conclusions, and recommendations contained herein are solely those of Beacon Health Options, and may not represent those of DSS, DMHAS, and DCF.

UTILIZATION REPORT FOR ADULT MEMBERS

Quarters 1 & 2 of 2019: January-June 2019

Reports Used:

The Connecticut Behavioral Health Partnership (CT BHP) is a partnership among the Department of Social Services (DSS), the Department of Children and Families (DCF), and the Department of Mental Health and Addiction Services (DMHAS). Beacon Health Options (Beacon) Connecticut continues to serve as the behavioral health Administrative Services Organization (ASO) for the CT BHP and manages behavioral health care for over 975,000 Medicaid/HUSKY members. Beacon's role is to serve as the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community services, promoting practice improvement, assuring the delivery of quality services, and preventing unnecessary institutional care. Additionally, Beacon is expected to enhance communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system, and provide integrated services supporting health and recovery by working with the Departments to recruit and retain both traditional and non-traditional providers. Throughout this document, you may see Beacon Health Options also referenced as Beacon or the ASO.

General Overview

On at least a semiannual basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the State for review. The shift to semiannual reports was designed to minimize noise created by quarter-to-quarter fluctuations that do not reflect a true trend in the data. The March deliverable serves as the annual report and covers four consecutive years of utilization data. The September deliverable covers 10 consecutive quarters with a focused analysis on the two most recent quarters, but may include the past four if there is information necessary to review that had not been analyzed previously.

This report focuses on the utilization management portion of these reports, evidenced in the 4A series, which reviews utilization statistics such as admissions per 1,000 members (Admits/1,000), days per 1,000 members (Days/1,000), and average length of stay (ALOS).

Within this interactive report, all utilization data is available via drop-down filters, but the narrative highlights the areas of interest related to certain utilization trends. In some cases, demographic breakouts are available to enhance the understanding of utilization. Additionally, the narrative identifies the underlying factors, which drive the trends and associated programmatic responses taken by Beacon Health Options to impact/mitigate or support the trend. Beacon also presents recommendations to address remaining challenges and reports progress related to these planned recommendations. The areas of focus for this deliverable are listed on the following page.

Methodology

The data contained in this report are based on authorization admissions and are refreshed for each subsequent set of updates during the year. Due to changes in eligibility, the results for each quarter or year may change from the previously reported values. The reports and analyses for all levels of care are affected by this change. Please note that utilization metrics may change with the refresh of the data. Therefore, the reader should be cautious when interpreting the latest quarter of data. The contractor will monitor the post-refresh changes closely. If warranted, methodology will be revisited.

The methodology for membership totals remains unchanged. For the Total Membership counts, each member is only counted once per quarter, even if he/she changes eligibility groups or experiences gaps in eligibility. For instance, if a member changes benefit groups within the quarter, that member is included in the totals for each benefit group, but only once for the total membership. This methodology is referred to in the graphs as "Unique Membership". For the benefit groups, members are counted in each group in which they were eligible during the time period (quarter or year). This means that the individual benefit group membership counts cannot be added to obtain an overall total, since members can shift between benefit groups.

The methodology for calculating age has changed, resulting in a slight shift in adult and youth membership totals. Previous to this report, counts for adults and youth were based on if a member met that age criteria during the time period. This meant that youth who were both 17 and 18 years old in a quarter were counted in both the adult and youth totals. In order to allow for the drill-down of demographic and age information, it was required that members be counted in only one group during a time period. Age group is now based on the age that a member was for the majority of the time period (quarter or year). Other demographics such as gender and race/ethnicity are based on the most recently updated eligibility. These demographics will update as needed as we want to report on the most accurate gender or race/ethnicity that a member identifies with.

Additionally, while unchanged from previous reporting periods, it is worth noting that the per 1,000 measures compare the utilization rates of the population to the population's "member months". This means that when viewing the Admits/1,000 of HUSKY D members the rate is based on the number of admissions within the HUSKY D population, not the entire adult population. This helps to analyze which populations are potentially more chronic, acute, or in need.

UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2 of 2019: January-June 2019

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Total Membership

In the first quarter of 2019, the Connecticut Medicaid membership, including duals, reached 895,386 members, the highest volume reported to date. However, in Q2 ’19, membership, including duals, declined 0.4% to 891,388 members, slightly less than membership volume seen during the fourth quarter of 2018.

In the first quarter of 2019, the Connecticut Medicaid membership, including duals, reached 895,386 members, the highest volume reported to date.

As noted in the calendar year (CY) 2018 semiannual, submitted in March 2019, dually eligible adult membership dropped steeply in Q1 ‘18 (down 19%), as many members lost dual eligibility at end of 2017. Dual membership fell a further 3% in Q2 ‘18 before rising to more historic volumes in Q3 ‘18. Beacon consulted with DSS and learned that Deloitte was not consistently sending the most recent third-party liability information on members. This issue was resolved in September 2018, but while the weekly file increased in members at the end of 2018, the volume of dually eligible members decreased in both Q1 and Q2 of 2019, down 4.2% (69,790 adult and youth members).

Adult members, including duals, continue to comprise 63% of the total Medicaid membership. In Q2 ‘19, there were 559,843 adult members, including dually eligible members. This represents a 0.5% decrease from Q1 ‘19, which was driven, in part, by the reduction in adult dual membership noted above, in addition to a 0.3% reduction of adults without duals.

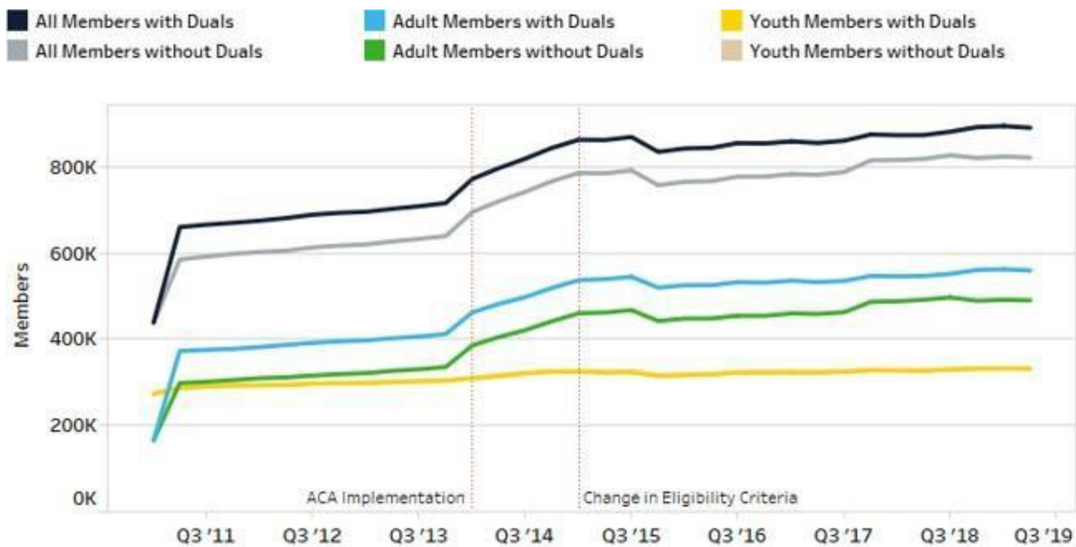

Figure 1: Quarterly Total Medicaid Membership

Please see the accompanying Tableau dashboards to view graphical representations of the data presented here, as well as to use filters to segment the data in different ways.

Membership Demographics

In the last quarter of 2018, membership including duals rose to its highest volume for females at 315,072 (56.1%). This decreased slightly in 2019, with females making up 55.9% of total membership by

the second quarter. Male membership including duals continued to increase over most of the last 10 quarters, however, males slightly decreased in Q2 ’19 (down 0.5% to 246,667, or 44.1%).

