UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2: January-June 2020 - Submitted September 1, 2020

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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 ADULTS

Quarters 1 & 2: January-June 2020

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 that 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 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. Beacon 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 demographic information on members, such as race, ethnicity, and primary spoken language, are pulled and categorized from the most updated eligibility file received by Beacon from DSS. Beacon has taken strides to update our reporting to include additional information on members’ demographics, such as separating Hispanic ethnicity apart from race and the inclusion of members’ primary spoken languages. These efforts enable us to track if demographic disparities exist within the Medicaid membership, and also allow us to better serve members (i.e., which is their preferred language). All member demographics are based on the most recently updated eligibility file. These demographics will update as needed and reflect the most current demographic information we have for each member.

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.

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

Introduction

This summary and analysis of Adult Utilization is accompanied by a series of Tableau dashboards that allow the user to drill deeper into various dimensions (demographics, benefit types, levels of care, etc.) and apply filters to examine the impact of combinations of dimensions on utilization (e.g. ethnicity, age, and benefit type). As a result, some details of lesser significance are not reported on here but can be further explored in the dashboard as the user sees fit.

Several enhancements were made to the membership and utilization Tableau workbooks this year, including additional membership demographics such as members' primary spoken language and the break out of Hispanic ethnicity from race. These demographic changes are a reflection of the Connecticut Behavioral Health Partnership's (CTBHP) commitment to enhancing and analyzing demographics that are known indicators for health disparities and inequities.[1] The Tableau dashboards were further enhanced through additional interactive features such as filters to view the data in new ways, the ability to show or hide filters, new demographic layers added to the dashboards, and additional information and visuals included in the tooltips for many graphs, such as the ability to see the number or percent difference from the prior quarter.

Several enhancements were made to the membership and utilization Tableau workbooks this year, including additional membership demographics such as members' primary spoken language and the break out of Hispanic ethnicity from race.

Impact of COVID-19 on Utilization and Membership Data

As a result of the enormous impact of the novel coronavirus (COVID-19), Connecticut made changes to Medicaid enrollment, including suspending the timeframes for renewal for current beneficiaries.[2] Benefits which were scheduled to end in March and April were automatically extended through June and July, respectively.

This policy change may impact membership reporting for 2020. HUSKY Health also developed an eligibility package specifically for COVID-19 testing, which includes expanding eligibility to uninsured residents of any income level, covering both citizens and qualifying non-citizens for testing and testing-related provider visits that occur between March 18 through the end of the pandemic.[3] This benefit is exclusively managed by Community Health Network (CHN). CTBHP will not receive this data and, therefore, cannot report on it.

This interim measure for select BH services – most notably Inpatient, Inpatient detoxification-hospital based, and several lower levels of care – went into effect for dates of service on or after April 1, 2020. As this Medicaid utilization report uses authorization-based data, the second quarter of 2020 (April 1 through June 30) cannot be accurately interpreted.

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, 2018 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. From 2018 to 2019, the HUSKY A population did not return to pre-eligibility change levels, and, in fact, decreased a further 1.7% from 224,354 to 220,485 adults in CY '19. Beacon hypothesized that this decline in HUSKY A membership may have been influenced by the decline in unemployment rates seen in prior years. However, the impact of COVID-19 on unemployment will likely increase benefit enrollment across all Medicaid programs: the Connecticut unemployment rate has risen from 3.4 in March to 9.8 in June 2020.[4]

In response to the Governor's declaration of a public health emergency due to the outbreak of COVID-19, the Department of Social Services (DSS) temporarily waived the prior authorization (PA) requirements for most of the behavioral health (BH) services discussed in this report. This interim measure for select BH services – most notably Inpatient, Inpatient detoxification-hospital based, and several lower levels of care – went into effect for dates of service on or after April 1, 2020. As this Medicaid utilization report uses authorization-based data, the second quarter of 2020 (April 1 through June 30) cannot be accurately interpreted. For levels of care not impacted by the temporary authorizations modification (e.g., Inpatient Detox Freestanding), the impact of COVID-19 can still be observed, including fewer admissions or authorizations for services due to the concern of COVID-19 transmission, the need to social distance, the restriction of non-emergency services, etc. Therefore, all graphs and tables in the accompanying Tableau dashboards include a red reference line indicating both the start of the "Temporary Effective Period" as it relates to change in prior authorizations, as well as the actual impact of COVID-19 on behavioral health services.

[1] Plant, R., Van der Heide, L., Hopkins, B. et al. (2015). Health Equity and Inequity in the Connecticut Medicaid Behavioral Health Service System. Connecticut Behavioral Health Partnership (CTBHP).
[2] HUSKY Health Connecticut. (2020). Special information and resources for HUSKY Health members about coronavirus (COVID-19). HUSKY Health. Available at: https://portal.ct.gov/HUSKY/Special-information-and-resources-for-HUSKY-Health-members-about-coronavirus
[3] Ibid.
[4] Connecticut Department of Labor. (2020). Labor Market Information. Updated July, 16, 2020. Available at: https://www1.ctdol.state.ct.us/lmi/unemprateCTUS.asp

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

Total Membership

For the first two quarters of 2020, the Connecticut Medicaid membership, including dually eligible members, remained steady having decreased less than 1% ending Q2 '20 with 895,539 members. Adults continued to make up the majority of members at 63%. The largest single age group in Q1 and Q2 '20 was 3-12 year olds at nearly 21%. Female members continued to make up the majority at 53.4%. The largest racial group continued to be Unknown at 42.6%, while non-Hispanic members made up the majority of ethnic groups at nearly 80%. The primary language spoken by Medicaid members, a new demographic added to the analysis this year, was English at 85%. Adults with dual membership remained the same, while Adult members without dual membership increased 0.7% since Q4 2019 at 500,144. Youth membership decreased 0.8% since the end of 2019. 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.

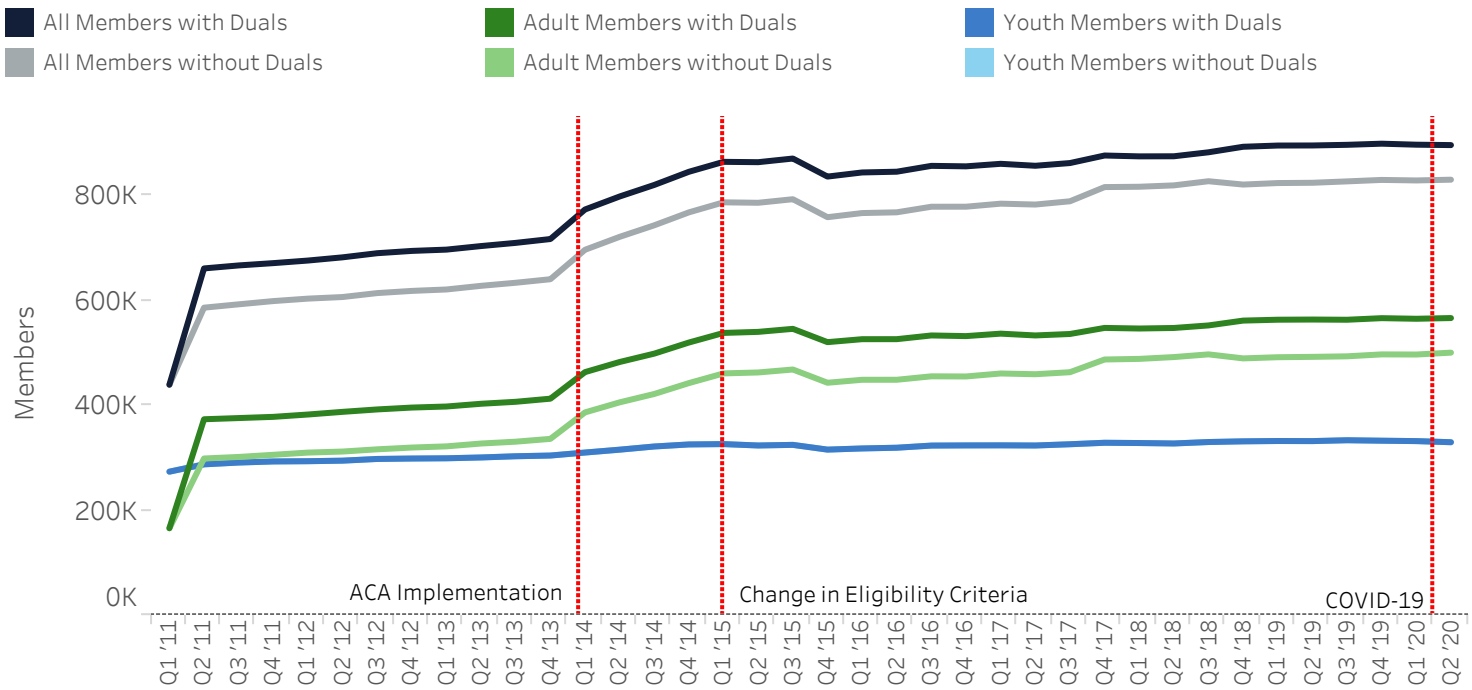

Figure 1: Connecticut Medicaid Total Membership

For the first two quarters of 2020, the Connecticut Medicaid membership, including dually eligible members, remained steady having decreased less than 1% ending Q2 '20 with 895,539 members.

Membership Demographics

To provide context for demographic comparisons for the Connecticut Medicaid population served by CTBHP, the following section begins by describing the Connecticut population as a whole, the Connecticut Medicaid population, and those who utilize behavioral health services.

There are an estimated 3.56 million people living in Connecticut based on the most up-to-date 2019 census data. Among whom 20.4% are under the age of 18, 51.2% are female, and 79.7% are White.[5]

Demographic	Percent
Age	
Under 5 years	5.1%
Under 18 years	20.4%
65+ years	17.7%
Gender	
Female	51.2%
Male	48.8%
Race	
White	79.7%
Black	12.2%
Hispanic or Latino	16.9%
Asian	5.0%
Other	3.2%

Figure 2: Connecticut 2019 Population Estimates

[5] U.S. Census Bureau. (2019). QuickFacts, Connecticut. Available at: https://www.census.gov/quickfacts/CT

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

From the 2019 annual membership and utilization report (the last available full calendar year), we know that 992,890 residents (an estimated 28% of all Connecticut citizens) were enrolled in Medicaid. According to CTBHP's 2018 Population Profile – the most up-to-date claims-based behavioral health utilization data describing the Connecticut Medicaid population – 286,882 (or 29.2% of the total Connecticut Medicaid population) were users of behavioral health services. Adult members who utilized behavioral health services made up 34.6% (215,319) of the total Medicaid population, whereas youth made up 19.9% (71,563).

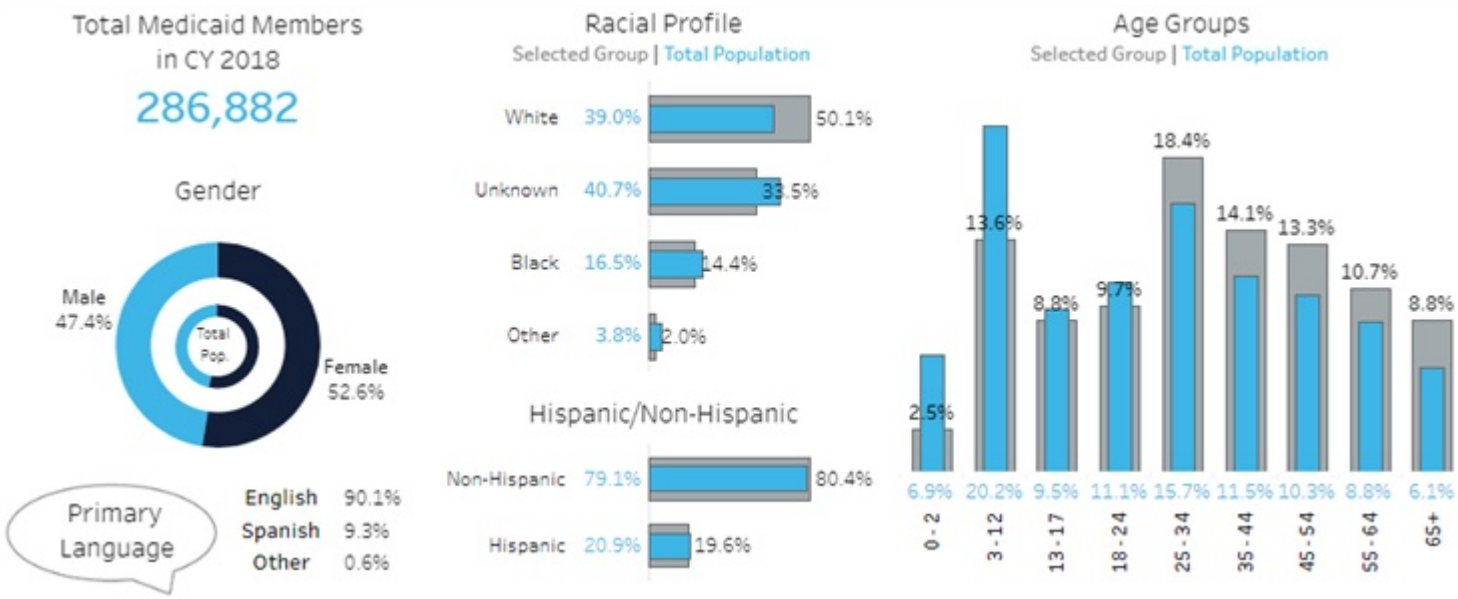

Figure 3: CTBHP 2018 Population Profile, Behavioral Health Service Utilization

For the first two quarters of 2020, adult membership excluding duals remained steady for males (44.8%) and females (55.2%), who are overrepresented by 3.9% when compared to the total Connecticut population estimate. Among adults, 25-34 year olds continue to be the largest age group at 27%, followed by 35-44 year olds at nearly 21%, an age group which has been steadily increasing since the end of 2018. Eighteen-to-24 year olds made up the third largest age group at nearly 20%.

Adult members who utilized behavioral health services made up 34.6% (215,319) of the total Medicaid population, whereas youth made up 19.9% (71,563).

Beacon has taken strides in updating its race and ethnicity data by separating Hispanic ethnicity from race in many of our reports, including both the adult and youth semiannual membership and utilization reports.

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 or ethnicity. The Unknown race group continued to increase among adults, excluding duals, up 0.5% since Q1 2019. Since this change, the Unknown category made up nearly 42% of the adult Medicaid population in Q2 '20. Beacon's investigations indicate that this is a true unknown, as members are not required to choose a race or ethnicity when applying for Medicaid. There are concerns that having a large group of unknown race and ethnicity will hinder efforts to identify and reduce health disparities, as we cannot know if the unknown group is evenly distributed among all racial and ethnic groups, or if certain groups are more likely to opt out of responding. Beacon understands that our state partners share our concerns and are seeking solutions as Executive Orders 5 & 6 call out the need for improved health equity reporting within Medicaid. As a result, Beacon has taken strides in updating its race and ethnicity data by separating Hispanic ethnicity from race in many of our reports, including both the adult and youth semiannual membership and utilization reports.

Also noteworthy is the known racial health disparity impact that COVID-19 is having across the United States, and Connecticut as well. It has been found in some areas of the country that Black and Hispanic populations are over twice as likely as non-Hispanic White populations to die from COVID-19.[6] In Connecticut, Black, Hispanic or Latino, and indigenous populations are experiencing disproportionately higher rates of infection and serious complications, and may also be disproportionally affected by the economic consequences of COVID-19. This warrants continued vigilance with regards to monitoring racial and ethnic disparities and their impact on behavioral health in the Medicaid membership in CT.

[6] Selden & Berdahl. (2020). COVID-19 And Racial/Ethnic Disparities In Health Risk, Employment, And Household Composition. Health Affairs. Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00897

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As previously noted, this is the first semiannual report on membership and utilization where ethnicity is separate from race, which provides a new layer of analysis as we broaden the demographics on which we are able to report. Unknown race continued to be the largest racial group for adults without dual members at 41.8% in Q2 '20, and continues to increase steadily over time. The ethnicity of the Unknown race group is 32% Hispanic. White members continued to be the largest known racial group with 37.7% in Q2 '20, of whom 12.8% were of Hispanic ethnicity. Black members remained stable at 16.5%, with 4.6% being of Hispanic ethnicity. Asian members made up 3.2% of adult membership without duals with less than 2% of Hispanic ethnicity, and all other races make up less than 1%, with 17.9% of Hispanic ethnicity.

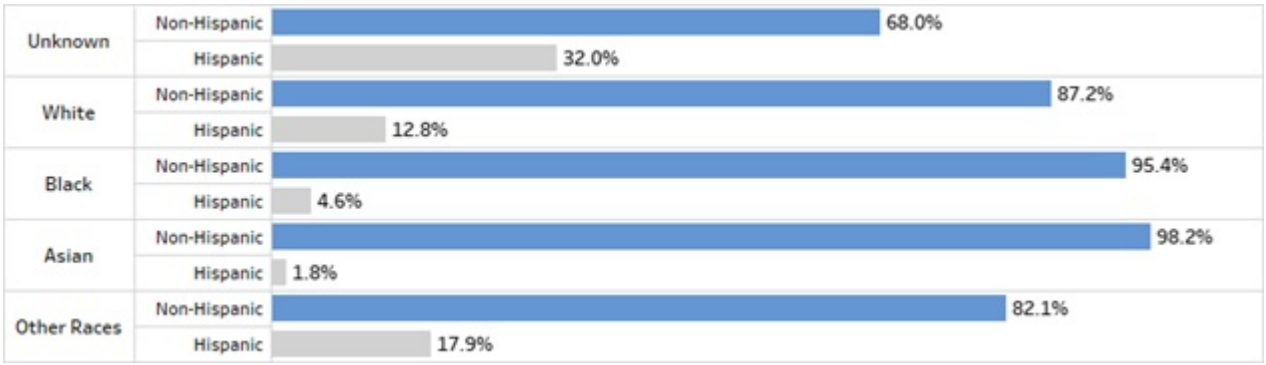

Figure 4: Percent of Adult Members by Hispanic Ethnicity within Race in Q2 2020

Of those who identify as Hispanic: 69.8% do not have a known race, 25.2% identified as White, 3.9% identified as Black, and 1% identified as other races. It appears that Hispanic ethnicity has been slowly decreasing in the adult Medicaid population since 2013, where Hispanic ethnicity was 23.3%; in 2020 it was 19.1%. Compared to the 2019 Connecticut population census estimate, Black and Hispanic Medicaid members in 2020 were overrepresented at 16.5% (a 4.3% difference) and 19.1% (a 2.2% difference), respectively, while Asian members were underrepresented at 3.2% compared to 5% in the state population.