Age group demographics were stable, with 25-34 year-olds remaining the largest age group at 27.5% of the adult non-dual population. The 35-44 age group continued to increase and remain the second largest group at 20.3%, followed closely by 18-24 year-olds at 19.7%; a slight decrease from previous quarters. Meanwhile, 45-54 year-olds continued to show a slight decrease, making up 16.9% of the adult non-dual population. The 55-64 age group remained relatively stable at 14.0%. The 65+ age group showed a sharp increase from Q4 ’17 to Q3 ’18, however, this decreased in late 2018 and was stable in 2019 at 1.7%.

Adult members, including duals, continue to comprise 63% of the total Medicaid membership. In Q2 ‘19, there were 559,843 adult members, including dually eligible members.

Racial and ethnic demographics continue to change. As noted in prior deliverables, modifications to the ImpaCT system used to manage member eligibility led to a significant increase in members identifying as "Unknown" race/ethnicity. The Unknown race/ethnicity group continued to increase among adults excluding duals, up 6.8% since the start of 2018. As of Q2 ‘19, more than one quarter of the adult Medicaid population (28.4%) is categorized as Unknown race/ethnicity. Beacon's investigations indicate that this is a true unknown, as members are not required to choose a race/ethnicity when applying for Medicaid. There are concerns that such a large unknown race/ethnicity group will hinder efforts in tracking utilization and outcomes to identify and reduce health disparities, as we cannot know if the Unknowns are evenly distributed among racial and ethnic groups, or if certain groups are more likely to opt out of responding. According to preliminary 2018 Connecticut Medicaid adult population data, of the 221,288 adults classified as Unknown, 31.1% (68,750 members) identified as Hispanic. Beacon hypothesizes that many members opting out of selecting a race are from minority groups who felt reluctant to answer due to fear of how the data would be used, or they did not see themselves represented in the available options. This belief is anecdotally supported by Beacon’s experience in meeting with the CFAC membership and a separate group of provider executives as part of the 2018-19 Health Equity Study. Many of the predominantly “people of color” participating in the CFAC meeting opted not to answer questions related to race/ethnicity while nearly all of the predominantly white provider representatives were willing to self-identify on race/ethnicity. Beacon understands that our state partners share our concerns and are discussing potential solutions, such as making the selection of a race or ethnic category mandatory.

As of Q2 ‘19, White members continued to be the largest racial/ethnic group for adults without dual membership at 32.7%. The Hispanic and Black membership remained stable, at 19.3% and 15.0% of the adult Medicaid population without duals, respectively. Members identifying as Asian (2.8%) and Other Races (1.8%) remained unchanged and represent a small portion of the non-dual Medicaid population.

HUSKY D continued to be the largest benefit group for adult Medicaid members without dual eligibility (56.8%), increasing by nearly 23% over the last 10 quarters to 281,050 members.

Benefit Membership

HUSKY D continued to be the largest benefit group for adult Medicaid members without dual eligibility (56.8%), increasing by nearly 23% over the last 10 quarters to 281,050 members. Over the same time, HUSKY A membership, the second largest benefit group among adults without dual eligibility, decreased 11.3% and accounted for 38% as of Q2 ’19. HUSKY C (ABD/Single) remained stable from Q4 ’18 to Q2

’19. These trends have important implications for utilization, as HUSKY D and HUSKY C (ABD/Single) tend to be higher utilizing groups.

As noted in prior semiannual deliveries, the income eligibility level for HUSKY A changed effective January 1, 2018, from 155% to 138% of the Federal Poverty Level (FPL) and letters alerted impacted members that they would lose eligibility. On July 1, eligibility returned to its previous level of 155% FPL; however, it is likely that many who were formerly enrolled in HUSKY A did not know they were again eligible, did not re-enroll, or waited to re-enroll so they have not yet been added back to membership rolls. There was an increase in HUSKY A membership in Q3 '18, after the eligibility requirements returned to their former levels; However, by Q4 ’18, membership dropped again, and there were nearly 6,200 fewer HUSKY A members than in Q4 '17. In the first two quarters of 2019, the HUSKY A population did not return to pre-eligibility change levels, and, in fact, decreased from 189,030 adults in Q4’ 18 to 187,950 adults in Q2 ’19, a slight reduction of 0.6%.

Despite overall declines in its membership, HUSKY A still covered 51.1% of females, 56.8% of 35-44 year-olds, and is the top benefit group for females ages 25-34 and 35-44, suggesting that HUSKY A continues to provide essential medical coverage for mothers and their children.

HUSKY D continued to be the largest single benefit group overall and among most demographic groups. Approximately 73% of adult males without duals and 60% of White adults had HUSKY D in the second quarter of 2019. HUSKY D was the largest benefit group for nearly every age group except 35-44 (which had mostly HUSKY A), and 65+ (which had mostly HUSKY C (ABD/Single)). Despite overall declines in its membership, HUSKY A still covered 51.1% of females, 56.8% of 35-44 year-olds, and is the top benefit group for females ages 25-34 and 35-44, suggesting that HUSKY A continues to provide essential medical coverage for mothers and their children.

HUSKY C (ABD/Dual) remained the largest dual benefit group, accounting for 70% of all adult dual members. The adult dual population continues to be older (59.3% were 65+), female (61.6%), and White (58.2%). Demographic trends were stable, showing all demographic groups decreased in dual membership consistently, with the exception of the “Unknown” race/ethnicity group, which saw a 20% increase in HUSKY C (ABD/Dual), and a 14.7% increase in HUSKCY C (LTC Dual) since Q4 ’18.

Inpatient Psychiatric Hospital Utilization

Discharge volume from inpatient psychiatric hospitals (in- and out-of-state, but excluding State facilities) remained consistent over the past 10 quarters, with 4,959 discharges in Q1 and Q2 ’19 combined for all members without duals. Discharge volume increased 3.8% from Q1 ’19 to Q2 ’19, which is consistent with seasonal fluctuations in inpatient psychiatric utilization with a peak in the second quarter (Spring) and low in the fourth quarter (Winter).

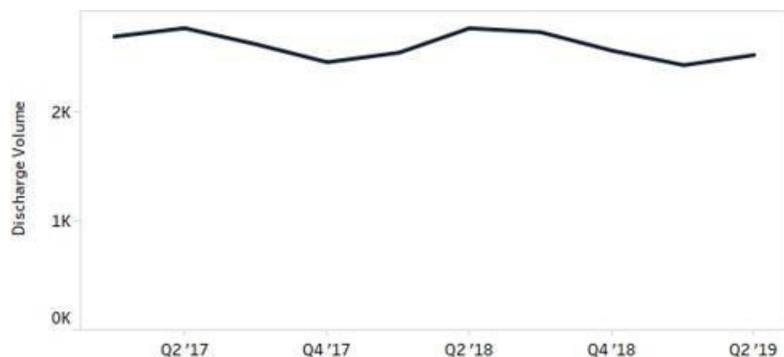

Figure 2: Adult Inpatient Psychiatric Facility (IPF) Quarterly Discharge Volume

As seen in prior quarters, 25-34 year-olds continued to have the most discharges in Q2 ’19 (694, 27.5%), although discharge volume among this age group is less than volumes observed in 2018. Males also continued to have more than half of discharges (54.4% for males vs. 45.6% for females), and White adults had the most discharges of all racial and ethnic groups (41% of discharges in Q2 ‘19). Males and White members remained disproportionately overrepresented in inpatient stays, as males represented 45% of the adult Medicaid non-dual population but had 54% of inpatient discharges, while 33% of the adult Medicaid non-dual population are White and had 41% of inpatient discharges.

HUSKY D members continued to have the highest percentage of discharges of adult non-dual members (73.3% in Q1 ’19 and 71.9% in Q2 ’19), followed by HUSKY A (15.7% in Q1 ’19 and 15.3% in Q2 ’19) and HUSKY C (ABD/Single) (10.9% in Q1 ’19 and 12.6% in Q2 ’19). Although membership volume of HUSKY D decreased slightly (0.2%) from Q1 to Q2 ’19, membership increased nearly every quarter since Q2 ’17, while the membership volume for HUSKY A decreased or remained stable. However, Beacon believes that membership changes alone do not account for the overall increase in HUSKY D and decrease in HUSKY A inpatient utilization, as noted in previous submissions. A change in severity, accounted for by an increase in the percent of HUSKY D members with a primary schizophrenia diagnosis, may explain the shift in utilization in recent years. Since mid-2017, the percentage of inpatient stays for schizophrenia increased nearly every quarter, accounting for approximately one quarter of inpatient stays among HUSKY D members in Q2 ‘19 (25.6%). On the other hand, the percentage of inpatient psychiatric stays for schizophrenia among HUSKY A members decreased in most quarters, despite an uptick in Q1 ’19 (20%) before decreasing to more historic levels (13.5%) in Q2 ’19.[1] Furthermore, preliminary 2018 Connecticut Medicaid adult population data shows that of the 23,537 non-dual adults identified as homeless, 85% (20,061) were HUSKY D members. Of this homeless Husky D population, nearly 35% had an Opioid Use Disorder Diagnosis in the past year. This metric highlights the structural and substance use issues that may compound health issues and cause increasing utilization among the HUSKY D membership.

The ALOS was steady for most racial and ethnic groups except Asian adults, who increased in both quarters of 2019, ending at 13 days. The ALOS for the Asian adult population remains the highest ALOS of any racial or ethnic group.

While the volume of IPF discharges decreased in Q1 ’19 before increasing in Q2 ’19, the reverse is true for ALOS, which increased to 10.2 days in Q1 ’19, then decreased 0.6 days to 9.5 days in Q2 ’19. This trend is to be expected, since more people would be moving through the system.

The ALOS remained fairly similar for members between 18 and 54 years of age, ranging from 8.2 days to 10.3 days in Q2 ’19. However, older groups tended to have longer lengths of stay (55-65 at 12 days and 65+ at 17.2 days), likely due to age-related medical comorbidities and overall duration of psychiatric diagnoses, among other factors. The ALOS increased in Q1 ’19 and decreased in Q2 ’19 for both males and females, however, this change was greater among males. In Q2 ’19, males had an ALOS of 9.7 days, just 0.3 days greater than females (9.4 days).

[1] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

The ALOS was steady for most racial and ethnic groups except Asian adults, who increased in both quarters of 2019, ending at 13 days. The ALOS for the Asian adult population remains the highest ALOS of any racial or ethnic group. As mentioned in prior submissions, Asian members consistently have low behavioral health inpatient utilization (only 51 IPF discharges in Q1 and Q2 ’19 combined), which may indicate that they had fewer prior services before an inpatient stay and therefore need a longer length of stay to stabilize. All other racial and ethnic groups have an ALOS between 9.1 days (Other Races) and 9.8 days (Unknown members).

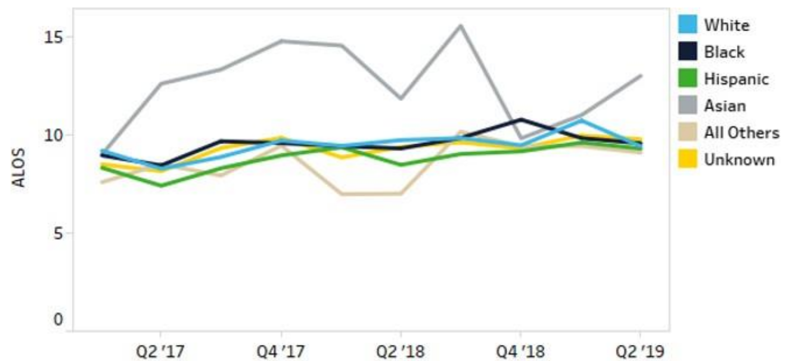

Figure 3: Quarterly Adult IPF Average Length of Stay by Race/Ethnicity

Concerning benefit group, the ALOS was largely stable among HUSKY A Family Single (eight days), HUSKY D (9.6 days), and HUSKY C - ABD/Other Single (11.1 days). Both HUSKY B and HUSKY C (LTC Single) had steep increases from Q1 to Q2 ’19 (13.3 days and 26.5 days, respectively). However, these benefit groups made up the least amount of discharges (only five in Q2 ’19), therefore the ALOS is less meaningful among these two groups.

In-state Provider Analysis and Reporting (PAR) Program hospitals, which excludes the Hospital for Special Care, Prospect Rockville Hospital’s eating disorder unit, Natchaug Hospital, and Sharon Hospital, accounted for 4,800 discharges in the first two quarters of 2019 combined. In that time, more than one third (33.9%) of these discharges came from the three largest facilities: Yale New Haven Hospital (585 discharges), Hartford Hospital (574 discharges), and St. Vincent's Medical Center (470 discharges). Prospect Manchester saw a decrease in discharge volume from the second half of 2018 through the first half of 2019, despite adding a geriatric unit in November 2017. The reduction of discharges may be attributed to staffing changes which occurred at the end of 2018. Conversely, The Hospital of Central Connecticut (THOCC) saw an increase in discharges from Q1 ’19 (97) to Q2 ’19 (139), an increase of 43.3%. The increase in discharge volume at HOCC may be the result of the decrease in ALOS from 13.3 days in Q1 ’19 to 10.9 days in Q2 ’19.

The ALOS for in-state PAR hospitals was 10 days in the first quarter of 2019, an increase of half a day from the prior quarter. In Q2 ’19, this decreased to 9.5 days, which was more consistent with earlier quarters. Yale, one of the largest providers by discharge volume, consistently had lengths of stay approximately three days longer than the statewide average. Hartford Hospital, another large inpatient provider in terms of discharge volume, had slightly lower ALOS than Yale. Yale's longer ALOS may be driven by the greater proportion of utilization by patients with schizophrenia (42.4% at Yale vs. 27.2% statewide in Q1 and Q2 ’19 combined).[2] With Hartford Hospital and Yale New Haven Hospital removed, the statewide ALOS drops to 9.2 days in Q1 ’19 and 8.6 days in Q2 ‘19.

[2] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

The ALOS was stable from Q3 ’18 to Q2 ’19 for most providers. The Hospital of Central Connecticut saw a decrease in length of stay from Q3 ’18 (15.9 days) to Q2 ’19 (10.9 days), a reduction of five days, consistent with the increase of discharge volume. While The Hospital of Central Connecticut has one of the lowest readmission rates (7-day readmission rate of 3.4% vs. the state average of 4.7% in Q1 and Q2 combined), this provider’s 7-day readmission rate increased from 2.1% in Q1 ’19 to 4.4% in Q2 ‘19.