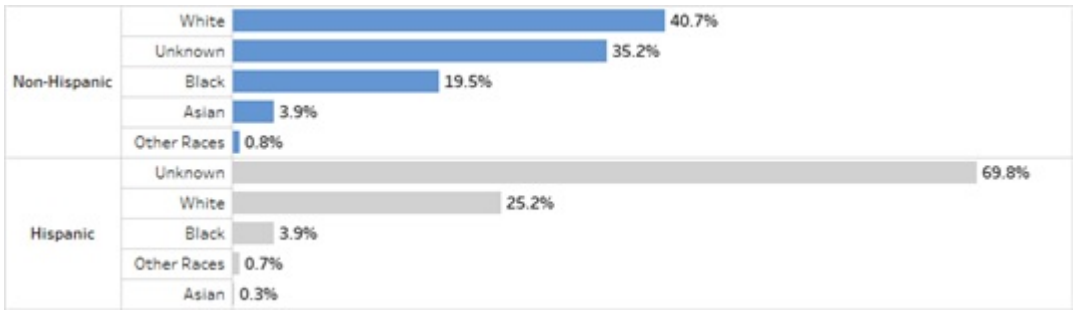

Figure 5: Percent of Adult Members by Race within Ethnicity in Q2 2020

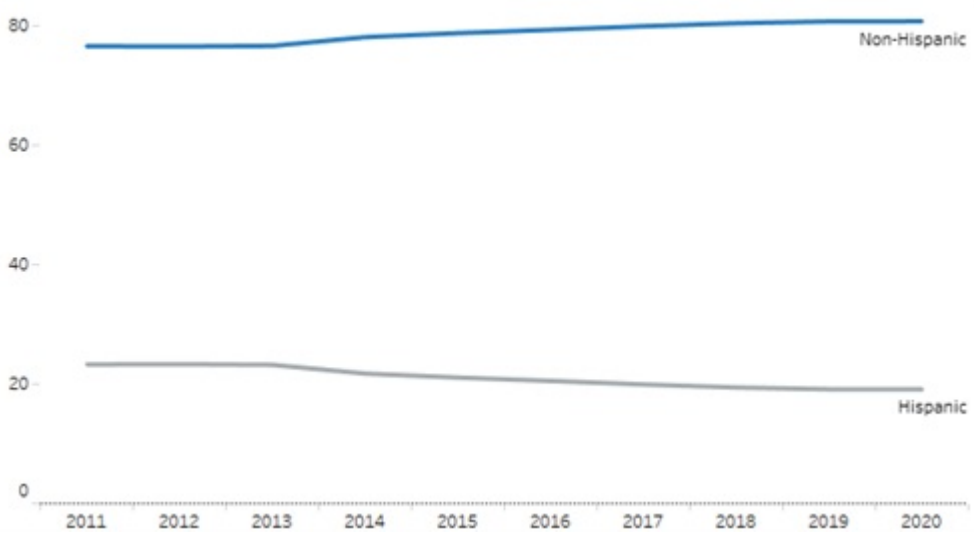

Figure 6: Hispanic Ethnicity Over Time Among Adult Medicaid Population

White members continued to be the largest known racial group with 37.7% in Q2 '20, of whom 12.8% were of Hispanic ethnicity.

Primary language is another new field added to this report. English is the predominant primary spoken language by adult members at 87.8% followed by Spanish at 11.1%. Other primary languages made up 1.1%.

Figure 7: Primary Languages Spoken by Adult Members

English is the predominant primary spoken language by adult members at 87.8% followed by Spanish at 11.1%.

Benefit Membership

Benefit groups remained steady in 2020, which may be partly influenced by COVID-19; in March it was announced that expiring eligibility would be pushed back in response to the pandemic. HUSKY D Medicaid for Low-Income Adults (MLIA) continued to be the largest benefit group for adult Medicaid members without dual eligibility (57.4%), followed by HUSKY A (Family Single) at 37.8% (a 0.8% increase since Q4 '19). HUSKY C, Medicaid for the Aged/Blind/Disabled (ABD/Other Single), also had a slight 0.2% decrease to 4.3% followed by HUSKY B (0.3%) and HUSKY C Long-Term Care (LTC Single) at 0.1%, both of which remained stable.

HUSKY D continued to be the largest single benefit group overall and among most demographic groups. HUSKY D was the largest benefit group for nearly every age group except 35-44 (which had HUSKY A at 56.7%), and 65+ (which had HUSKY C (ABD/Other Single) at nearly 80%). HUSKY A covered over 50% of females and 56.7% of 35-44 year-olds, and is the top benefit group for females ages 25-34 and 35-44, suggesting that HUSKY A continued to provide essential medical coverage for mothers and their children. In prior years, HUSKY A was also the most enrolled benefit group among Asian members, however, in 2019 this gap nearly closed with HUSKY D: HUSKY A making up 46.8% of Asian members compared to HUSKY D at 46%. Among primary languages spoken, HUSKY D was the largest benefit group among those whose primary language was English, and in 2020, was also the largest benefit group for primary Spanish-speakers; a switch with HUSKY A that appears to have occurred in late 2019.

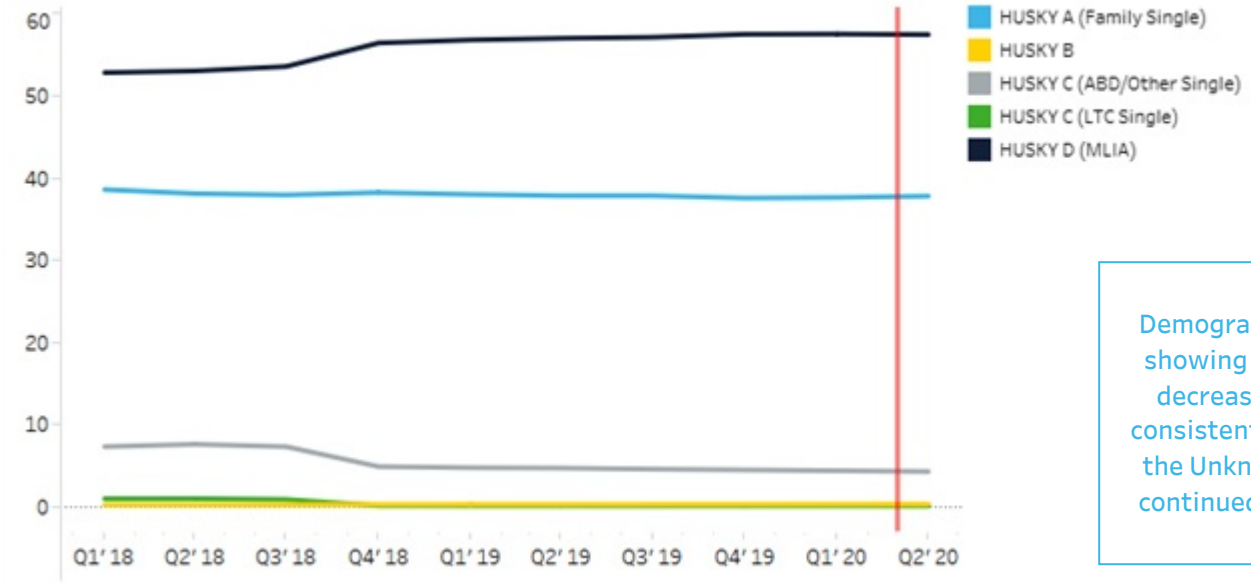

Figure 8: Adult Membership by Single Benefit Groups

Demographic trends were stable, showing all demographic groups decreased in dual membership consistently, with the exception of the Unknown racial group, which continued to increase since 2018.

HUSKY C (ABD/Other Dual) remained the largest dual benefit group, accounting for 69.6% of all adult dual members in Q2 '20. The adult dual population continued to be older (59.7% were 65+), female (61.3%), and White (73.8%). Demographic trends were stable, showing all demographic groups decreased in dual membership consistently, with the exception of the Unknown racial group, which continued to increase since 2018.

Inpatient Psychiatric Hospital Utilization[7]

As mentioned above, prior authorization was not required for admissions to acute psychiatric inpatient hospitals after April 1, 2020 due to COVID-19, therefore, Q2 '20 utilization data cannot be accurately interpreted as the data utilized for our utilization reporting is authorization based. As such, the focus of this section will be on Q1 '20. Discharge volume from inpatient psychiatric hospitals (in- and out-of-state, but excluding state facilities) remained consistent from 2019 into 2020. Average length of stay (ALOS) increased 3.1% from Q4 '19 (9.7 days to 10 days in Q1 '20), but has not changed drastically from the first quarter of 2019. Admissions per 1,000 decreased 2.9% in Q1 '20 for adults without duals – a 5.5% decrease since Q3 '19, when the downward trend began.

[7] Note: with prior authorization waived due to COVID-19, Q2'2020 cannot be interpreted for inpatient psychiatric hospital utilization.

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Twenty-five to 34-year-olds remained the largest age group for inpatient psychiatric hospital utilization.

Twenty-five to 34-year-olds remained the largest age group for inpatient psychiatric hospital utilization. All ages saw a slight decrease or remained steady in Q1 '20 except for 35-44 year olds which increased 11.2% from Q4 '19. The ALOS remained stable across ages except for the 65+ age group, which saw a 1.5-day decrease from 15.8 days in Q4 '19 to 14.3 days in Q1 '20. Older age groups continued to have longer lengths of stay likely due to age-related comorbidities and overall duration of psychiatric diagnoses.

Discharges among gender remained stable with males having disproportionately more discharges (56%) and a longer ALOS at 10.1 days compared to females (9.9 days). White members continued to account for most discharges (43.5%), followed by Unknown race (38.9%). The ALOS for most racial groups were between 9.7 days and 10.2 days. Discharges and ALOS remained stable for Hispanic ethnicity, with 15.9% of discharges and an ALOS of 9.4 days. Discharges and ALOS by primary language appear consistent over time. Spanish-speaking members saw a slight increase in ALOS, up to 9.6 days compared to 7.8 days observed in Q4 '19.

In-state Provider Analysis and Reporting (PAR) Program hospitals – which excludes Prospect Rockville Hospital's eating disorder unit, and Sharon Hospital – accounted for the majority of discharge volume, approximately 2,432 discharges in Q1 '20, nearly the same volume as was seen in Q4 '19 with 2,437 discharges. Of these discharges, 35% were from the three largest hospitals: Hartford Hospital, SVMC Holdings (formerly St. Vincent's Medical Center), and Yale New Haven Hospital.

	Discharges									ALOS								
	Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20
BRIDGEPORT HOSPITALINC	128	121	133	124	138	140	139	135	139	7.9	9.0	8.7	7.3	8.8	7.9	8.9	7.1	7.7
BRISTOL HOSPITAL INC	92	98	96	88	68	90	70	77	74	6.5	9.2	7.0	7.3	9.9	7.5	8.1	7.9	9.1
CHARLOTTE HUNGERFORDHOSPITAL	64	42	45	69	57	76	82	84	80	5.3	7.0	8.6	7.3	8.8	7.6	8.2	8.0	8.8
DANBURY HOSPITAL	55	57	73	63	81	78	54	43	49	8.7	10.1	10.2	6.1	8.4	8.8	5.6	7.7	7.7
DAY KIMBALL HOSPITAL	60	65	66	77	54	79	69	62	60	6.1	5.2	6.5	5.5	5.9	5.3	5.2	5.6	6.6
GRIFFIN HOSPITAL	89	102	101	82	82	76	76	83	81	8.3	6.6	7.1	7.9	5.9	8.7	9.0	8.0	8.2
HARTFORD HOSPITAL	307	319	321	293	298	279	266	299	324	11.7	11.2	11.3	11.5	11.6	12.1	13.5	12.4	12.2
HOSPITAL OF CENTRALCT	90	90	92	98	97	140	131	102	107	11.7	16.3	15.9	13.3	13.3	10.9	11.2	11.4	12.7
JOHNSON MEMORIAL HOSPITAL	53	73	80	73	95	88	81	63	77	7.0	6.7	7.4	7.0	6.3	7.5	7.5	7.2	7.6
LAWRENCE & MEMORIALHOSPITAL	89	96	103	85	81	83	91	85	87	8.5	6.2	7.0	7.3	7.3	9.0	7.1	7.4	8.0
MIDDLESEX HOSPITAL	100	97	117	99	89	87	97	101	95	7.8	7.8	6.2	7.4	7.7	7.1	6.4	7.0	7.0
NATCHAUG HOSPITAL INC	12	22	16	14	18	26	16	18	16	9.8	11.4	10.4	8.6	9.3	11.7	11.6	7.8	8.8
NORWALK HOSPITAL ASSOCIATION	52	53	49	31	40	42	47	41	35	7.6	5.5	8.2	10.1	7.5	4.4	6.9	6.7	6.2
PROSPECT MANCHESTERHOSP INC	127	142	159	156	107	131	128	114	117	7.6	7.3	7.7	7.9	8.5	9.6	7.5	9.9	9.9
PROSPECT WATERBURYINC	98	125	128	123	110	103	131	129	122	11.8	10.8	10.0	11.3	14.7	12.1	11.5	14.2	12.0
ST FRANCIS HOSPITAL& MEDICAL CTR	168	187	179	198	173	176	197	200	189	8.5	7.8	8.5	9.1	8.5	7.8	8.0	8.2	8.9
ST. MARYS HOSPITALINC	82	92	95	91	59	90	87	94	75	6.8	7.2	8.0	7.3	9.8	7.0	6.0	7.0	7.4
STAMFORD HOSPITAL	69	75	77	83	60	74	85	64	60	10.4	8.4	13.5	10.0	10.6	10.5	9.1	10.7	7.9
STATE OF CONNECTICUTJ. D. HOSPITAL	54	68	59	69	56	66	53	56	54	6.4	6.4	9.0	9.5	9.4	9.0	8.4	7.4	9.9
SVMC HOLDINGS, INC.	278	276	265	230	230	245	203	201	220	9.5	8.8	10.0	8.9	9.7	9.3	10.3	9.5	9.8
WILLIAM W. BACKUS HOSPITAL, THE	77	97	73	79	80	71	60	65	63	8.9	9.8	9.1	8.6	8.8	8.6	10.3	9.9	9.7
YALE NEW HAVEN HOSPITAL	328	396	347	296	313	278	340	321	308	11.4	12.5	11.6	13.7	13.2	13.0	14.7	12.2	13.4
ALL PROVIDERS	2,472	2,693	2,674	2,521	2,386	2,518	2,503	2,437	2,432	9.2	9.4	9.5	9.4	10.0	9.5	9.9	9.6	10.0

Discharges: 12 – 396

Average Length of Stay (Days): 4.4 – 16.3

Figure 9: Adult Inpatient Psychiatric Facility PAR Provider Discharges and ALOS

The ALOS for in-state PAR hospitals was 10 days in Q1 '20, a 0.4-day increase from Q4 '19. The majority of members stayed between 4-7 days. Only 8.6% (209 discharges) of members discharged in Q1 '20 stayed 20 days or longer, a slight increase from Q4 '19 which had 8.1% (197 discharges) with the same length of stay. Predominant primary diagnoses among members discharged from inpatient psychiatric facilities in Q1 '20 were depressive disorders (47.5%; ALOS 8.2 days), schizophrenia and other psychotic disorders (28.2% of discharges; ALOS 13.6 days), and bipolar disorders (19.7% of discharges; ALOS 9.3 days).

Unlike most PAR providers, Yale continued to have a higher percent of discharges with a primary diagnosis of schizophrenia compared to depressive disorders: 38.3% of discharges in Q1 '20 had a primary diagnosis of schizophrenia compared to 30.8% who had depressive disorders, consistent with prior years. Yale's ALOS for Q1 '20 was 13.4 days, which was 3.4 days greater than the statewide average. However, when looking specifically at members whose primary diagnosis was schizophrenia: Yale's ALOS rises to 16.7 days; Hartford's ALOS rises from 12.2 days to 17 days; and SVMC Holdings' ALOS increased from 9.8 days to 11.8. This finding continues to show that members who have a primary diagnosis of schizophrenia contribute to the increase in ALOS for these high-volume providers.

Sixty-one discharges (2.5% of all discharges) were awaiting placement in Q1 '20, which is consistent with prior quarters. The ALOS among those awaiting a state inpatient bed and residential rehabilitation were also steady when compared to the average lengths of stay seen in 2019. Among the discharges awaiting placement, 31 were awaiting residential rehabilitation with an ALOS of 20.2 days, consistent with prior quarters.

This finding continues to show that members who have a primary diagnosis of schizophrenia contribute to the increase in ALOS for these high-volume providers.

Providers with an ALOS above the statewide average were: Hartford Hospital, Hospital of Central CT, Prospect Waterbury, and Yale. The Hospital of Central CT and Yale were the only high ALOS providers to increase from 2019, 1.3 and 1.2 days respectively. Prospect Waterbury's ALOS notably decreased from Q4 '19 from 14.2 days to 12 in Q1 '20, a reflection of a more concerted treatment approach in screening and assessment, stabilization of symptoms, discharge planning, and connecting to care efforts.