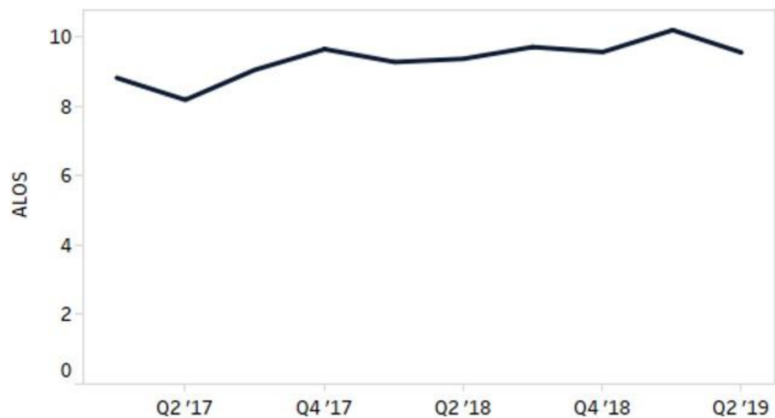

Figure 4: Quarterly Adult IPF Average Length of Stay

In the first quarter of 2019, Prospect Waterbury’s ALOS increased nearly three-and-a-half days from 11.3 to 14.7 days. In Q2 ‘19, their ALOS decreased to 11.9 days. Waterbury’s ALOS in Q1 ‘19 appeared to be driven by five members waiting for a state bed and one member waiting for Residential Rehab. With these members removed, the ALOS for Q1 ’19 is 11.1 days, consistent with prior quarters[3].

In order to increase support to the facilities with higher ALOS, Beacon began sharing data with providers about members that are at greater risk of having longer lengths of stay based on risk factors (e.g., need for ECT, age, housing status, others) utilized within our predictive modeling. Beacon has also increased support around discharge planning and coordinating aftercare plans by making phone calls to providers outside of the standard authorization review timeframes to provide this assistance. Additionally, members that are awaiting state, residential rehabilitation, or skilled nursing beds are rounded more frequently with our medical directors.

Per the data shared with providers as part of the PAR program, the statewide 7-day readmission rate increased slightly every quarter since Q3 ’18, ending Q2 ’19 at 4.7%.[4] On the other hand, the 30-day readmission rate slightly decreased during that time, ending Q2 ’19 at 14.3%. The four providers with notably long ALOS in the first two quarters of 2019 (Hartford Hospital, Yale New Haven Hospital, The Hospital of Central Connecticut, and Prospect Waterbury) had lower than average 7- and 30-day readmission rates, with the exception of Prospect Waterbury with a 30-day readmission rate of 14.6%, just 0.2% greater than the statewide average of 14.4%. The majority of readmissions went to different providers for both 7-day and 30-day measures (60.8% and 56.6%, respectively).

Inpatient Intermediate Duration (IDA) beds are an alternative to a state hospital bed for members who require longer treatment and stability, but likely can return to the community. Discharge volume from IDA is relatively low, ranging between six and 10 discharges per quarter over the last 10 quarters.

3Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

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Admission to this level of care is more difficult, as stable housing and weekly contact with an outside provider is needed. In the first two quarters of 2019, there were 16 discharges at St. Vincent's Medical Center.[5] Since these are 30-45 day beds, higher ALOS is expected. In Q1 '19, the ALOS increased from 1.days to 34.3 days, before decreasing to 25.7 days in Q2 '19. In Q2 '19, IDA was utilized primarily by members who are male (60%) and White (40%) with HUSKY D membership (90%).

Recommendation 1: *Continue Adult Inpatient PAR Program*
Regional Network Managers continued to conduct Provider Analysis and Reporting (PAR) meetings with the adult inpatient psychiatric hospitals during CY 2018. Clinical and Medical Affairs staff from Beacon are able to participate in PAR discussions as needed. These conversations provide an important forum to understand the varied clinical philosophies, community resources, treatment approaches, and cultural influences at each hospital and within each community. Understanding a provider's performance within this context furthers our ability to shape provider practice via the PAR program.

As noted in the previous semi-annual, variation in ALOS and readmission rates across the network persist. While discussions continue to focus on barriers and best practices for attaining and/or maintaining efficient length of stay and low readmission rates, implementation of the new three-tiered, case-mix bypass program has infused new energy and focus into the conversation toward facilitating improvement of the identified metrics. Through the refined bypass structure, hospital predictive ALOS is now based on hospital specific populations, offering new insight when assessing historical variables influencing ALOS such as: timely access to state hospital and residential beds; homelessness; electro-convulsive therapy (ECT); older age; and schizophrenia diagnosis.

The RNMs continue to provide support to inpatient units when provider specific or systemic challenges are identified. For example, through The Hospital of Central Connecticut (THOCC) PAR meetings, homelessness, first episode psychosis, and resources for the geriatric population were identified as contributors to longer lengths of stay. In response, the Regional Network Manager connected THOCC with the following resources:

- CMHA for the use of respite beds post inpatient discharge.
- The Director of the DMHAS Nursing Home Diversion Program to identify diversion resources available for elderly individuals post inpatient discharge.
- Beacon's FEP Intensive Care Manager to support in the coordination of care for this cohort post inpatient discharge.

We have also closely monitored performance and provided regular feedback on their ALOS. As noted above, through the combined efforts of Beacon, DMHAS and hospital leadership, their quarterly ALOS decreased from a high of 16.5 days in Q2 '18 down to 10.9 days in Q2 '19.

[5] St. Vincent's Medical Center is the only provider of IDA services. However, in Q4 '18, one IPF authorization at Hartford Hospital was erroneously classified as IDA. This error has since been resolved and will not be present in future semiannual data once refreshed for CY 2019.

Predicated on Beacon's analyses that have shown evidence of missed opportunities for the provision of universal screening, assessment, and evidence-based treatment for individuals with OUD receiving inpatient psychiatric care, expansion of the Changing Pathways pilot to inpatient psychiatric units is occurring.

PAR meetings and statewide workgroups function as central platforms for improving efficiencies across hospital systems and serve as a catalyst for promoting new and existing initiatives and best practices. For example, the Spring 2019 statewide workgroup focused on the implementation of the enhanced bypass program. Following a series of smaller provider meetings to develop the new structure, the statewide meeting was held to introduce the updated bypass program to the network and to achieve buy-in. Examples of other best practices promoted in PAR meetings include the use of long acting injectable medications to improve medication compliance, and call backs within 24 or 48 hours post discharge that have a direct impact on connect-to-care and suicide rates.

Building on momentum gained during CY 2018, CT BHP/Beacon has moved to expand the availability of Medication Assisted Treatment (MAT) for members with an Opioid Use Diagnosis (OUD) while on an inpatient unit– a focal strategy/theme that remains in development for CY 2019. Predicated on Beacon's analyses that have shown evidence of missed opportunities for the provision of universal screening, assessment, and evidence-based treatment for individuals with OUD receiving inpatient psychiatric care, expansion of the Changing Pathways pilot to inpatient psychiatric units is occurring. Expansion of this practice will allow CTBHP to grow the pilot of Changing Pathways, testing the model in two different but equally important treatment settings across three provider organizations. More broadly, this strategy reflects best practice in addressing the public health crises, supporting multiple approaches and access points for care to combat the opioid epidemic. It also aligns with recent proposals from DPH and the ADPC to expand access to MAT inductions in hospital settings. Additionally, Beacon and the Connecticut Hospital Association are in discussions around holding a training event, in collaboration with the CT BHP, on improving access to MAT within the hospital setting. This event is tentatively planned for the Fall 2019.

Lastly, a growing understanding of the social determinants of health has mandated the evolution of the health care system towards a more integrated approach. Health systems can no longer work in isolation to manage the array of social factors negatively impacting population health. Unmet social needs not only impede progress toward recovery, they tend to be drivers of emergency and inpatient visits and can exacerbate hospital LOS and readmission rates. In fact, homelessness is identified as one of the factors affecting LOS in the case-mix methodology. To that end, CHA recently announced that it has partnered with Unite Us, a leading social care coordination platform, to build a statewide coordinated care network of health and social services providers to deliver integrated care. The aim of the platform is to better connect patients to local social service agencies that help with housing, food, transportation, employment, and more.

Recommendation 2: *Modify Inpatient Bypass Program*
While the Inpatient Bypass Program used the same three measures consistent with previous years for the first two quarters of the year, preparations were underway to implement the new bypass program which incorporated case mix bymid-year.

The case-mix methodology and application to the bypass program, as well as the additionalnew bypass metrics, were presented to the hospitals in collaboration with Connecticut Hospital Association on April 16, 2019. The

presentation was well attended with representation from the majority of providers. The hospital providers were also informed that follow up meetings could be scheduled and the information would be reviewed again with additional parties as needed. In some cases, separate meetings were held, and in others, the information was reviewed during the inpatient PAR meetings, which began in July. Providers were given performance data for Q2 and Q3 '18 on the bypass metrics so that they could begin to see how they would perform on the bypass.

In the new bypass model, providers are evaluated on the following metrics and accumulate points based on the points associated with each measure:

	Measures	Child		Adult	
		Standard	Pts.	Standard	Pts.
1	7-Day Readmit	5%	1	6%	1
2	Discharge Form Completion	90%	1	90%	1
3	BH ED Visit within 7-Days of Discharge	9%	1	13.5%	1
4	Length of Stay Difference	>= -0.5 >= -1.0	2 1	>= -0.5 >= -1.0	2 1
5	Length of Stay Improvement or Maintenance Improvement Maintenance	>= 1 day difference >= 0 day difference	1	>= 1 day difference >= 0 day difference	1
6	Bed Tracking	90%	1	90%	1

The number of points accumulated and whether or not requirements are met are then translated in an associated tier and authorization process. The following grid delineates each of the tiers by points, performance requirements, and earned authorization process:

Tier	Point Range	Requirements	Authorization Process
Tier 1	5 – 7	• At least 1 point must come from the Length of Stay Difference measure **and** • At least 1 point must come from the 7- Day Readmit measure	Auto approval based upon the facility's average predicted LOS based on discharges within the previous quarter
Tier 2	3 – 4	• At least 1 point must come from the Length of Stay Difference **or** the Length of Stay Improvement/Maintenance Measure	7 units auto approved for initial requests
Tier 3	1 – 2	--	3 units auto approved for initial requests

The data for new bypass measures for Q1 '19 performance ran on July 1, 2019. Providers were informed of their performance in late July with a go-live of the new tiered system and associated authorization

process in early August. Hospitals' performance will be reevaluated every three months and authorization adjusted accordingly. The length of stay will be monitored closely to assess for potential impact of the new bypass.

Recommendation 3: *Tracking of Adult Awaiting Recommended Services*
With the increase in the length of stay, Beacon has begun increased tracking of the reasons for adult members remaining in the hospital beyond the acute portion of their stay. Starting in Q1 '19, Clinical Care Managers are now able to track if members are remaining in care awaiting beds for various locations and/or services – skilled nursing facility, state beds, adult group homes, residential rehabilitation, and receiving services from the Department of Developmental Services. This will allow the CT BHP to better determine where the waits are occurring within the system in order to highlight and then strategize ways to address the barriers. Beacon anticipates reporting out on preliminary findings in the 2019 annual report, following three full quarters of tracking the various reasons for delay.

Inpatient Detoxification – Hospital Utilization

Discharge volume and admissions per 1,000 for Inpatient Detoxification in the Hospital (IPDH) increased throughout 2018 before declining 12% in the first quarter of 2019, remaining steady in the second quarter with 857 discharges made by approximately 660 unique members, indicating many repeat utilizers.[6] These trends appear driven largely by White males in the HUSKY D benefit group.

As expected due to the greater medical risks involved with alcohol detoxification, hospital detoxification discharges were mostly for alcohol use (95.8%)[7]. Due to detoxification protocols, the ALOS was fairly steady over quarters, increasing to 5.7 days in Q1 '19 before decreasing to 5.3 days in Q2 '19. However, using member-level PAR data, Beacon discovered an error was made during the authorization process, which inflated the ALOS in Q1 '19.[8] With the erroneous length of stay removed, the ALOS in Q1 '19 was 5.3 days, consistent with other quarters. This error also had an impact by demographic, incorrectly increasing the ALOS for females, White members, the 25-34 age group, and HUSKY D membership in Q1 '19.[9]

The vast majority of IPDH discharges are coming from HUSKY D members, accounting for 748 discharges in Q2 '19. Discharges from this benefit group increased since 2017 and is overrepresented with 56.8% of the adult non-dual Medicaid population and 87.3% of IPDH discharges. Males are also overrepresented, as they make up 45% of the adult Medicaid non-dual population and 70% of IPDH discharges. The ALOS for both males and females were very similar throughout 2017 and the first quarter of 2018. However, ALOS for male members increased to a high of 5.8 days in Q3 '18 and decreased steadily since, ending Q2 '19 at 5.3 days. Females' ALOS steadily decreased to 4.9 days in Q4 '18 and Q1 '19 (excluding the aforementioned data entry error) but increased in Q2 '19 to 5.4 days, just slightly higher than males.

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[6] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

[7] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

[8] The member's admission date was entered as 2018 instead of 2019, resulting in a LOS of 369 days instead of the four days the member actually stayed.

[9] With the erroneous 369 LOS removed, the actual ALOS in Q1 '19 for females was 4.9 days (vs. 6.4 days), age group 25-34 was 4.7 days (vs. 7.5 days), White was 5.5 days (vs. 6.2 days), and HUSKY D was 5.3 days (vs. 5.8 days). This error will be resolved and absent from the CY 2019 data refresh.

IPDH Discharges were stable among all race/ethnic groups, with more than half coming from White members, who are also disproportionally overrepresented as they make up 32.7% of the adult non-dual Medicaid population and 55.2% of IPDH discharges. The ALOS was also stable among most race/ethnic groups, clustered around five days.

Discharges decreased among all age groups from the end of 2018 to the first quarter of 2019. In the second quarter of 2019, IPDH discharges slightly increased for 35-44 and 45-54 year-olds while the remaining groups saw a further decrease. The majority of discharges are from adults aged 45-54 years-old and are disproportionally overrepresented in the Inpatient Detoxification—Hospital service class, as they represent 17% of the total adult Medicaid population and 36% of the IPDH population. The ALOS varies the most by age group. In the first two quarters of 2019, ALOS for 25-34, 35-44, 45-54, and 55-64 were relatively stable.[10] Age groups 18-24 and 65+ saw a decrease from Q4 ’18 to Q2 ‘19, however these groups are made up of a small proportion of discharges so this should be interpreted with caution.

In the first two quarters of 2019, Yale New Haven Hospital (321 discharges) and St. Francis Hospital (255 discharges) were the top two providers for IPDH, accounting for 35% of discharges. Yale saw a reduction in discharge volume over the last four quarters, from 210 in Q3 ’18 to 163 in Q2 ’19, a decrease of 22.4%. Bridgeport Hospital and Charlotte Hungerford also saw a reduction in discharge volume, but the majority of providers were stable. Statewide, the ALOS was steady, ranging from 5.3 to 5.8 days.[11]

PAR meetings were held in the second half of 2018 with the two highest volume providers, St. Francis and Yale. The focus of the PAR meetings was on increasing the utilization of Medication Assisted Treatment (MAT) for both Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD).

From the data shared in the PAR program, the total 7-day readmission rates for all in-state IPDH providers (excluding state facilities) increased from 9.2% in Q4 ’18 to a high of 11.7%. This rate then decreased to 10.7% in Q2 ‘19, however, this rate is still higher than 7-day readmission rates seen in prior quarters.[12] On the other hand, the 30-day readmission rate decreased slightly from 30% in Q4’ 18 to 29.5% in Q1 ’19 and then decreased further in Q2 ’19 to 27.2%. For both 7- and 30-day readmissions, slightly more than half readmitted to the same provider.