Recommendation 1: Continue Adult Inpatient PAR Program

Regional Network Managers continued to conduct PAR meetings with the adult inpatient psychiatric hospitals during the first two quarters of 2020. Clinical and Medical Affairs staff participate in PAR meetings as needed. Discussions focused on provider-specific and statewide data shared from Tableau; a presentation medium that informs a cogent, interactive conversation, lending insight to the variation in ALOS, readmission rates, and other accepted industry utilization and quality measures among CT providers.[8] Understanding a hospital's performance through this digital, cross-network lens furthers our ability to shape provider practice via the PAR program.

Adjusting for COVID-19, adaptation of this modified workgroup structure further allowed inpatient teams to consult, strategize, and share protocols for the treatment of psychiatric patients exhibiting symptoms or testing positive for COVID-19.

In responding to COVID-19, PAR and hospital workgroup meetings, along with other system enhancement activities migrated to virtual platforms: a strategic move that enabled Beacon to convene in real-time with inpatient psychiatric PAR hospitals to further understand the operational challenges and downstream effects imposed by the pandemic. This rapid response also served to support uninterrupted network cooperation, including the exchange and dissemination of best practice in service delivery and cross system collaboration.

Adjusting for COVID-19, adaptation of this modified workgroup structure further allowed inpatient teams to consult, strategize, and share protocols for the treatment of psychiatric patients exhibiting symptoms or testing positive for COVID-19. These contingency planning strategies included setting up temporary COVID-19 units and isolation rooms, assessing the use and availability of PPE, suspending visitation and adjusting patient daily schedules to encourage social distancing, and other actions to mitigate further contagion of the virus among staff and patients.

There was hospital unanimity around the struggle to find adequate shelter for homeless patients discharging from an inpatient unit – a barrier further exacerbated by COVID-19. Yale and Stamford hospitals emphasized the impact homelessness continues to have on ALOS and the need for alternative interventions. With a representative from the CT Department of Housing (DOH) participating on the call, there was opportunity to improve cross-system collaboration and explore viable solutions to support timely discharges for homeless Medicaid members. Subsequent to this meeting, Regional Network Managers were able to bridge connections between leaders from the CT DOH, local Coordinated Access Networks (CAN) and inpatient hospitals. As a result, three inpatient psychiatric hospitals: SVMC Holdings, St. Mary's, and Hartford Hospital re-engaged with their local CAN leadership to identify opportunities for strategic planning to support Medicaid homeless members discharging from an inpatient psychiatric unit. Hospitals also noted a decline in utilization of inpatient services for elderly members during the early stages of the pandemic, sighting fearfulness of increased exposure risk for contracting COVID-19. During these calls, providers were educated as to other CTBHP services, including ongoing Clinical Care Management technical assistance and Intensive Care Management (ICM)/Peer Support Specialist interventions to resolve discharge and connect to care barriers. Providers were also directed to the CTBHP member Warm Line; a resource for Medicaid members facing life challenges.

[8] Due to the lifting of PA (beginning in Q2) for inpatient psychiatric hospital utilization, inpatient detoxification hospital utilization (and select other levels of care), data reported on AMA rates, readmission rates, and connect-to-care cannot be reported, as the data may not represent the full volume of members who admitted to a hospital post discharge (for example: readmission rates can occur within 30 days post-discharge, which could have occurred in Q2, and not have been accurately captured using authorization data).

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

As hospitals continue to make adaptations to their internal operations in response to the evolving health crisis, Regional Network Managers will continue to use the CTBHP PAR and workgroup platforms to monitor the potential impact on quality and access to care, making recommendations for system enhancements accordingly.

In the first half of 2020, Regional Network Managers continued to share pharmacy claims data to highlight areas for improvement including the need to further support member's medication adherence after an inpatient stay through interventions such as use of long-acting injectables (LAIs). Hospitals with strong pharmacy partnerships tend to rank higher in their performance for this measure.

Best practices from Lawrence & Memorial and Griffin hospitals were shared to improve provider practice for hospitals falling below the statewide 14-day prescription fill rate average of 76.3% for Q1 '20. This is a 2.2% improvement from Q4 '19. Beyond maintaining positive relationships with community pharmacies, Middlesex Hospital strengthened connect to care efforts within their continuum of care to further improve performance. In Q1 '20 the Hospital of Central CT (HOCC), reported starting a "Bed to Med" program with the hospital-based pharmacy, a practice where the pharmacy will be available for patient consult during a warm hand off of the medications at the time of discharge. Beacon will monitor the impact of this practice.

The below chart on prescriptions filled by medication type within 14 days' post discharge during Q1 2020 indicates opportunity for improvement across all hospitals in the use of medications to treat opioid and alcohol use disorders.

Given the reported increase in use of substances among members admitted and the increase in prevalence of readmissions to withdrawal management (detox) post an inpatient psychiatric stay, a review of prescriptions by medication type was conducted to better understand the use of medications for Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD) by inpatient units. The below chart on prescriptions filled by medication type within 14 days' post discharge during Q1 2020 indicates opportunity for improvement across all hospitals in the use of medications to treat opioid and alcohol use disorders. This will be a continued area of focus as Regional Network Managers promote the practice of MOUD and medications for AUD during upcoming PAR and workgroup meetings.

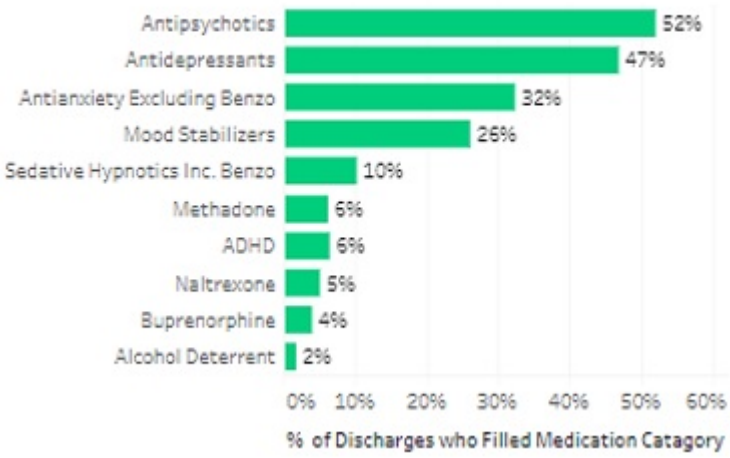


Figure 10: Prescriptions Filled by Medication Type within 14-days Post-Discharge

Recommendation 2: Implement and Monitor Impact of Modified Inpatient Bypass Program

The Bypass program, adopted in 2019, continued in 2020. Providers were informed in late January 2020 about their performance on metrics related to discharges from Q3 '19 and again in late April on discharges from Q4 '19. For a provider to qualify for Bypass, they must meet the 15% BID (twice a day) rate in the quarter being assessed.

Tier	Point Range	Requirements	Authorization Process
Tier 1	5 – 7	• At least 1 point must come from the Length of Stay Difference measure • 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

Figure 11: Bypass Tier Requirements and Authorization Process

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

In Q3 ’19, the overall results for the adult providers were as follows:

- 7-day readmission rate was 4.13%, a decrease from 4.73% in Q2 ’19
- Discharge form completion rate within 2 days was 93.57%, a decrease from 95.26% in Q2 ’19
- Percentage of BH ED visits within 7-days post IPF discharge was 11.73%, a decrease from 12.39% in Q2 ’19
- Statewide Predicted ALOS was 9.23 days compared to the Actual ALOS was 9.68 days (a difference of -0.45 days), and the ALOS increased slightly from 9.48 days in Q2 ’19
- Bed-tracking rate was 89.12%, a decrease from 93.07% in Q2 ’19

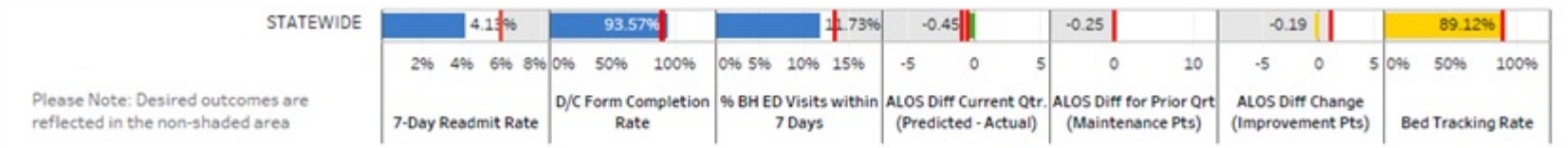


Figure 12: Statewide Bypass Adult Results for Q3 2019

Eleven providers changed tiers with five providers improving and moving from Tier 2 to Tier 1. The Q3 ‘19 adult bypass evaluation concluded with 12 providers on Tier 1 (50%), five providers on Tier 2 (21%), and the remaining seven providers on Tier 3 (29%).

The Q3 ‘19 adult bypass evaluation concluded with 12 providers on Tier 1 (50%), five providers on Tier 2 (21%), and the remaining seven providers on Tier 3 (29%).

In Q4 ’19, the overall results for the adult providers were as follows:

- 7-day readmission rate was 4.44%, a slight increase from 4.13% in Q3 ’19
- Discharge form completion rate within 2 days was 96.54%, an improvement from 93.57%
- Percentage of BH ED visits within 7-days was 12.81%, an increase from 11.73% in Q3 ’19
- The Predicted ALOS was 8.98 days compared to the Actual ALOS was 9.48 days (a difference of -0.5 days) and the ALOS was slightly down from the 9.68 days seen in Q3 ’19
- Bed-tracking rate was 90.62%, an improvement from 89.12% in Q3 ’19

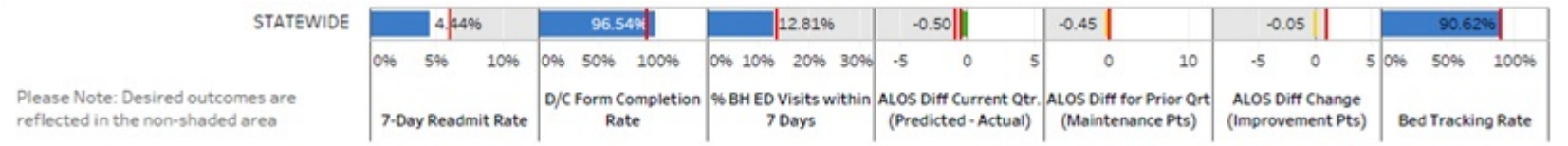


Figure 13: Statewide Bypass Adult Results for Q4 2019

Nine providers changed tiers, with four providers moving up tiers and five moving down tiers. The Q4 ‘19 adult bypass evaluation concluded with similar breakout over the tiers from the previous quarter with 12 providers on Tier 1 (50%), five on Tier 2 (21%), and the remaining seven on Tier 3 (29%).

Since inception of the new bypass structure, four hospitals have maintained a tier one rating (Bristol, Charlotte Hungerford, Lawrence & Memorial, and Griffin), other hospitals have varied in their status. However, Hartford Hospital and the Hospital of Central CT remain outliers within the Hartford Healthcare (HHC) system and across the broader provider network. As such, both hospitals have maintained a Tier 3 rating throughout the same identified period. To support HHC with attaining a more favorable bypass rating for these two hospitals, Regional Network Managers held post-ad hoc PAR meetings and provided supplemental data to aid providers’ leadership in their knowledge of the metrics and understanding their corresponding performance.

The PAR meetings continued to review the Bypass performance in more provider specific detail. For providers who did not meet the length of stay difference metric: data details for all members discharged by the provider during the assessment period were shared and providers were encouraged to review cases where the member stayed longer than the predicated length of stay so that those factors could be further evaluated and discussed at later meetings. In some cases, it was determined that enhanced communication was needed around discharge plans related to residential rehabilitation to ensure that accurate information was captured by the Clinical Care Manager. Clinical Care Managers continue to work with providers when there are delays to timely discharge. Length of stay continues to be monitored to assess the potential impact of the tiering system on length of stay.

Recommendation 3: Increase Focus on Changing Pathways
The Clinical team continued to request that the provider ensure a release of information is on file so that a substance use disorder (SUD) history can be shared, particularly in instances where it does not appear that the inpatient provider is aware of the history. The goal of sharing this information is to assist with improved discharge planning.

Beacon continued to work toward the expansion of the Changing Pathways Pilot and use of Medications for OUD (MOUD) across the inpatient provider network with an equal emphasis on promoting best practices for AUD. To achieve this goal, Regional Network Managers brokered connect to care meetings to improve access to outpatient MOUD post an inpatient psychiatric stay with providers providing MOUD across the state. Regional Network Managers also facilitated and maintained connections between hospitals and community-based MOUD providers, and provided education to inpatient psychiatric units on the benefits and positive outcomes of induction to MOUD and use of medications for AUD. St. Francis Hospital was the first inpatient psychiatric unit pilot for the expanded CTBHP Changing Pathways initiative, and, as of March 1, 2020, inductions onto MOUD started to occur with regularity.

The Peer Specialist continued to play a pivotal role in supporting this practice change at St. Francis.

The Peer Specialist continued to play a pivotal role in supporting this practice change at St. Francis. While embedded on the unit or through virtual communication, the Peer continued to function as a resource for improving member engagement and helped to facilitate and bridge members access to treatment post the inpatient stay. As a person in recovery, the Peer is available to support members choosing Medication Assisted Treatment (MAT) inductions by addressing barriers that negatively impact adherence to MAT 90-days after an inpatient stay. With the onset of COVID-19, Beacon's Peer Specialist pivoted to providing telephone support to members at each of the Changing Pathways locations. The plan is to re-integrate the Peer Specialist back on site as each location permits and travel restrictions are lifted. Throughout the remainder of 2020, Beacon will continue to provide education about MAT induction to members with co-occurring OUD and promote adoption of this evidence-based program by inpatient providers.

To further replicate the practice of induction on inpatient units, Beacon will partner with the Connecticut Hospital Association, in-state providers, and Boston Medical Center to organize a MOUD Education Forum that will discuss best practices and regulatory concerns regarding adoption of this best practice.

Lastly, the Adult ICMs effectively pivoted from field-based member support to telephone support as the COVID-19 crisis evolved. ICMs continued to provide members with emotional support, assuring connect to care, and coordinating services with providers. They assisted members in terms of social determinants of health, such as establishing and maintaining housing and food security. Beacon's liaison coordinated transportation needs with Veyo for members enrolled in MAT; ensuring the availability of transportation to maintain their recovery plans. ICMs and Peer Specialists continued to participate remotely in area CCT meetings to ensure coordinated efforts in matching members with the appropriate community supports. As the risks associated with the pandemic begin to lessen, adult ICMs are prepared to re-engage in community based member support based on need and member comfort.

Recommendation 4: Continue to Track Adults Awaiting Recommended Services and Address Identified Barriers
In 2020, calls have continued with the LMHAs to ensure that diversionary options are fully explored given the number of limited residential rehabilitation beds for meeting the needs of psychiatrically complex individuals with medical comorbidities. As social distancing guidelines required shifts in how many residential and inpatient programs operated, wait times were reported anecdotally to have grown, although, without the prior authorization data this information will not be evidenced in the PAR data. Moving forward Regional Network Managers will continue to monitor different services for which there is a reported delay in access which may contribute to increased lengths of stay in the inpatient psychiatric hospitals.

Inpatient Detoxification – Hospital Utilization

Utilization for inpatient detoxification in the hospital, excluding state facilities, remained consistent from 2019 into Q1 '20. As noted above, due to prior authorization being lifted in response to COVID-19, Q2 '20 data cannot be interpreted. Discharges decreased slightly by 2.5% from the end of 2019 to 905 discharges in Q1 '20. 691 unique members made up 884 discharges (78%) indicating repeat utilizers. Consistent with prior quarters, the majority of episodes (60.5%) lasted between 4-5 days and, due to the greater medical risks involved with alcohol detoxification, nearly 97% of discharges had a primary diagnosis of alcohol-related disorders. These trends appear driven largely by white males in the HUSKY D benefit group.

The vast majority of inpatient detoxification in hospital discharges came from HUSKY D members, a benefit group that has continued to increase since 2018 and is overrepresented with 57.5% of the adult non-dual Medicaid population and 88.7% of discharges. White members also continued to be disproportionally overrepresented as they made up 37.7% of the adult non-dual Medicaid population but 57.9% of discharges. Unknown race is the only group that increased in Q1 '20 by nearly 10% from Q4 '19 to comprise 32.4% of discharges. Black members had the highest ALOS (a 0.6-day increase since 2019) to 5.5 days in 2020. Inpatient detoxification in the hospital discharges remained stable among age groups. Males are also overrepresented, as they made up 44.9% of the adult Medicaid non-dual population and 71.7% of discharges. The following graph depicts this overrepresentation of males for this level of care; please note that the red line indicates the starting point of COVID-19's impact and the un-interpretable Q2 '20 data.