Recommendation 4: *Continue Hospital-based Detoxification PAR Program with high-volume facilities*
PAR meetings were held in the second half of 2018 with the two highest volume providers, St. Francis and Yale. The focus of the PAR meetings was on increasing the utilization of Medication Assisted Treatment (MAT) for both Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD). As noted in the last semi-annual, Yale and Trinity Health have both invested in new Addiction Medicine expertise and resources, with the goal of expanding access to MAT across the hospital. Key to this practice change is forging new provider relationships within and beyond established catchment and geographical boundaries to ensure access to MAT for all individuals across the continuum of care. As such, Beacon

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[10] Excluding the erroneous LOS of 369 days from the 25-34 age group.

[11] Middlesex had the largest ALOS in Q3 ’18 at 19.8 days. However, this was driven by a data entry error, falsely showing one individual with a total LOS of 367 days instead of the two days the member actually stayed. Removing this error, Middlesex Hospitals ALOS was 5.9, consistent with other quarters. Similarly, Danbury Hospital’s ALOS increased over 10 days in Q1’19 (from 6.4 to 16.5). This increase was also driven by one data entry error, falsely showing an individual with an LOS of 369 days instead of four days. Removing this error, Danbury’s ALOS would be 6.4 days, also consistent with prior quarters.

[12] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

has continued to collaborate with the medical leadership, particularly at Yale, to establish referral pathways from the hospital to outpatient MAT. For example, Beacon organized several meetings to introduce the Yale Addiction Medicine team to community partners in various parts of the state to promote successful handoffs for members started on MAT within the hospital.

Additionally, Beacon has developed a new measure to assess prescriptions filled for Medication Assisted Treatment for AUD (naltrexone or alcohol deterrent) post inpatient hospital detoxification. The baseline data from April to December 2018 revealed notable variation across the hospital network. Provider specific rates for discharges with a prescription filled for naltrexone within 30 days ranged from 1% to 28%. For an alcohol deterrent (disulfiram or acamprosate) and/or naltrexone within 30 days, provider specific rates ranged from 6% to 38%. The RNM team is working with Clinical and Medical Affairs to develop a strategy to try to address the variation and to promote use of MAT as a best practice.

Inpatient Detoxification – Freestanding Utilization

Similar to IPDH, Inpatient Detoxification at Freestanding Centers (IPDF) continued to be utilized mainly by White males in the HUSKY D benefit group. However, IPDF serves a younger population than IPDH. In the first two quarters of 2019, discharges increased very slightly by 3% (from 2,719 in Q4 ’18 to 2,805 in Q2 ’19) and were mainly for alcohol (51%) or opioid (46%) withdrawal. Given that most facilities usually operate at full capacity, it is not surprising that discharges have remained steady despite the ongoing opioid epidemic. The ALOS decreased slightly in the first two quarters of 2019, from 4.4 days in Q4’18 to 4.2 days in Q2 ‘19. The ALOS was 3.9 days for opioid withdrawal (with a 24.9% Against Medical Advice (AMA) rate), and 4.3 days for alcohol withdrawal (with a 19.1% AMA rate).[13] An increase in induction on Medication Assisted Treatment (MAT) could result in changes in the ALOS for opioid withdrawal, but we are not yet sure what those changes may be. In the past six months, however, providers with the lowest length of stay across both quarters, Cornell Scott-Hill Health (3.6 days), Intercommunity (3.6 days), and Rushford Center (4.0 days), all had the highest rates of induction for members with OUD among the freestanding detox facilities. Cornell Scott-Hill Health had an induction rate of 40.0%, Rushford 25.5%, and Intercommunity at 15.3%. Shifts in practice change to induct members with an Opioid Use Disorder on MAT with a warm-handoff to community providers may attribute to lower lengths of stay, compared to providers who are continuing to practice traditional detox to zero protocols, requiring longer lengths of stay to ensure an adequate withdrawal management process. In addition, AMA rates for members with OUD was considerably lower for induction (14.1%) versus detoxification (25.6%) in Q2 and Q2 ‘19.

An increase in induction on Medication Assisted Treatment (MAT) could result in changes in the ALOS for opioid withdrawal, but we are not yet sure what those changes may be. In the past six months, however, providers with the lowest length of stay across both quarters, Cornell Scott-Hill Health (3.6 days), Intercommunity (3.6 days), and Rushford Center (4.0 days), all had the highest rates of induction for members with OUD among the freestanding detox facilities.

HUSKY D continued to account for the vast majority (87.8%) of discharges from IPDF, while HUSKY A (9.2%) and HUSKY C (ABD/Single) (3.0%) showed far lower volumes. Consistent with prior quarters, ALOS was nearly identical across benefit groups at 4.2 to 4.3 days.

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13 Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

By gender, discharges were steady in the first two quarters of 2019, with males having more discharges (69.2%) than females, which is again a disproportional overrepresentation of males in the adult non-dual Medicaid population (45%). The ALOS for males and females was nearly identical across quarters, ending Q2 ’19 at 4.2 for both genders. Discharges remained stable across racial and ethnic groups, with White members having approximately half of IPDF discharges in Q2 ‘19 (50.1%)—again, a disproportional overrepresentation compared with White members' proportion of the total population (32.7%). The ALOS did not fluctuate much by race/ethnicity over the quarters, with Q2 ’19 ranging between 3.9 days (Hispanic members) to 4.8 days (All Other race category).

Discharges remained fairly stable across age groups in the first two quarters of 2019. Consistent with prior quarters, members in the 25-34 year-old age group had the most discharges (33.9%) in Q2 ’19, followed by 35-44 year-olds (26.7%) and 45-54 year-olds (22.5%). The ALOS remained stable across age groups, clustered around four days, with the exception of the 65+ age group, which increased nearly a day and a half (6.3 days), likely due to more medical complications requiring more time to stabilize, however, it is important to note this was based on 10 discharges in the first two quarters of 2019 combined.

For members with OUD, the readmission rates were considerably lower for induction versus detoxification, with a 7-day rate of 3.8% versus 5.5%, and a 30-day rate of 13.9% versus 20.9%

Consistent with prior quarters, there were seven in-state inpatient freestanding detox providers, accounting for 2,726 discharges in Q1 ’19 and 2,804 discharges in Q2 ‘19. The largest IPDF provider continued to be Intercommunity Recovery Center, which had 1,337 discharges in the first two quarters of 2019 combined, approximately 24% of all IPDF discharges during that time. Recovery Network of Programs had the second highest number of discharges (939, or 17% of the total) in Q1 and Q2 of 2019, followed closely by Stonington Behavioral Health (836, 15%). Because treatment is protocol driven, there is little variance among providers for ALOS. In Q2 ’19, the ALOS ranged from 3.5 days at Cornell Scott-Hill Health to five days at Stonington Behavioral Health.

From the data shared in the PAR program, the 7-day readmission rates for all in-state freestanding detoxification providers decreased in Q1 ’19 to 5.3% after reaching a high of 6.4% in Q3 ‘18.[14] However, the 7-day readmission rate increased the following quarter, reaching 6.1%. In contrast, the 30-day freestanding detox readmission rate was stable in the first two quarters of 2019 (19.8% and 20.1%, respectively). The majority of discharges (80.8% of 7-day readmissions and 63.3% of 30-day readmissions) readmitted to a different provider. For members with OUD, the readmission rates were considerably lower for induction versus detoxification, with a 7-day rate of 3.8% versus 5.5% and a 30-day rate of 13.9% versus 20.9% in Q1 and Q2 ‘19.

Recommendation 5: *Continue Provider Workgroup Meetings and PAR Program*
During Q1 and Q2 ‘19, Beacon continued to meet with the freestanding detoxification facilities to engage in discussions about the PAR measures used in Inpatient Medical Detox dashboards which include ALOS, readmissions, AMA rates, discharge form completion, and connection to MAT post discharge rates. A major focus of the PAR meetings and workgroup meetings continues to be on shifting the practice of traditional detoxification to a different, evidenced-based treatment philosophy to manage individuals with Opioid Use Disorder (OUD). Induction onto a Medication Assisted Treatment

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14 Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.

(MAT) option while in detox, such as methadone or buprenorphine, is best practice when treating OUD . The transparency of the PAR data has been instrumental in engaging providers in meaningful discussions about the need for this critical practice change.

While there continues to be variability across the system in terms of the adoption of MAT induction, all providers have been receptive to feedback on the importance of shifting practice. The accompanying graph shows the rate of members with an OUD inducted on MAT by provider in Q1 and Q2 '19. It is important to note this information is self-reported by the facility and may be an underrepresentation for the non-pilot facilities. We will continue to work with all of the providers on accurate data entry.

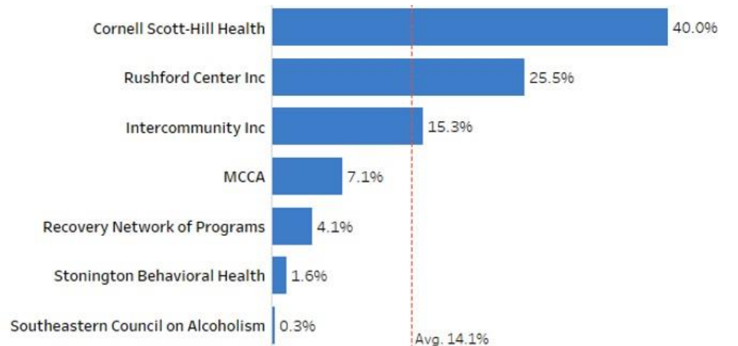

Figure 5: Percent of OUD Discharges Inducted on MAT by Provider in Q1 and Q2 '19

In addition to improvement in the MAT induction rates, claims data showing the number of prescriptions filled for naltrexone and buprenorphine and the number of methadone claims post discharge has steadily increased over the past two years. The statewide connection to MAT rate for individuals with a primary opioid diagnosis continues to increase from 21.4% in Q1 '17 to 37.4% in Q1 '19. All seven providers have increased their provider specific rates over the two-year period.

Figure 6: Statewide OUD Discharges with a Connection to MAT

The Changing Pathways Pilot has demonstrated tremendous success in highlighting MAT as a standard of care in effectively treating the growing opioid epidemic. Continued progress in this area with increasing access to MAT is crucial in addressing this statewide health crisis. Therefore, at a recent provider workgroup meeting, the pilot providers shared best practices and successes with the network with the intention of promoting MAT as a standard of care across the network. Common feedback given by providers as to barriers to the acceptance of MAT include the continued stigma perceived by family members. With a high percentage of young adults receiving treatment at the detox level of care, focusing on providing education to address this stigma is imperative to the work of providing multiple pathways to recovery for Medicaid members.

The statewide connection to MAT rate for individuals with a primary opioid diagnosis continues to increase from 21.4% in Q1 ‘17 to 37.4% in Q1 ’19. All seven providers have increased their provider specific rates over the two-year period.

Additionally, a common challenge identified through the pilot and in PAR meetings has been the increase in the volume of members presenting to detox with fentanyl in their system. Providers acknowledged ongoing barriers with patients who are withdrawing from fentanyl, indicating that the onset of withdrawal symptoms is delayed and that they might have to wait up to 36-48 hours after the member presents for withdrawal management prior to giving the first withdrawal management medication dose. Ultimately, this has led to some members leaving AMA due to experiencing subjective discomfort. This is a statewide trend that has been seen amongst other freestanding detox providers as well and is something that Beacon’s medical directors have been working on with providers to continue to facilitate conversations and education on this complex issue.

While a major emphasis of the PAR program has been on improving treatment for members with an OUD, we acknowledge that the greatest volume of discharges continues to be for alcohol use disorder and that there is also opportunity to enhance the care provided to members with AUD. At the May 2019 provider workgroup, data was shared on the rates of connection to MAT (naltrexone, acamprosate, disulfiram) for AUD. Similar to the OUD MAT rates, there is great variability in the provider specific rates of AUD MAT post discharge. Use of MAT for AUD was discussed as an important evidence-based practice. This data will be reviewed in more detail during the upcoming individual PAR meetings.

While a major emphasis of the PAR program has been on improving treatment for members with an OUD, we acknowledge that the greatest volume of discharges continues to be for alcohol use disorder and that there is also opportunity to enhance the care provided to members with AUD.

Recommendation 6: *Increase Focus on Readmissions and Changing Pathways*
From the data shared in the Provider Analysis and Reporting (PAR) Program, the total readmission rates for all in-state freestanding detoxification providers decreased slightly from Q3 and Q4 ‘18 to Q1 and Q2 ‘19. The semiannual 7-day readmission rate was 6.1% for Q3 and Q4 ’18 and decreased slightly to 5.7% for Q1 and Q2 ’19. The 30-day readmission rate has also seen a slight reduction from 20.6% in Q3 and Q4 ’18 to 19.9% in Q1 and Q2 ’19. Stonington Institute, who continues to have on average the lowest readmission rates for both 7- and 30-days, attributes this to engaging members in their own continuum at a Partial Hospital Program (PHP). This level of care includes a housing component to address the SDOH and ensure continued recovery efforts in a sober living environment. Future focus on establishing a PAR Program for the Intensive Outpatient (IOP) level of care may provide data to support how utilization of one’s own continuum of care helps to contribute to the reduction in readmission rates among the freestanding detox providers. Additionally, providers such as Intercommunity have partnered with local pharmacies to provide members leaving detox with naloxone. Future promotion of collaboration with local pharmacies to help infiltrate the system with naloxone will continue to be explored as a standard best practice of care.

As noted above, Beacon has continued efforts to promote a systemic shift in practice for withdrawal management providers with the Changing Pathways Pilot Project. Provider check-in meetings with Intercommunity and Rushford were scheduled both in Q1 and Q2 ’19 to further evaluate pilot successes and challenges. Since the implementation of this pilot, Rushford and Intercommunity noted the rapidly

increasing rates of MAT inductions. Rushford saw induction rates increase from 13.7% in Q4 ’18 to 27.2% in Q2 ’19. Additionally, Intercommunity significantly increased MAT induction rates from 4.8% in Q4 ’18 to 23% in Q2 ’19.

With the implementation of the Changing Pathways Pilot and promotion of best practices for MAT induction while at an inpatient level of care, Beacon developed a dashboard to explore trends among members inducted on MAT versus those who underwent a traditional detox protocol. This data highlights a reduction in AMA rates and 7- and 30-day readmission rates for members with MAT induction. The RNMs will continue to disseminate this data through the Provider Analysis and Reporting Program to highlight the significance of this practice change in promoting improved pathways to recovery.

An integral piece of the Changing Pathways Project has been establishing warm hand-off relationships with community providers so that members can safely continue their care and be provided with options regarding MAT medications as not all providers can offer all three FDA approved medications (methadone, buprenorphine, and naltrexone). Rushford and Intercommunity both expanded their relationships with two methadone providers in the community to help develop a smooth process for warm hand-offs. With assistance from the RNMs who coordinated meetings between methadone clinics and the pilot providers, the process of referring transfers and connecting to care has been enhanced resulting in an overall expeditious warm hand-off process. As a result, both Intercommunity and Rushford have increased their number of methadone inductions, and ultimately have provided more options for care to Medicaid’s members. Beacon will continue to offer support to the freestanding providers in terms of establishing warm hand-off relationships to ensure a successful transition post discharge.