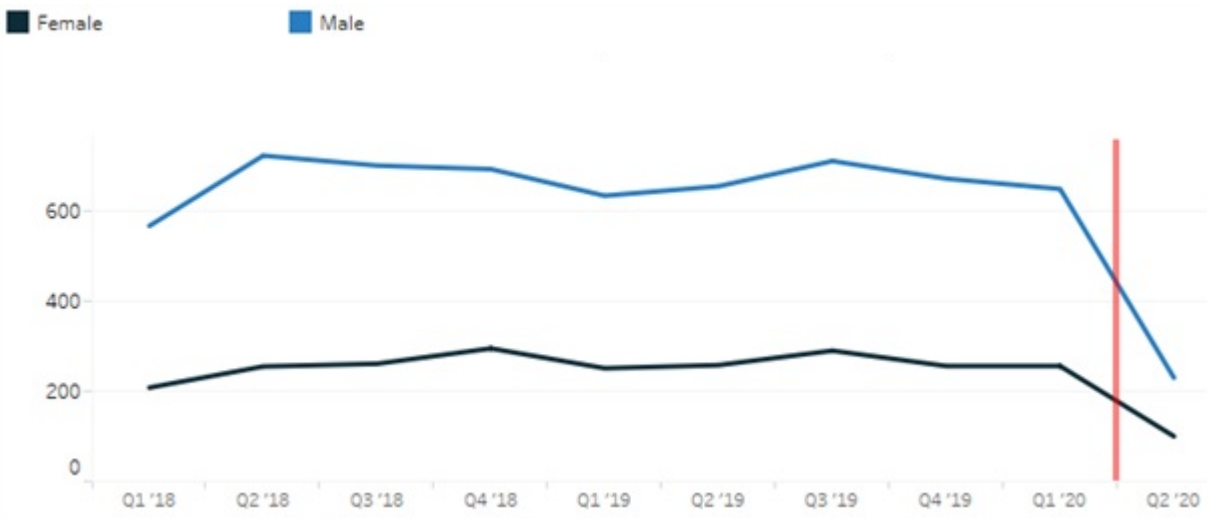


Figure 14: Inpatient Detoxification in the Hospital Utilization by Gender (Males Overrepresented)

Yale New Haven Hospital (167 discharges) and St. Francis Hospital (107 discharges) continued to be the top two providers for inpatient detoxification in the hospital, accounting for 31.5% of in-state discharges in Q1 '20. ALOS remained consistent for Q1 '20 for most providers except William Backus Hospital which increased by nearly 3 days to 8.2 days, but only reflects 17 discharges.

Recommendation 5: Continue Hospital-Based Detoxification PAR Program with High-Volume Facilities

PAR meetings convene annually with the two highest volume providers, St. Francis Hospital and Yale New Haven Hospital. In calendar year 2019, Beacon continued to support the establishment of referral pathways to outpatient treatment. While both Yale and St. Francis have entry points of service that are well networked to a variety of outpatient recovery providers, this knowledge has not yet been shared among all nursing and social work staff. This disconnect is complicated by the absence of a central detoxification unit. Members admitting for detox are triaged and placed across various hospital floors based on the medical need associated with the acute alcohol withdrawal. During the upcoming 2020 PAR meeting, Beacon will continue to discuss and explore strategies to improve discharge planning and connect to care efforts for ongoing MAT for AUD/OUD treatment.

While ALOS for inpatient detox freestanding remained steady in Q1 and Q2 of 2020 (4.3 and 4.1 days respectively), discharge volume began to drop off in Q2 '20 most likely due to the impact of COVID-19.

Inpatient Freestanding Detoxification – Utilization

Despite the COVID-19 pandemic, the authorization process was not altered for inpatient freestanding detoxification utilization, therefore, data reported in Q2 '20 can be viewed in its entirety. As noted in prior deliverables, inpatient freestanding detoxification serves a younger population than inpatient detoxification in the hospital, which is to be expected since the rate of medical comorbidities and severity of the disease tend to worsen with age. While ALOS for inpatient detox freestanding remained steady in Q1 and Q2 of 2020 (4.3 and 4.1 days respectively), discharge volume began to drop off in Q2 '20 most likely due to the impact of COVID-19.

Discharges dropped by 22% (604 discharges) from Q1 to Q2. Most discharges are White (52.9%), non-Hispanic (87%) males (73.5%) between the ages of 25-34 (31.9%) and enrolled in HUSKY D (88.1%) – consistent with demographic trends we have seen in the past. Similar to inpatient detoxification in the hospital, White males are overrepresented in this level of care compared to their composition in the overall Medicaid population. Alcohol-related disorders made up over half of discharges (56.1%, 1,537 discharges): a 4% increase compared to 2019. Opioid-related disorders accounted for 41% of discharges' primary diagnosis (1,122 discharges), a 3.4% decrease compared to 2019.

Figure 15: Inpatient Detoxification Freestanding, COVID-19 Impact on Utilization

Consistent with prior years, there were seven in-state inpatient freestanding detox providers, accounting for 4,880 discharges in Q1 and Q2 '20. The largest inpatient detox freestanding provider continued to be Intercommunity, Inc. with 1,159 discharges, approximately 24% of all inpatient freestanding detox discharges in 2020. Recovery Network of Programs continued to have the second highest number of discharges (753, or 15.4% of the total), followed by Stonington Behavioral Health (738, or 15.1% of the total). Due to treatment being protocol driven, there is little variance among providers for ALOS, which ranged from 3.6 days to 5 days in 2020. Providers with the lowest lengths of stay in Q1 and Q2 of 2020 – Cornell Scott-Hill Health (3.6 days), Intercommunity (3.9 days), Rushford Center (3.8 days), and Southeastern Council on Alcoholism (4.4 days) – all had high or above average rates of induction onto MOUD among the freestanding detox facilities. Cornell Scott-Hill Health had an induction rate of 51.4%, Southeastern Council on Alcoholism of 39.2%, Intercommunity at 36.3%, and Rushford at 27%.

Recommendation 6: Continue Freestanding Provider Workgroup Meetings and PAR Program with Focus on Changing Pathways Model
During Q1 and Q2 2020, Beacon continued to meet with freestanding detoxification facilities to collaboratively discuss PAR measures from the Withdrawal Management Tableau dashboard. Historically, the focus of these meetings has been to leverage data in support of highlighting the need for practice change in-line with the Changing Pathways model to address opioid use disorder. While Changing Pathways remains at the forefront of PAR meetings, efforts were shifted to focus on the large and growing alcohol use disorder population. The union of the PAR and workgroup meetings brought awareness to the increasing AUD population and encouraged advancements of evidence-based practices, such as the use of medications to effectively treat this population.

While implementation of the Changing Pathways model varies across all seven withdrawal management facilities, this practice change continues to demonstrate positive outcomes. In Q1 and Q2 2020, 574 members left against medical advice (21.5% of discharges); a decreasing trend compared to 2019 (22.2%) and 2018 (23.2%). Data deomonstrates a steady upward trend in induction rates, improved AMA (leaving against medical advice) rates, and connect-to-care rates for members who were inducted versus those who were detoxed to zero during a withdrawal management episode.

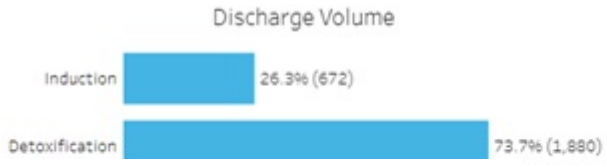


Figure 16: Freestanding Withdrawal Management Inpatient: Induction vs. Detoxification

Despite a significant decrease in volume of over 600 less discharges from Q1 to Q2 2020, MOUD inductions continued to be a consistent practice statewide with rates slightly increasing from 23.6% in Q3 and Q4 2019 to 26.3% in Q1 and Q2 2020. While all withdrawal management providers report MOUD education as being a key element in promoting this model, barriers continued to exist. Rushford reported seeing an increase in the young adult population with "fixed beliefs" around MOUD contributing to them choosing traditional detox protocols, despite rigorous MOUD education at various touchpoints throughout their treatment. Additionally, the Midwestern Connecticut Council of Alcoholism (MCCA) also reported seeing a younger cohort who are reportedly "not ready" to pursue treatment options in support of their recovery, therefore contributing to higher AMA rates across this population. Of note, providers were faced with unique challenges related to COVID-19 in Q2 2020 which may have contributed to a slight increase in AMA rates due to members' reluctance to engage in treatment in congregate care settings. As such, continued efforts focused on reducing stigma and providing education to family members who are included in the member's recovery plan should continue to help overcome these stated barriers with the young adult population.

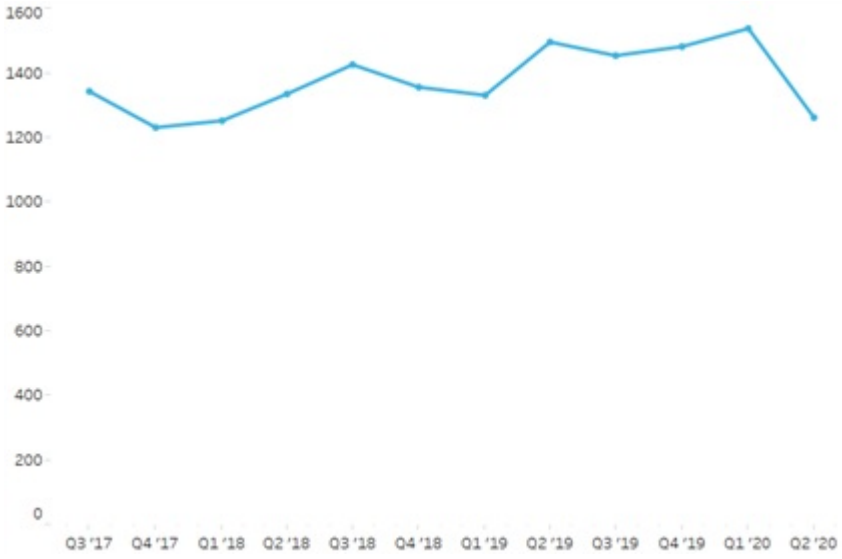


Figure 17: Discharges with a Primary Diagnosis of AUD Over Time

EXECUTIVE SUMMARY FOR ADULTS

Quarters 1 & 2: January-June 2020

Data suggests that there is a growing number of members with a primary AUD diagnosis across the provider network. In Q4 2019, the number of individuals with a primary AUD diagnosis was 54% which increased to 59.4% in Q2 2020. Continued focus on the increasing population of members with AUD is necessary, especially during the pandemic. The data outlines an area of opportunity to continue the promotion of medications for treating AUD as well as to identify improvements to discharge planning inclusive of care coordination efforts, which emphasize community supports in addition to traditional Alcoholics Anonymous (AA) resources.

Continued focus on the increasing population of members with AUD is necessary, especially during the pandemic.

With the lifting of prior authorizations, many of Beacon's Clinical Care Managers (CCMs) were able to pivot to support CTBHP members and providers in different ways. In order to better assist individuals who might benefit from an outreach call, Beacon identified those members who had been recently discharged from inpatient, withdrawal management programs, and intermediate level of care. Proactive outreach calls were made to members to see if they had been able to connect with services that were providing telehealth and/or if members needed support to find providers with whom they could connect. Assistance was also provided around accessing food and shelter, as needed. Beacon introduced its Warm Line during this time in order to provide assistance to members in connecting to alternative services, navigating existing services, and to lend a listening ear.

Beacon introduced its Warm Line during this time in order to provide assistance to members in connecting to alternative services, navigating existing services, and being a listening ear.

Initial Changing Pathway pilot providers, Rushford Center, and Intercommunity have successfully transitioned to the sustainability phase of this project according to Beacon's STEPS model for program implementations. This has been demonstrated by steady MAT inductions over Q1 and Q2 2020, ongoing reports of positive relationships with warm hand-off providers, and consistent education provided to internal staff to further acculturate this best practice within the programs. In May, a third provider site was added to the pilot: Southeastern Council on Alcoholism and Drug Dependence (SCADD). This important step was marked by a Changing Pathways kickoff meeting on May 12, 2020 including participation by SCADD, Rushford, Intercommunity, Beacon leadership, and the CTBHP state partners.

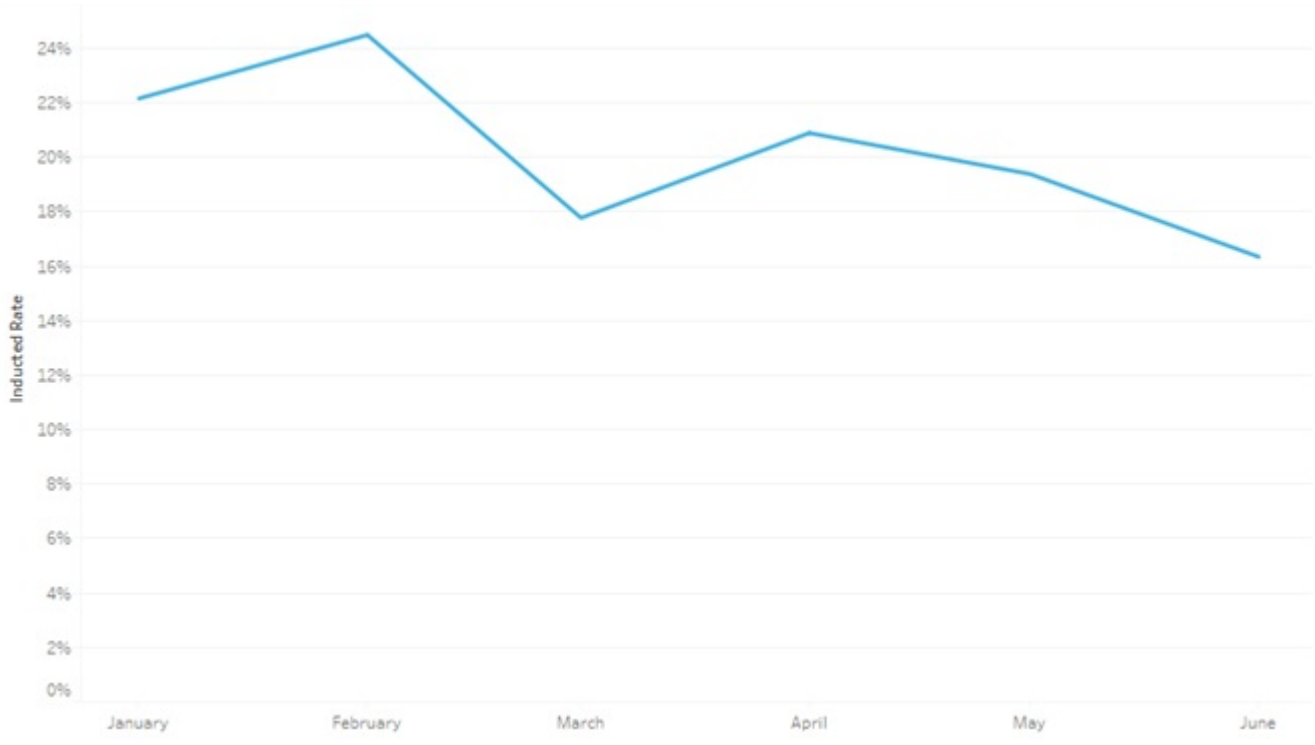


Figure 18: Changing Pathways MAT Induction Rates by Intercommunity and Rushford

Home Health Utilization[9]

In response to COVID-19, the state enabled Beacon to provide a 90-day extension for Home Health Services authorizations set to end at the end of April and May 2020, allowing analysis for Q2 2020. Total admissions (authorization initiations) for Medication Administration first decreased by 2.1% from the end of 2019 into Q1 '20 (595 admissions) before dropping in Q2 down 28.7% to 424 admissions, which we believe is correlated to COVID-19's impact on admission volume. Within dual benefit groups, HUSKY C (ABD/Other Dual) continued to have the most amount of Medicaid Administration admissions with 176 admissions in Q1 '20 and 108 admissions in Q2. For single benefit groups, HUSKY D (MLIA) continued to have the highest admission volume with 64.5% of the total in 2020. HUSKY C (ABD/Other Single) was the second largest single benefit group for home health admissions in 2020, with 26.7% of admissions before dropping to 25.5 in Q2 '20.

Admissions (authorization initiations) for Medication Administration first decreased by 2.1% from the end of 2019 into Q1 '20 (595 admissions) before dropping in Q2 down 28.7% to 424 admissions, which can be assumed as a result of COVID-19's impact on admission volume.

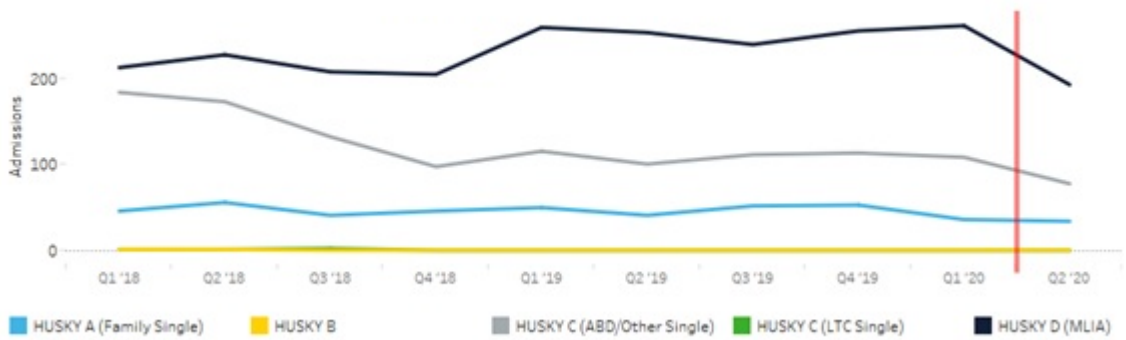


Figure 19: Home Health Utilization Medication Administration - Admissions

When looking at Medication Administration via claims data, instead of authorization-based utilization data (Bypass claims data is only available up to Q4 2019), the twice daily (BID rate) had been steadily increasing over time until Q4 '19 where it dropped from 15.5% in Q3 to 13% in Q4. The once daily (QD) administration rate remained higher than BID, but also decreased in Q3 and Q4 2019 from 38% in Q3 to 34% in Q4. The emergency department (ED) rate decreased 1.0% from 28.4% in Q3 '19 down to 27.4% in Q4 '19. The inpatient rate was similar with a slight decrease from 9.4% in Q2 to 8.5% in Q4 '19. The 23-hour observation rate increased 0.3% in Q3 '19 to 5.4 before decreasing in Q4 '19 to 4.9%.