Home Health Utilization

Admissions (authorization initiations) for Medication Administration increased for adults with and without dual membership in the first quarter of 2019 before decreasing in the second quarter of 2019. As noted in prior submissions, HUSKY D (MLIA) replaced HUSKY C (ABD/Other Dual) for having the highest admission volume, with HUSKY D having 242 admissions and HUSKY C (ABD/Other Dual) with 162 admissions in Q2 ’19. In Q1 and Q2 ’19 combined, HUSKY D members between 25-34 years of age had the highest volume of Medication Administration, continuing the observed shift in the population receiving this service which had, in prior quarters, been largely HUSKY C (single and dual) between the ages of 55-64. However, HUSKY C (ABD/Other Single) consistently had the highest admissions per 1,000 each quarter.

The twice daily (BID rate) for Medication Administration increased nearly every quarter since reaching a low of 10.4% in Q3 ’17. By the fourth quarter of 2018, the BID rate reached 15.5%. The once daily (QD) administration rate remained higher than BID, increasing sharply from 33.5% to 37.9% in Q3 ’18 before a very slight decrease in Q4 ’18 to 37.7%. While more members received Medication Administration services multiple times per day in recent quarters, emergency department (ED) and inpatient (IP) rates have continued to decrease slightly over time (ED rate from a high of 32.3% in Q3 ’14 to 28.6% in Q4 ’18; IP rate from a high of 11.3% in Q2 ’15 to 8.8% in Q4 ’18).

As noted in prior submissions, Start of Care/Resumption of Care authorizations continued to replace Skilled Nursing authorizations. The use of a Skilled Nursing visit is now limited to a once weekly pre-pour of medications, in-home wound care for members receiving behavioral health services, or a full nursing assessment in the event of a change in condition. Utilization of Skilled Nursing declined to just 80

admissions for members including duals in Q1 and Q2 ’19 combined. In contrast, Utilization for Start of Care/Resumption of Care for members with and without duals was 295 admissions in Q1 and Q2 combined, however, all groups saw a decrease from Q4 ’18 to Q1 ’19 before increasing in Q2 ’19, except for HUSKY A (Family Single); which remained stable from Q4 ’18 to Q1 ’19 before a slight decrease in Q2 ’19. Since Skilled Nursing and Start of Care/Resumption of Care are authorized in conjunction with Medication Administration, the trends by benefit and age group are the same as for Medication Administration.

Home Health Prompting, Home Health Aide, Med Box, and Med Tech requests for new authorizations have been exceptionally low with only one or two admissions per quarter, if any.

Recommendation 7: *Continue Home Health Bypass Program*
Beacon continued the Bypass and Bypass Plus Program for home health agencies in 2019. The Bypass Program provides administrative relief for Home Health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The agencies on bypass are authorized for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. The Bypass Program eligibility criteria continues to be achievement of a BID medication administration target rate and emergency department visit rate.

Beacon held a Statewide Home Health Provider Meeting on June 25, 2019, and presented the most recent claims data (Q3 ‘18 and Q4 ‘18), which included performance on the Bypass metrics. In Q4 ‘18, the Statewide BID rate was 15.5%, the ED rate was 28.6%, and the QD rate was 37.7%. Seven of the 19 providers are on Bypass Plus (36.8%), while eight of the 19 providers are on Bypass (42.1%). Three providers remained off the bypass program in Q4 ’18. One provider was removed from the bypass program after not meeting the targets for three consecutive quarters. One provider was at risk due to missing the metrics for the first quarter, and three providers were at risk due to missing the metrics for two consecutive quarters. The Q4 ’18 Home Health Bypass evaluation concluded with fifteen of the nineteen (78.9%) providers receiving the administrative benefits provided by the bypass program.

The Q4 ’18 Home Health Bypass evaluation concluded with fifteen of the nineteen (78.9%) providers receiving the administrative benefits provided by the bypass program.

All providers excluded from the Bypass program or at risk of being removed from the Bypass program were encouraged to work closely with Beacon staff around best practices identified by other providers.

Lower Level of Care Utilization
Outpatient admissions and admissions per 1,000 continued to represent the vast majority (79.1%) of all admissions to Lower Levels of Care. From Q4 ’18 to Q1 ’19, there was a 9.8% increase in Outpatient admissions (31,760), but in Q2 ’19, this declined 7.7% to 29,329. Intensive Outpatient continued to be the second largest service with 5,162 admissions in Q2 ’19, making up nearly 14% of admissions. Partial Hospitalization (PHP) saw a 7.4% decrease in Q1 ’19 (1,132 admissions) and a 7.2% increase in Q2 with 1,214 admissions. Methadone maintenance saw the opposite trend, with an increase of 6.3% in Q1 ’19 before decreasing 6.0% in Q2

Outpatient admissions and admissions per 1,000 continued to represent the vast majority (79.1%) of all admissions to Lower Levels of Care.

’19 with 1,329 admissions, despite the ongoing opioid epidemic. Beacon hypothesized that more providers are recommending alternative MAT, such as buprenorphine and naltrexone, to methadone.

Recommendation 8: *Develop an Intensive Outpatient Provider Analysis and Reporting (PAR) Program*

Over the past several months, Quality, Clinical, and Medical Affairs have collaborated to establish performance measures for IOP.

Through our IOP retrospective record reviews, IOP clinical study, data analytics, and UM experience, we believe there is notable variation in practice across the IOP network. Over the past several months, Quality, Clinical, and Medical Affairs have collaborated to establish performance measures for IOP, including the following metrics: Engagement in Care; Emergency Department (ED) Utilization During Care; ED Utilization Post Discharge; Higher Level of Care Utilization During IOP; and Higher Level of Care Utilization Post Discharge. A kick-off workgroup meeting will be held with the IOP providers in September 2019 with the plan to roll out an IOP PAR program during Q4 ’19.

Enhanced Care Clinics (ECCs)

The total non-ECC registration volume continued to increase over time, while ECC volume was relatively stable. In Q2 ’19, non-ECC registration represented 92.6% of total outpatient registrations and reached a high of 32,644 registrations in the first quarter of 2019. Adult ECC volume saw a 9% increase in Q1 ’19 with 2,628 registrations, but decreased 10% in Q2 ’19 to 2,371 registrations.

The 95% access standard was consistently met at nearly 100% for two of the three access types for ECCs (Routine and Emergent). However, Urgent standards was not met for the last three quarters (90.5% in Q4 ’18, 92.3% in Q1 ’19, and 90% in Q2 ’19). Across all outpatient evaluations in both quarters of 2019, ECCs continued to have higher rates of meeting the 95% access standard than non-ECC clinics. This was expected, due to the level of attention given to the access standards by the ECCs, however, the non-ECC clinics continued to demonstrate a strong performance without added incentives.

Recommendation 9: *Assess ECC initiative*

Beacon recommends that some or all of these changes to the ECC program structure would help to improve efficiency and maximize outcomes for participating programs.

Many meetings were held over the last year with key stakeholders to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, incorporation of value based payment methodologies, and opportunities to broaden the initiative. Beacon recommends that some or all of these changes to the ECC program structure would help to improve efficiency and maximize outcomes for participating programs. These discussions remain ongoing. During the September 2018 Operations Subcommittee, an open invitation for feedback on ECC redesign was given to providers. While the subsequent Operations Subcommittee meetings have not generated any additional feedback, the CT BHP ECC team remains open to provider input.