Utilization for Start of Care/Resumption of Care for members including duals had 88 admissions in Q1 '20 and 167 in Q2 '20, similar to rates seen in 2019. However, the downward trend from 2018 continued with similar dips in admissions in Q1 in 2018 and 2019. Since Start of Care/Resumption of Care is authorized in conjunction with Medication Administration, the trends by benefit and age group are the same for both services. Similarly, as with previous submissions, Home Health Prompting, Home Health Aide, Med Box, and Med Tech requests for new authorizations have been exceptionally low with very few admissions each year.

Recommendation 7: Continue Home Health Bypass Program

Home Health providers received their Q3 and Q4 '19 data in early June as part of the Bypass program. When the Q3 '19 claims data ran in February to inform the providers performance for the Bypass, it was identified that the claims were missing for the month of August. It was also identified at that time that the reports needed to be updated to reflect current practice of how data are pulled from claims. Once the claims were recovered and the reports were updated, it was time for the Q4 '19 data to run; both quarters were shared with the providers and performance of the Bypass metrics were applied in June 2020 based on Q4 '19 claims data. For a provider to qualify for Bypass, their BID rate (twice a day) must be 20% or lower in the time period assessed. For a provider to qualify for Bypass Plus, they must meet the ED target rate of 32% in addition to meeting a BID rate of 15%. The administrative relief that providers receive is as follows:

- Bypass: Initial Requests - 4 month authorizations and Concurrent - 3 month authorizations
- Bypass Plus: Initial Requests - 4 month authorizations and Concurrent - 4 month authorizations

In Q3 '19, the statewide results were as follows:

- The BID rate was 15.7%, a decrease from 15.8% in Q2 '19
- The ED rate was 28.4%, a decrease from 29.5% in Q2 '19
- The QD rate was 38.3%, a decrease from 39.1% in Q2 '19

[9] Note: DSS COVID-19 Bulletin 23 states that Home Health Services authorizations set to end at the end of April and May 2020 will be identified by CTBHP and given a 90-day extension from the date the current authorization is set to end, allowing analysis for Q2'2020. Find more information at: https://www.ctdssmap.com/CTPortal/

Five of the 16 providers are on Bypass Plus (31.3%), while six are on Bypass (37.5%). The evaluation of Q3 '19 claims data concluded with 12 of the 16 (75.0%) providers receiving the administrative benefits provided by the Bypass program.

In Q4 '19, the statewide results were as follows:

- The BID rate was 13.0%, a decrease from 15.7% in Q3 '19
- The ED rate was 27.4%, a decrease from 28.4% in Q3 '19
- The QD rate was 34.1%, a decrease from 38.3% in Q3 '19

Q4 '19 claims data concluded with 14 of the 16 (87.5%) providers receiving the administrative benefits provided by the Bypass program, which was a significant improvement.

Seven of the 16 providers are on Bypass Plus (43.8%) and five are on Bypass (31.3%). The evaluation of Q4 '19 claims data concluded with 14 of the 16 (87.5%) providers receiving the administrative benefits provided by the Bypass program, which was a significant improvement.

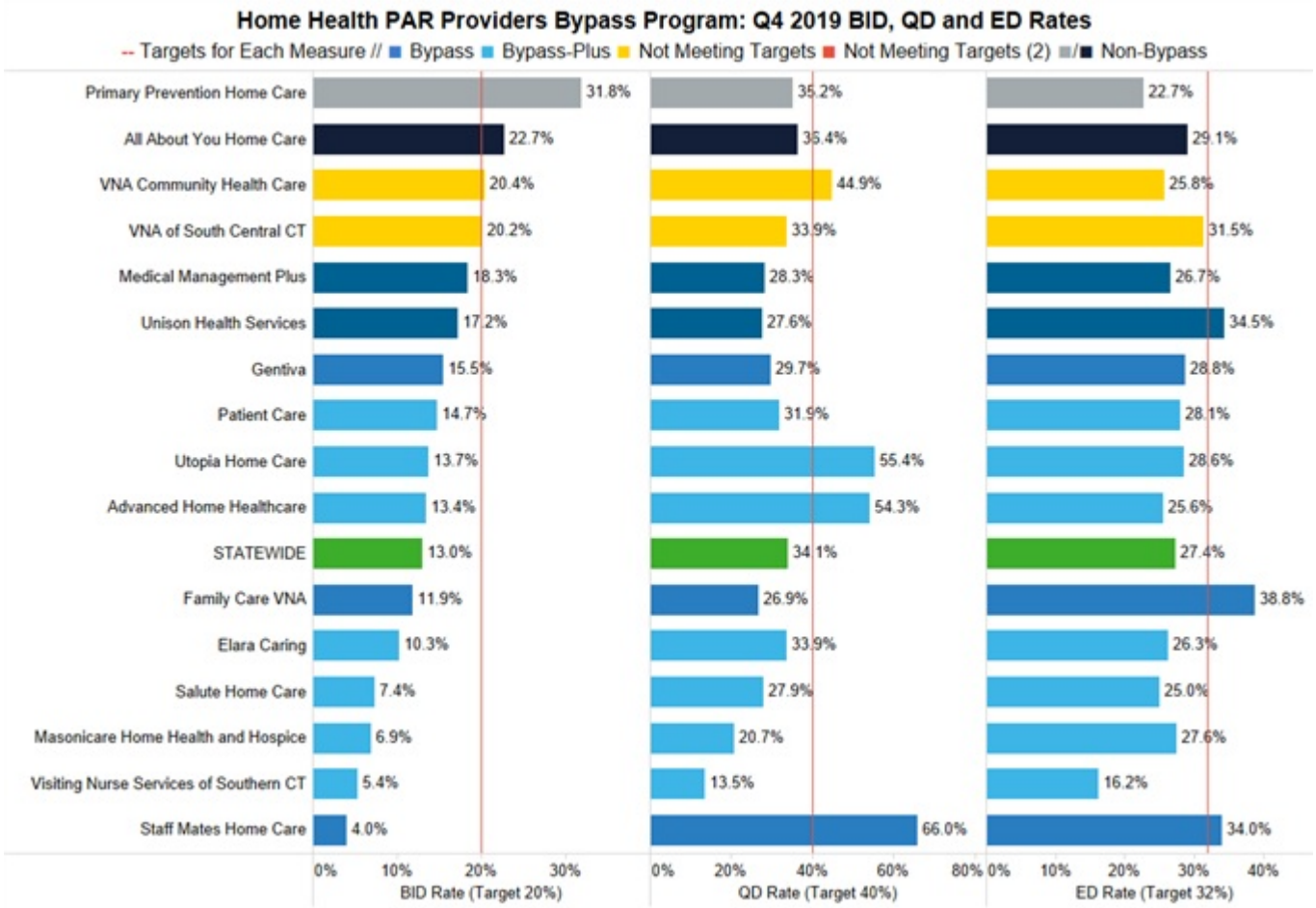


Figure 20: Q4 2019 Home Health Bypass BID, QD, and ED Rates

With the BID rate starting to trend back down in Q2 '19 and continuing in Q3 and Q4 2019, Beacon decided not to make any modifications to the Bypass program at this time as providers are making adjustments as needed. The Clinical Care Managers continue to work closely with provider to ensure that members receiving a high intensity of services are being regularly evaluated and assessed to determine whether or not the services can be delivered at a reduced frequency.

A Home Health provider meeting was held in mid-June where the Bypass data was shared as well as an extensive discussion about the impacts of COVID-19 on the industry. Providers gave support to one another through the sharing of best practices and highlighting opportunities for improvement. Providers also indicated that services dramatically changed with the onset of the pandemic with members reluctant to have the nurses coming into their homes. Telehealth was utilized as an alternative to going in the home when possible. Obtaining PPE was a challenge for all providers in the early days of the pandemic but by the time the meeting took place, most were able to secure PPE and were beginning to return to see members in their homes where necessary.

Lower Level of Care Utilization

Outpatient admissions continued to represent the vast majority (81% in Q1 '20) of all non-dual adult admissions to lower levels of care; a slight increase of 6.5%) from the end of 2019. Intensive outpatient (IOP) had the second highest number of admissions (4,508) and appeared to continue a slight decreasing trend since Q1 '19. Methadone maintenance saw a 14.6% increase from Q4 '19 with nearly 60% of total admissions. Partial hospitalization continued to decrease slightly since Q2 '19 from 47% of admissions to 39.1% in Q1 '20.

Recommendation 8: Continue to Explore Methods of Improving the Access, Quality, and Outcomes of Outpatient Clinic-Based Services and ECCs

Of all Medicaid funded behavioral health services, outpatient clinic services are the most often utilized and are a foundational element of the behavioral health service system. Year over year trends show continued growth in this level of care which is often the initial entry point for behavioral health service users. Although the cost per session of outpatient care is relatively low, outpatient has the highest PMPM rate of all behavioral health services. The previous study by the CTBHP (Plant, 2015) has demonstrated challenges with initial engagement, racial and ethnic disparities in access, and a paucity of data regarding outcomes attained. The ECC program appears to have been successful at improving initial access to care but is widely regarding as offering questionable additional benefit despite significant effort and resources devoted to its continuation.

Although the cost per session of outpatient care is relatively low, outpatient has the highest PMPM rate of all behavioral health services.

Various strategies to improve access, quality, and outcomes of outpatient clinics in general and ECC's in particular have been recommended in the past, including value-based care, use of measurement-based care, and the implementation of quality metrics for outpatient/ECC service. It is recommended that Beacon and the state partners engage in a reevaluation of recommended strategies towards the design of a pilot to achieve the goals described above. Once an initial plan for a meaningful and feasible pilot is developed, Beacon could begin the work of introducing the project to stakeholders, possibly through a performance target in 2021.

Recommendation 9: Develop an Intensive Outpatient Provider Analysis and Reporting (PAR) Program

In Q1 and Q2 '20, Beacon successfully launched the Intensive Outpatient (IOP) Provider Analysis & Reporting Program. Initial discussions were based on mutually agreed-upon quality metrics embedded within the new IOP Tableau dashboard. Beacon's Regional Network Managers, Clinical, and Medical Affairs used these introductory meetings as a foundational first step to gain a system-wide perspective of the IOP level of care, understand the vast variation in performance and begin to improve provider practice across the IOP network.

There are 68 IOP adult programs statewide. Of those, 39 facilities comprise the PAR program and account for nearly the total volume of care delivered. In 2019, adult PAR providers had a total of 17,237 episodes. MCCA accounted for 2,116 of those episodes, followed by Stonington Behavioral Health with 1,411, comparatively.

Across all quality metrics, treatment engagement demonstrates the widest variation in care. This performance metric is measured by the number of visits that occur within the ideal range of nine to 16 visits, as defined by Beacon's IOP clinical study and also includes a recommended length of stay of 22 to 35 days. Beacon's 2015 clinical study of IOP programs demonstrated that this range of nine to 16 visits by a Medicaid member statistically correlates with a corresponding lower rate of ED and higher level of care visits. 66.7% of IOP PAR programs fell within the target range for number of visits, the greatest variation was in the number of days it took to complete those visits: the average length of an episode of IOP care ranged from 20.5 days (Intercommunity) to 79.7 days (Hartford Hospital).

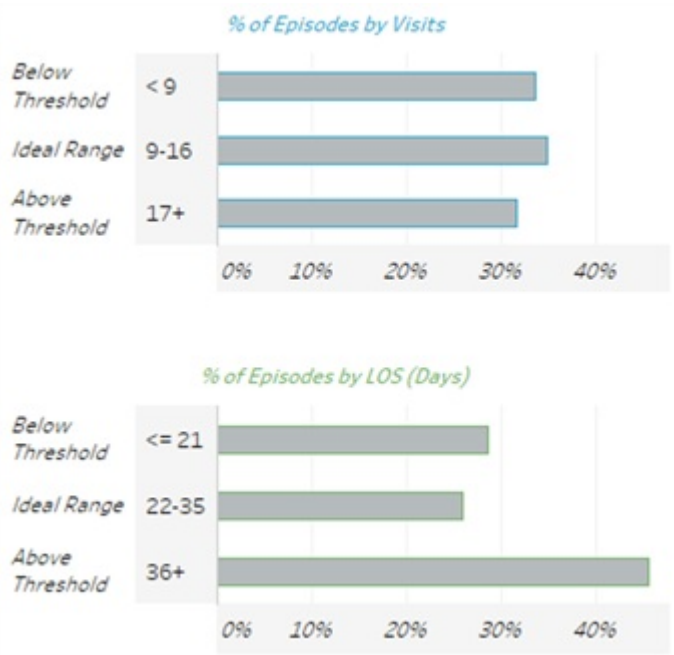


Figure 21: Percent of IOP Episodes by Visits and Days

While Beacon's retrospective reviews, IOP clinical study, data analytics, and utilization management (UM) experience demonstrated the wide variation in service delivery for the IOP level of care, PAR discussions helped to shed light on potential underlying contributing factors to this variation: increase in member acuity, differences between hospital and community based facilities, mental health and substance use disorder programs, specialty tracks, and the availability of case management services.

Accordingly, behavioral health emergency department and higher level of care visits are similarly impacted and show patterns of program variability in utilization during and post an IOP episode (seven and 30 days). There was agreement among IOP programs that outcomes related to BH ED visits are highly dependent upon relationships between the IOP provider and the BH ED provider. ED communication is typically enhanced for IOP providers that operate within a hospital continuum and share electronic health records access. This interoperability supports a seamless transition for members returning to outpatient or admitting to inpatient care. Conversely, community-based facilities can be disadvantaged by the absence of this type of system connectivity, especially when competing clinical opinions emerge between ED and IOP practitioners. This dynamic is mitigated for agencies opting into EPIC's "care everywhere" system, a platform that allows providers access to up-to date health information, improving patient flow between levels of care.

For the metrics measuring higher levels of care (HLOC) (inpatient & PHP) for admissions during and after an IOP episode, the statewide averages trend quite low in comparison to BH ED utilization. Performance for this metric range from 0% (Farrell Treatment Center) to 8.9% (Hartford Hospital) of individuals admitting to a HLOC during an IOP episode. Admission to inpatient psychiatric care was the most common type of HLOC admission seen during an IOP episode: 1.1% of all IOP episodes had an admission to an inpatient psychiatric hospital during the episode.[10] Feedback from providers during IOP PAR meetings indicated that in addition to low HLOC rates, providers consider strong engagement, medication adherence, and success in harm-reduction strategies as markers of a successful IOP episode. Beacon will continue to use PAR and workgroup platforms to shape practice and promote continuity of care across the IOP network.

	Percent by Episode	Sum of Episodes
Hartford Hospital	8.9%	26
Farrell Treatment Center	0.0%	0

(Red: Statewide Average)

Figure 22: Percent of Adult Members Admitting to HLOC during IOP Episode

Enhanced Care Clinics (ECCs)

Demographic information was added to this data for the first time in this submission, enabling demographic comparisons to be drawn from membership utilization. The percent of adult registration volume from ECCs remained steady through Q1 '20 at 7.2%; whereas non-ECC adult registrations increased 4.4% from the end of 2019 up to 92.8% of total registrations. The largest age group served by ECCs in Q1 '20 were 25-34 year olds (31%), however this age group has been decreasing since Q2 '19 while 35-44 year olds increased (23.5%). In Q1 '20, gender is nearly evenly split with females making up slightly higher registration volume for ECCs at 50.2%. White members continued to be the largest racial group for ECCs at nearly 50% followed by Unknown (36%), and Black members (14%). Hispanic ethnicity made up 18.6% of ECC registrations. English was the primary language for both ECC (94.9%) and Non-ECC registrations (93.7%), followed by Spanish at 5.0% for ECCs and 5.9% for Non-ECCs.

The 95% access standard was consistently met for all three access types for adult ECCs in Q1 '20 (Routine at 99.5%, Emergent at 100%, and Urgent at 100%).

Recommendation 10: Reassess ECC initiative

As noted above it is recommended that the ECC initiative be reassessed in the context of a broader re-envisioning of the outpatient clinic system of which ECCs are part.

[10] Please note: members must be continuously eligible to be counted during these time periods.

UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2: January-June 2020 - Submitted September 1, 2020

Areas of Focus:

Membership
Membership Volume & Demographics
DCF & Non-DCF, Benefit Groups

Inpatient Psychiatric Facility
Inpatient Detoxification Hospital-Based
Inpatient Detoxification Freestanding
Discharge Volume & Average Length of Stay
Admits/1,000 & Days/1,000

Home Health Services
Admits/1,000, Medication Administration
Utilization Rates

Lower Levels of Care
Admissions & Admits/1,000

Outpatient Enhanced Care Clinics (ECC)
Registration Volume & Access Standards

New Features in 2020:

Two additional demographic fields: Hispanic Ethnicity and Primary Language
"Viz" in the tooltips and additional detail
Increased interactivity
Demographic breakout in ECC dashboards
Ability to show or hide filters

Adult Medicaid Membership

Total Membership Volume

Select Time Period
2020, Q2

Membership Type
Adult Members without ..

✔ In Q2 '20, there was a total of 500,144 Adult Members without Duals

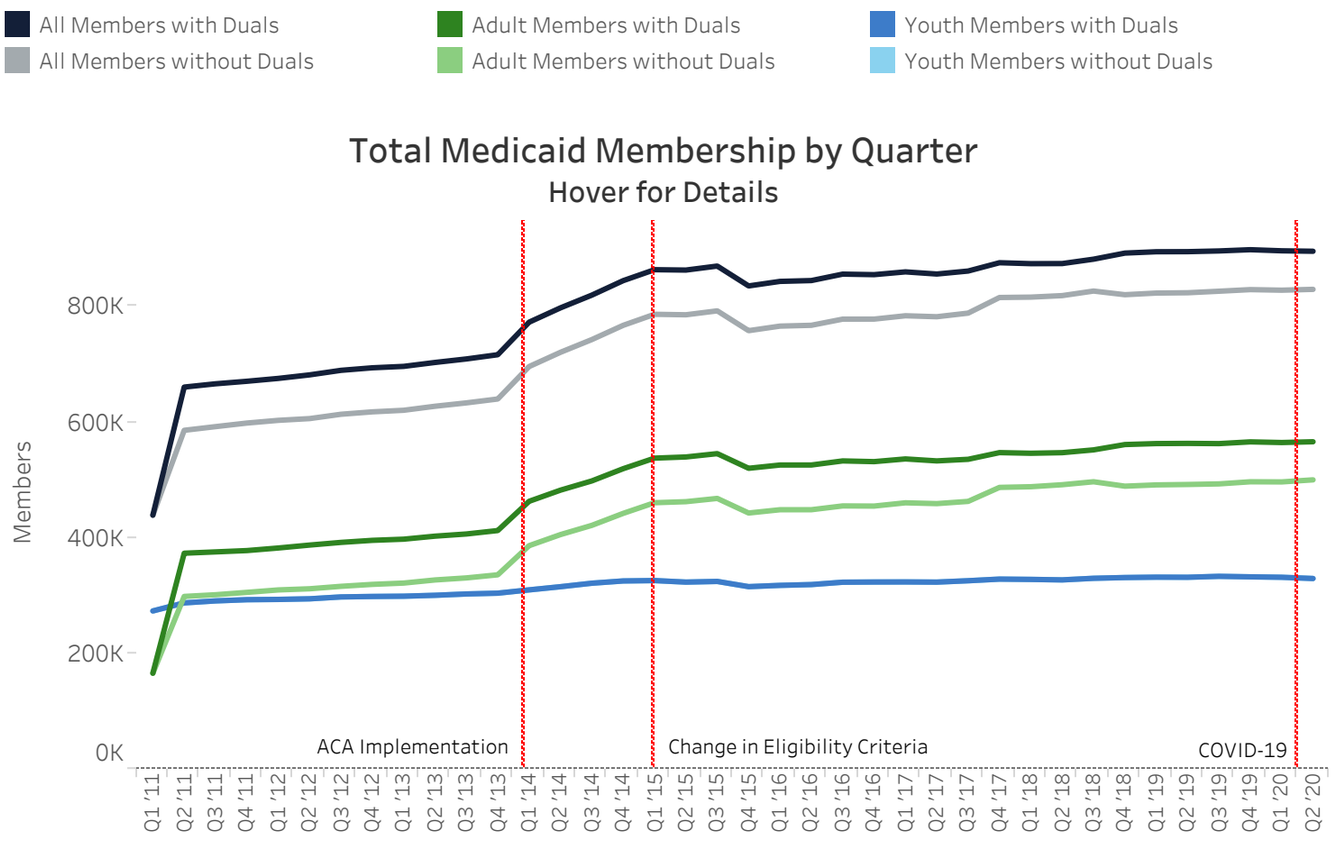
✔ Members ages 25 - 34 were the largest single age group at 27.0% (135,214).

✔ Females made up the majority of the Adult Members without Duals population at 55.2% (276,079).

✔ The largest racial group was Unknown, which was 41.8% of the population (209,063).

✔ Non-Hispanic members made up the majority of the population at 80.9% (404,405).

✔ The Primary language for the majority of members (87.8%) was English.



		Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20
All Members	All Members with Duals	874,064	874,237	881,832	892,361	894,680	894,821	896,060	898,224	896,304	895,539
	All Members without Duals	816,183	818,806	826,701	820,356	823,214	823,742	826,404	829,185	828,191	829,634
	All Members Duals Only	59,629	57,935	73,037	73,113	72,013	71,626	70,205	69,909	68,612	66,242
Adults	Adult Members with Duals	546,122	547,138	551,975	561,200	562,877	563,196	562,801	565,844	564,684	566,045
	Adult Members without Duals	488,245	491,710	496,846	489,197	491,412	492,118	493,147	496,807	496,575	500,144
	Adult Members Duals Only	59,625	57,931	73,033	73,110	72,011	71,624	70,203	69,906	68,608	66,238
Youth	Youth Members with Duals	327,942	327,099	329,857	331,161	331,803	331,625	333,259	332,380	331,620	329,494
	Youth Members without Duals	327,938	327,096	329,855	331,159	331,802	331,624	333,257	332,378	331,616	329,490
	Youth Members Duals Only	4	4	4	3	2	2	2	3	4	4

Methodology

Membership Count Methodology

Dual Eligibility Information

Adult Medicaid Membership

Demographic Composition

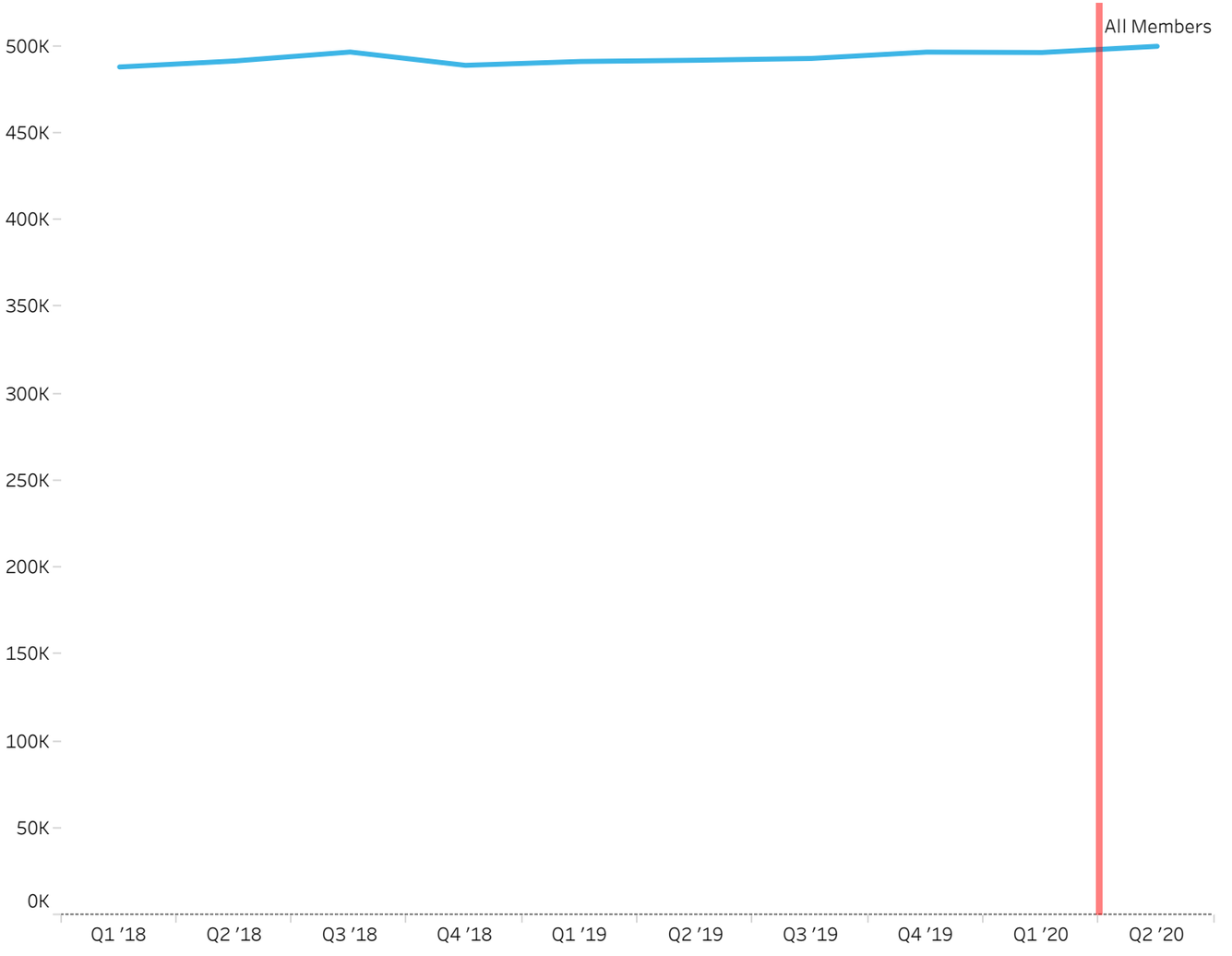
Select Demographic
All Members

Total Members or Percent of Total
Total Members

Select Benefit Type
Adult Members without Duals

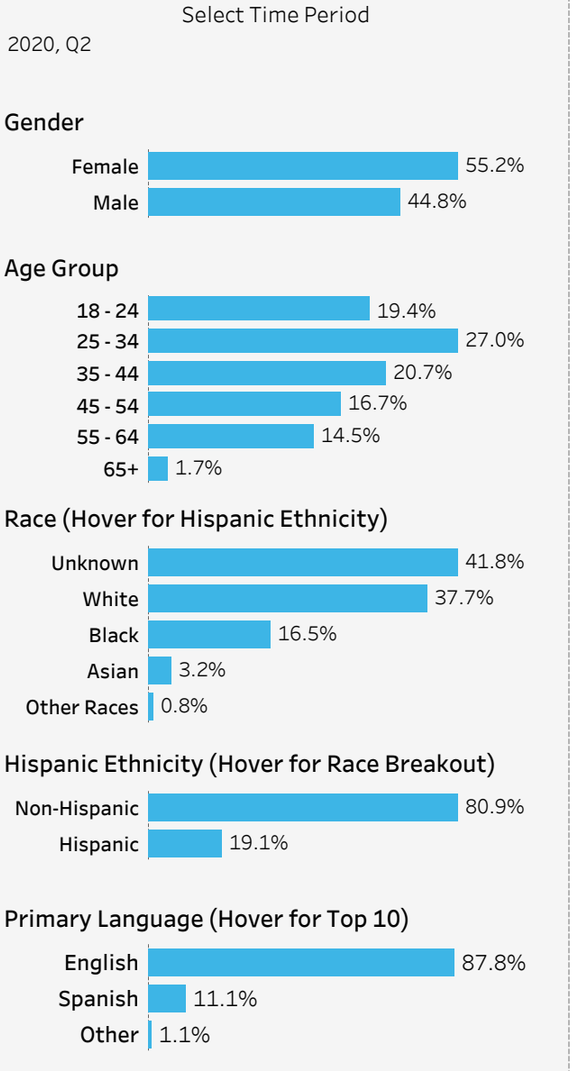
Total Members Over Time by All Members

Adult Members without Duals



Note: The red line indicates the start of the impact of COVID-19.

Select Time Period
2020, Q2



Adult Medicaid Membership

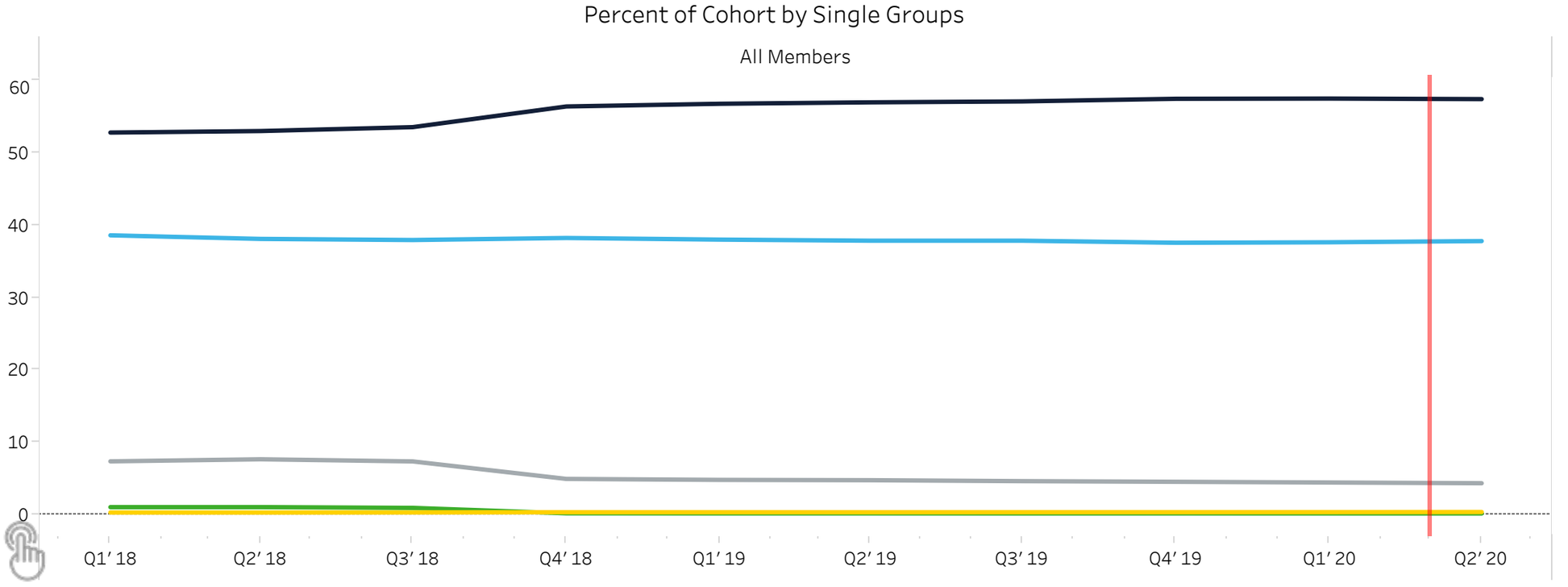
Membership by Benefit Group

Select Group Type
Single Groups

Select Individual Types
All

Choose Demographic
All Members

Total Members or Percent of Total
Percent of Cohort



	Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20
HUSKY A (Family Single)	190,344	188,772	190,813	188,706	188,431	187,857	188,325	188,137	188,436	189,630
HUSKY B	1,294	1,279	1,363	1,478	1,490	1,466	1,520	1,544	1,583	1,661
HUSKY C (ABD/Other Single)	36,173	37,763	36,846	24,219	23,658	23,464	22,874	22,578	22,073	21,611
HUSKY C (LTC Single)	4,939	4,979	4,531	735	676	686	653	677	662	647
HUSKY D (MLIA)	260,428	262,690	269,321	278,487	281,604	282,840	284,181	287,853	287,961	288,142

Note: The red line indicates the start of the impact of COVID-19.

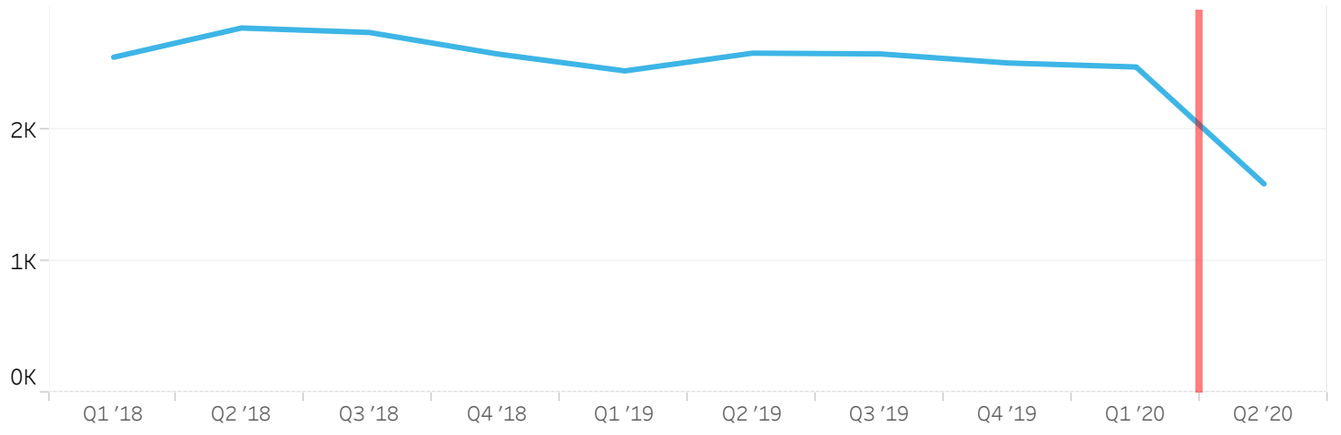
Adult Inpatient Psychiatric Facility

Excluding State Facilities

Service Class	Membership Type	Choose Demographic	# or % of Discharges	In/Out-of-State/PAR	Add or Remove Providers
Inpatient Psychiatric Facili..	Single Benefit Groups	All Members	Discharges	All	All

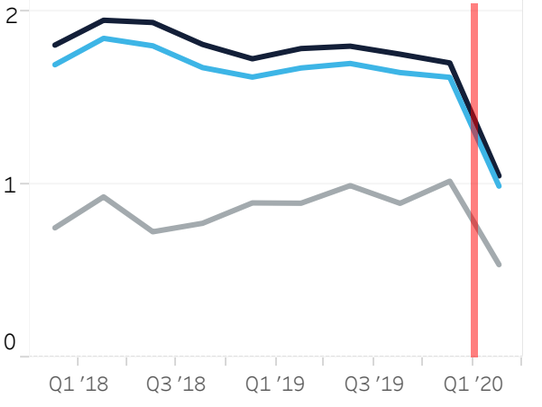
All Members

Inpatient Psychiatric Facility-(Excluding State Facilities) Discharges

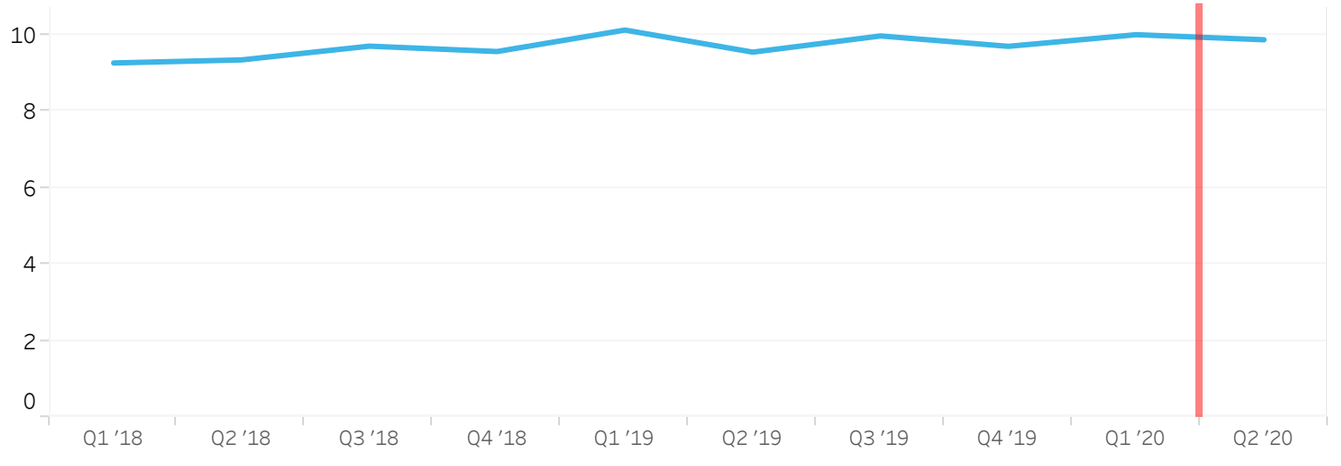


Inpatient Psychiatric Facility-(Excluding State Facilities) Admits/1,000

With Duals ● Without Duals ● Duals Only

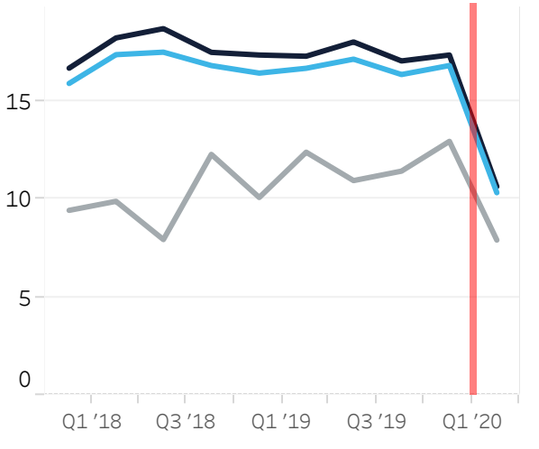


Inpatient Psychiatric Facility-(Excluding State Facilities) Average Length of Stay (ALOS)



Inpatient Psychiatric Facility-(Excluding State Facilities) Days/1,000

With Duals ● Without Duals ● Duals Only



Note: The red line indicates the start of the impact of COVID-19.

Adult Inpatient Psychiatric Facility

Provider Comparison

Service Class
Inpatient Psychiatric Facility

In/Out-of-State/PAR
In-State, PAR

Add/Remove Providers
Multiple values

Group Type
All Members without Duals

	Discharges										ALOS									
	Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20	Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20
BRIDGEPORT HOSPITALINC	128	121	133	124	138	140	139	135	139	24	7.9	9.0	8.7	7.3	8.8	7.9	8.9	7.1	7.7	11.3
BRISTOL HOSPITAL INC	92	98	96	88	68	90	70	77	74	87	6.5	9.2	7.0	7.3	9.9	7.5	8.1	7.9	9.1	8.8
CHARLOTTE HUNGERFORDHOSPITAL	64	42	45	69	57	76	82	84	80	71	5.3	7.0	8.6	7.3	8.8	7.6	8.2	8.0	8.8	8.1
DANBURY HOSPITAL	55	57	73	63	81	78	54	43	49	10	8.7	10.1	10.2	6.1	8.4	8.8	5.6	7.7	7.7	10.8
DAY KIMBALL HOSPITAL	60	65	66	77	54	79	69	62	60	14	6.1	5.2	6.5	5.5	5.9	5.3	5.2	5.6	6.6	5.4
GRIFFIN HOSPITAL	89	102	101	82	82	76	76	83	81	78	8.3	6.6	7.1	7.9	5.9	8.7	9.0	8.0	8.2	7.5
HARTFORD HOSPITAL	307	319	321	293	298	279	266	299	324	246	11.7	11.2	11.3	11.5	11.6	12.1	13.5	12.4	12.2	11.8
HOSPITAL OF CENTRALCT	90	90	92	98	97	140	131	102	107	39	11.7	16.3	15.9	13.3	13.3	10.9	11.2	11.4	12.7	15.4
JOHNSON MEMORIAL HOSPITAL	53	73	80	73	95	88	81	63	77	10	7.0	6.7	7.4	7.0	6.3	7.5	7.5	7.2	7.6	8.5
LAWRENCE & MEMORIALHOSPITAL	89	96	103	85	81	83	91	85	87	75	8.5	6.2	7.0	7.3	7.3	9.0	7.1	7.4	8.0	7.1
MIDDLESEX HOSPITAL	100	97	117	99	89	87	97	101	95	23	7.8	7.8	6.2	7.4	7.7	7.1	6.4	7.0	7.0	9.7
NATCHAUG HOSPITAL INC	12	22	16	14	18	26	16	18	16	19	9.8	11.4	10.4	8.6	9.3	11.7	11.6	7.8	8.8	12.4
NORWALK HOSPITAL ASSOCIATION	52	53	49	31	40	42	47	41	35	31	7.6	5.5	8.2	10.1	7.5	4.4	6.9	6.7	6.2	8.2
PROSPECT MANCHESTERHOSP INC	127	142	159	156	107	131	128	114	117	25	7.6	7.3	7.7	7.9	8.5	9.6	7.5	9.9	9.9	10.0
PROSPECT WATERBURYINC	98	125	128	123	110	103	131	129	122	133	11.8	10.8	10.0	11.3	14.7	12.1	11.5	14.2	12.0	10.0
ST FRANCIS HOSPITAL& MEDICAL CTR	168	187	179	198	173	176	197	200	189	168	8.5	7.8	8.5	9.1	8.5	7.8	8.0	8.2	8.9	8.1
ST. MARYS HOSPITALINC	82	92	95	91	59	90	87	94	75	78	6.8	7.2	8.0	7.3	9.8	7.0	6.0	7.0	7.4	6.8
STAMFORD HOSPITAL	69	75	77	83	60	74	85	64	60	55	10.4	8.4	13.5	10.0	10.6	10.5	9.1	10.7	7.9	8.6
STATE OF CONNECTICUTJ. D. HOSPITAL	54	68	59	69	56	66	53	56	54	12	6.4	6.4	9.0	9.5	9.4	9.0	8.4	7.4	9.9	7.3
SVMC HOLDINGS, INC.	278	276	265	230	230	245	203	201	220	45	9.5	8.8	10.0	8.9	9.7	9.3	10.3	9.5	9.8	12.0
WILLIAM W. BACKUS HOSPITAL, THE	77	97	73	79	80	71	60	65	63	42	8.9	9.8	9.1	8.6	8.8	8.6	10.3	9.9	9.7	10.1
YALE NEW HAVEN HOSPITAL	328	396	347	296	313	278	340	321	308	261	11.4	12.5	11.6	13.7	13.2	13.0	14.7	12.2	13.4	11.5
ALL PROVIDERS	2,472	2,693	2,674	2,521	2,386	2,518	2,503	2,437	2,432	1,546	9.2	9.4	9.5	9.4	10.0	9.5	9.9	9.6	10.0	9.8

Discharges
10 — 396

Average Length of Stay (Days)
4.4 — 16.3

Note: The red line indicates the start of the impact of COVID-19.

Home Health Services

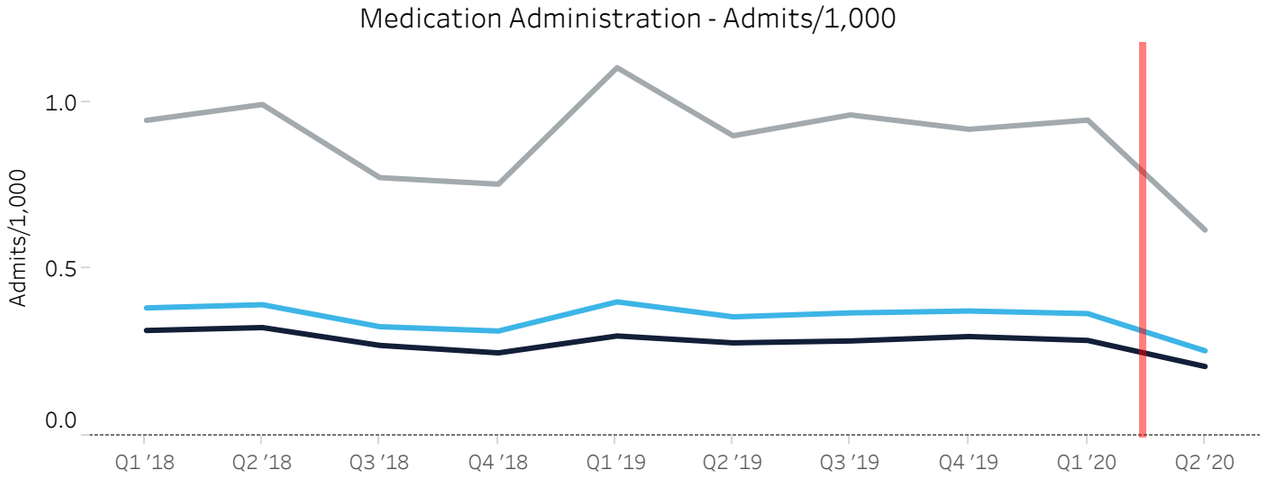
Admissions & Admits/1,000

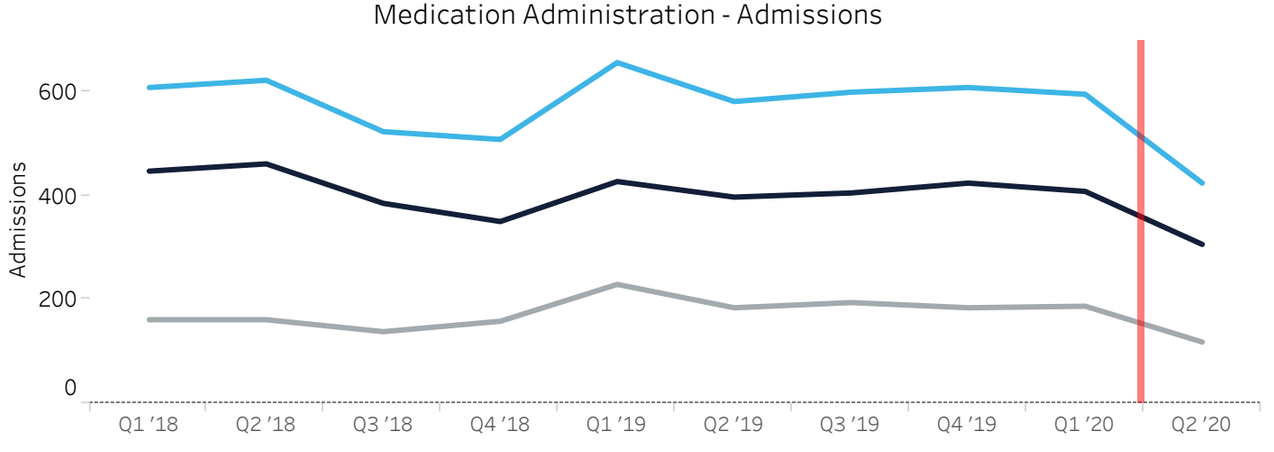
Group Type
Totals Group

Select Benefit Groups
All

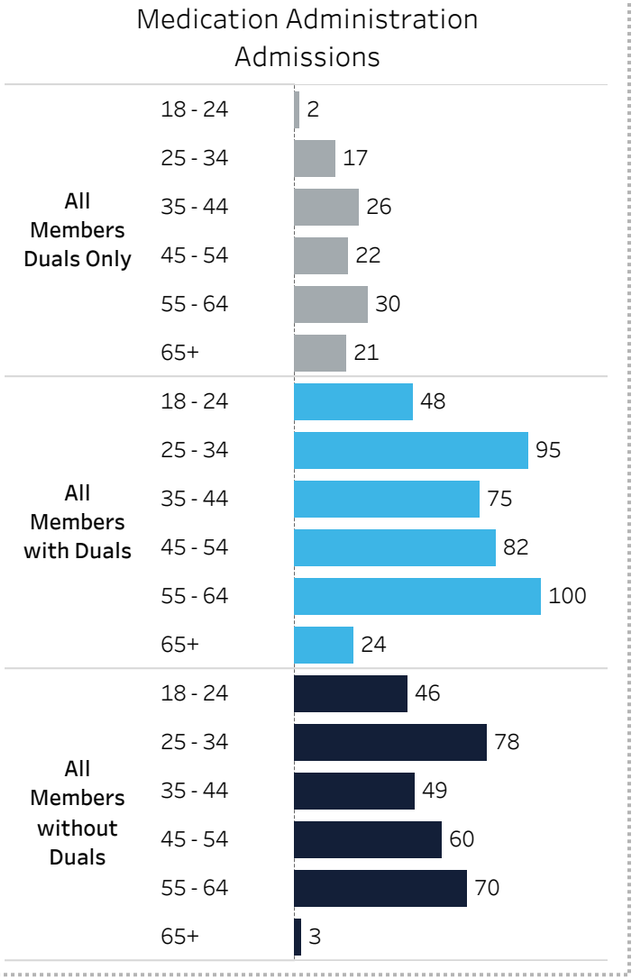
Service Class
Medication Administration

All Members Duals Only
All Members with Duals
All Members without Duals





Select Time Period
2020, Q2

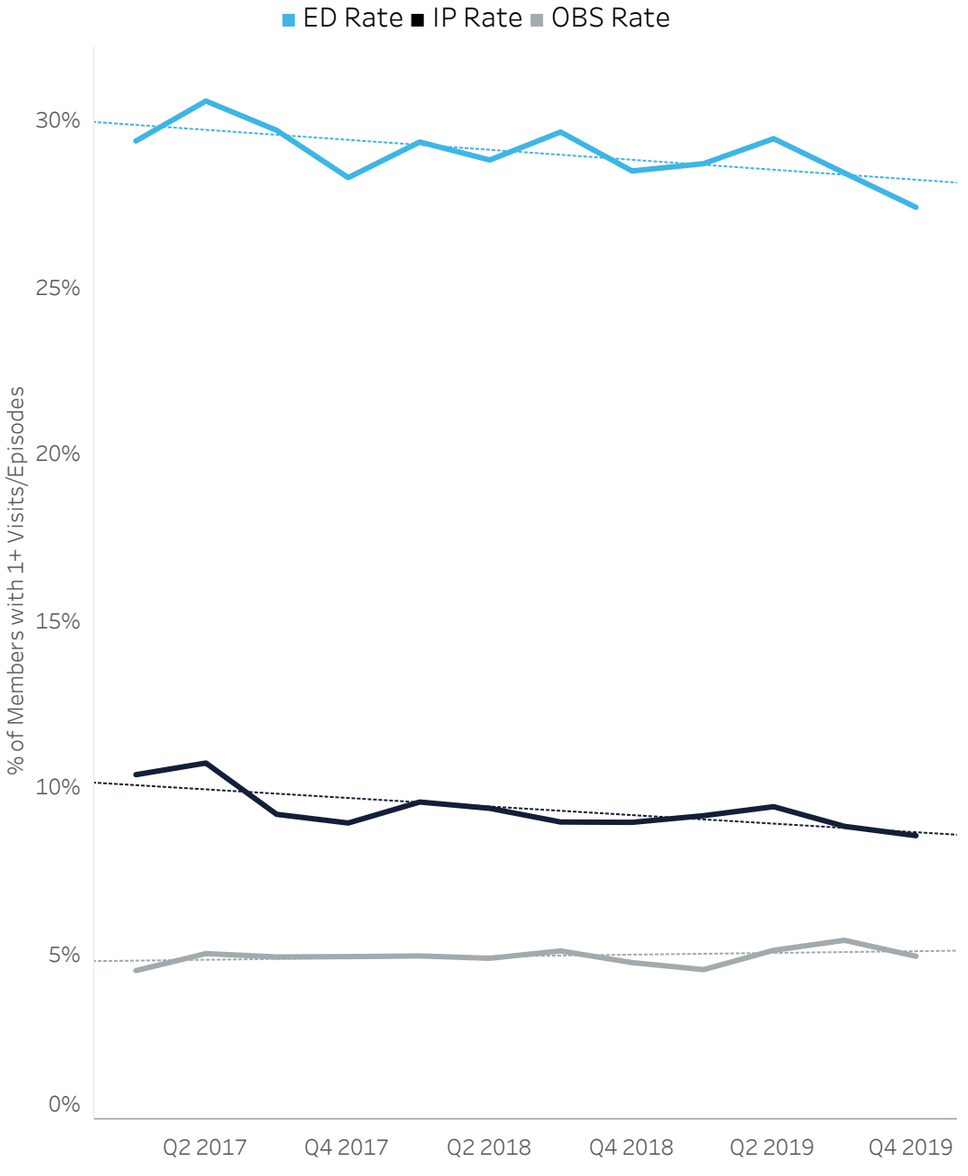


Note: The red line indicates the start of the impact of COVID-19.

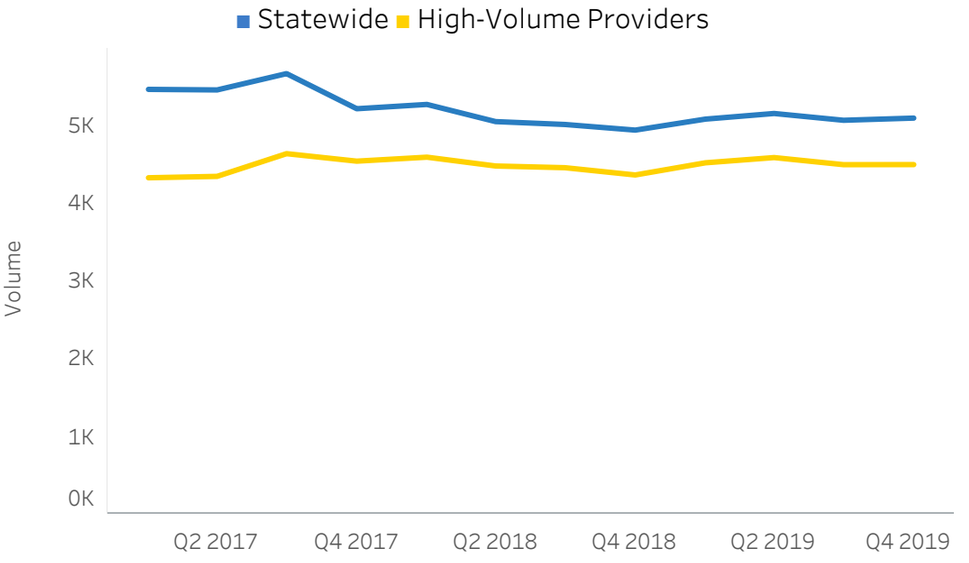
Home Health Services

Medication Administration & Utilization Claims

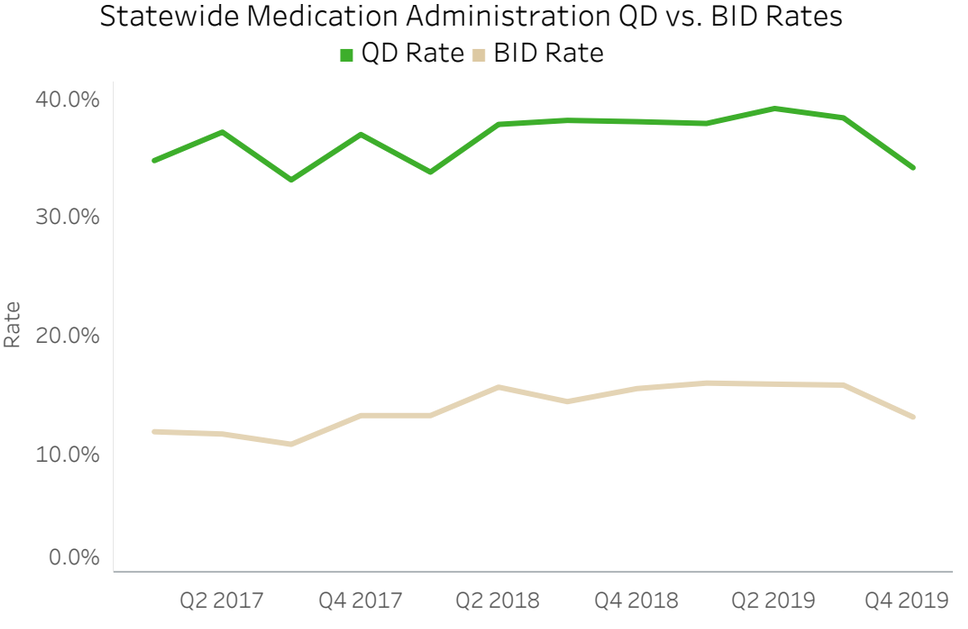
Statewide Emergency Department, Inpatient Hospitalization and 23-Hour Observation Bed Utilization Rates



Medication Administration Volume



Statewide Medication Administration QD vs. BID Rates



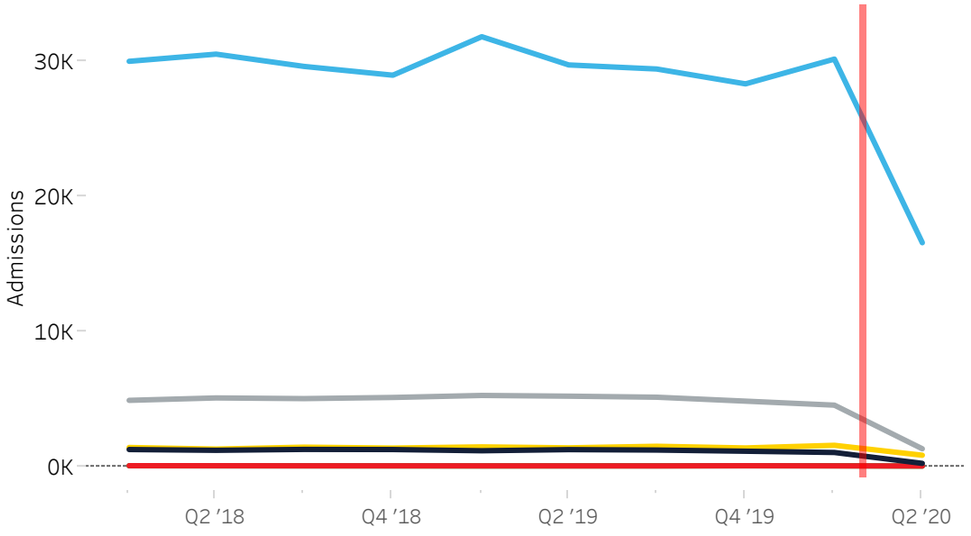
Lower Levels of Care

Admissions & Admits/1,000

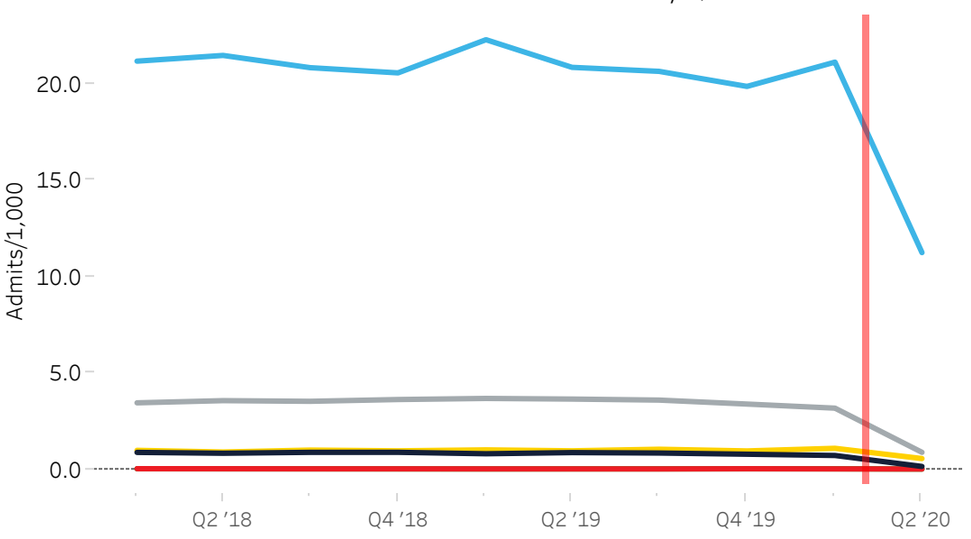
Group Type
All Members without Duals

Service Class
All

Lower Levels of Care - Adult Admissions



Lower Levels of Care - Adult Admits/1,000



		Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20
Partial Hospitalization (PHP)	Admissions	1,223	1,166	1,232	1,223	1,133	1,217	1,185	1,098	1,005	199
	Admits/1,000	0.86	0.82	0.87	0.87	0.79	0.85	0.83	0.77	0.70	0.14
Intensive Outpatient (IOP)	Admissions	4,863	5,042	4,992	5,077	5,226	5,172	5,096	4,804	4,508	1,278
	Admits/1,000	3.43	3.55	3.51	3.61	3.66	3.63	3.58	3.37	3.16	0.87
Ambulatory Detox	Admissions	26	23	17	16	13	12	10	23	13	5
	Admits/1,000	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.00
Methadone Maintenance	Admissions	1,374	1,257	1,397	1,331	1,420	1,348	1,464	1,340	1,536	803
	Admits/1,000	0.97	0.88	0.98	0.95	1.00	0.95	1.03	0.94	1.08	0.55
Mental Health Group Home	Admissions	21	16	15	12	8	12	14	19	17	2
	Admits/1,000	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.00
Outpatient	Admissions	29,953	30,483	29,575	28,925	31,774	29,684	29,384	28,283	30,118	16,527
	Admits/1,000	21.16	21.45	20.82	20.55	22.27	20.83	20.63	19.85	21.11	11.23

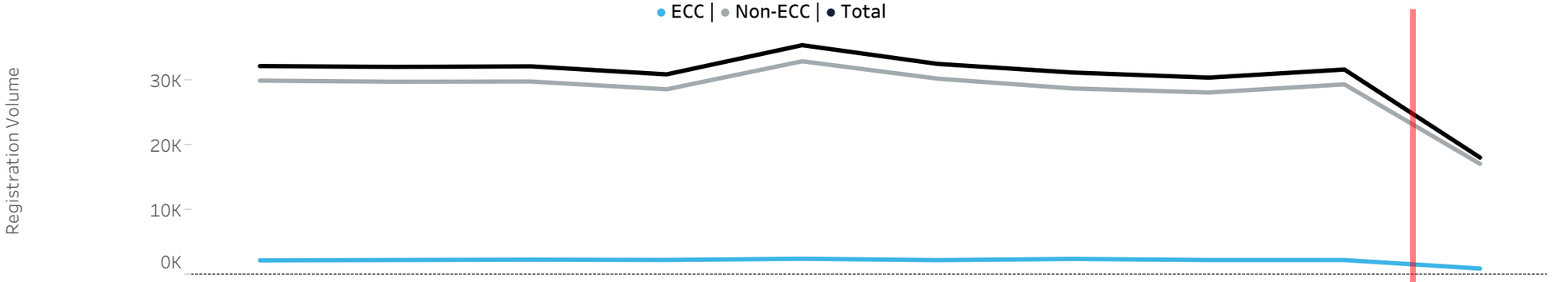
Note: The red line indicates the start of the impact of COVID-19.

Adult Outpatient Registration Volume

Enhanced Care Clinics (ECC) vs. Non-ECC Providers

Adult Total Outpatient Registration Volume

● ECC | ● Non-ECC | ● Total



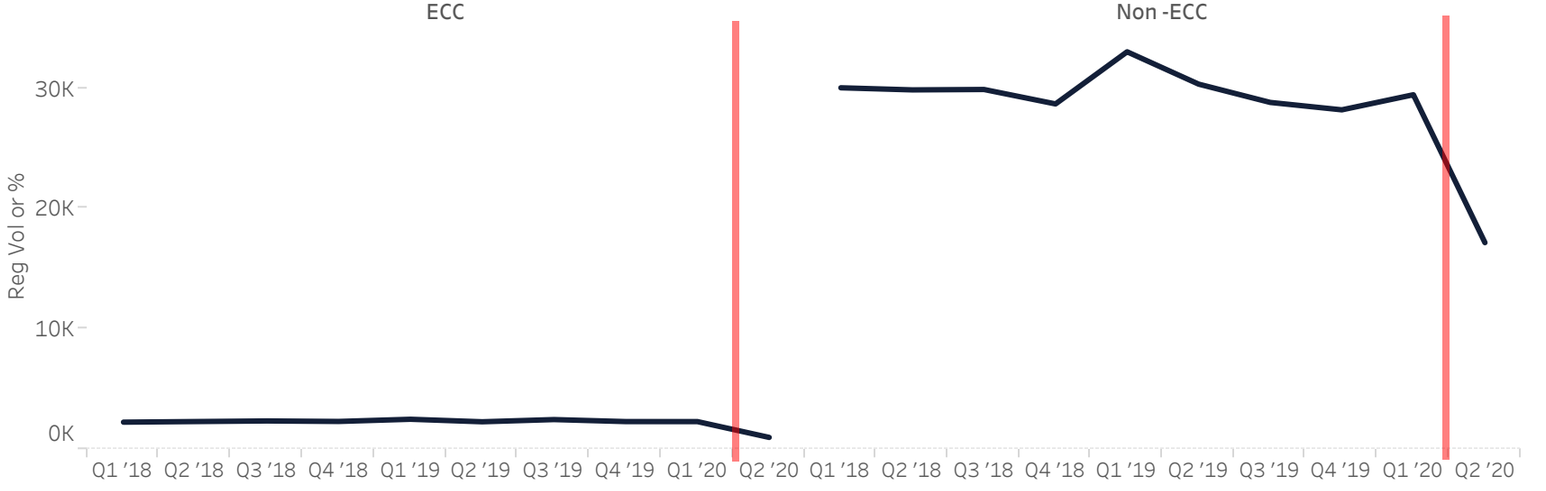
		Q1 '18	Q2 '18	Q3 '18	Q4 '18	Q1 '19	Q2 '19	Q3 '19	Q4 '19	Q1 '20	Q2 '20
ECC	Volume	2,247	2,297	2,347	2,306	2,487	2,279	2,461	2,295	2,293	980
	% of Total	7.0%	7.1%	7.3%	7.4%	7.0%	7.0%	7.9%	7.5%	7.2%	5.4%
Non -ECC	Volume	30,014	29,840	29,873	28,674	33,003	30,316	28,798	28,183	29,436	17,154
	% of Total	93.0%	92.9%	92.7%	92.6%	93.0%	93.0%	92.1%	92.5%	92.8%	94.6%
Total	Volume	**32,261**	**32,137**	**32,220**	**30,980**	**35,490**	**32,595**	**31,259**	**30,478**	**31,729**	**18,134**
	% of Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Volume of % of Total
Registration Volume

Registration Volume by All Members

Select Demographic
All Members

■ All Members

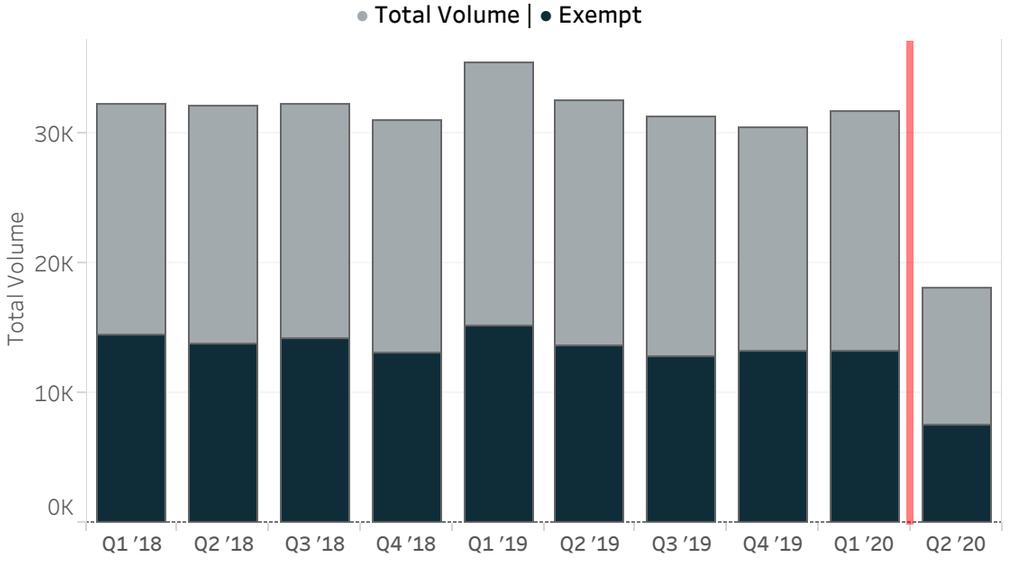


Note: The red line indicates the start of the impact of COVID-19.

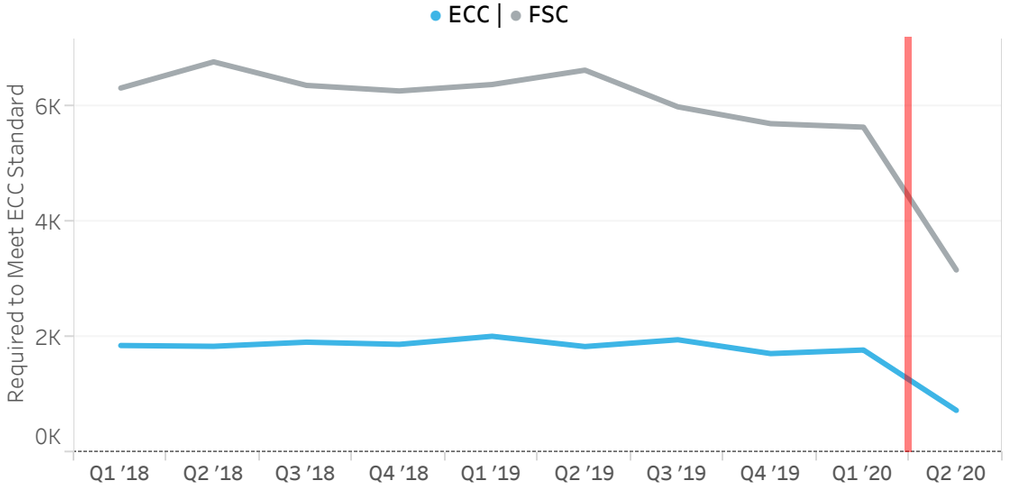
Adult Outpatient Access Standards

Enhanced Care Clinics (ECC) vs. Non-ECC Providers

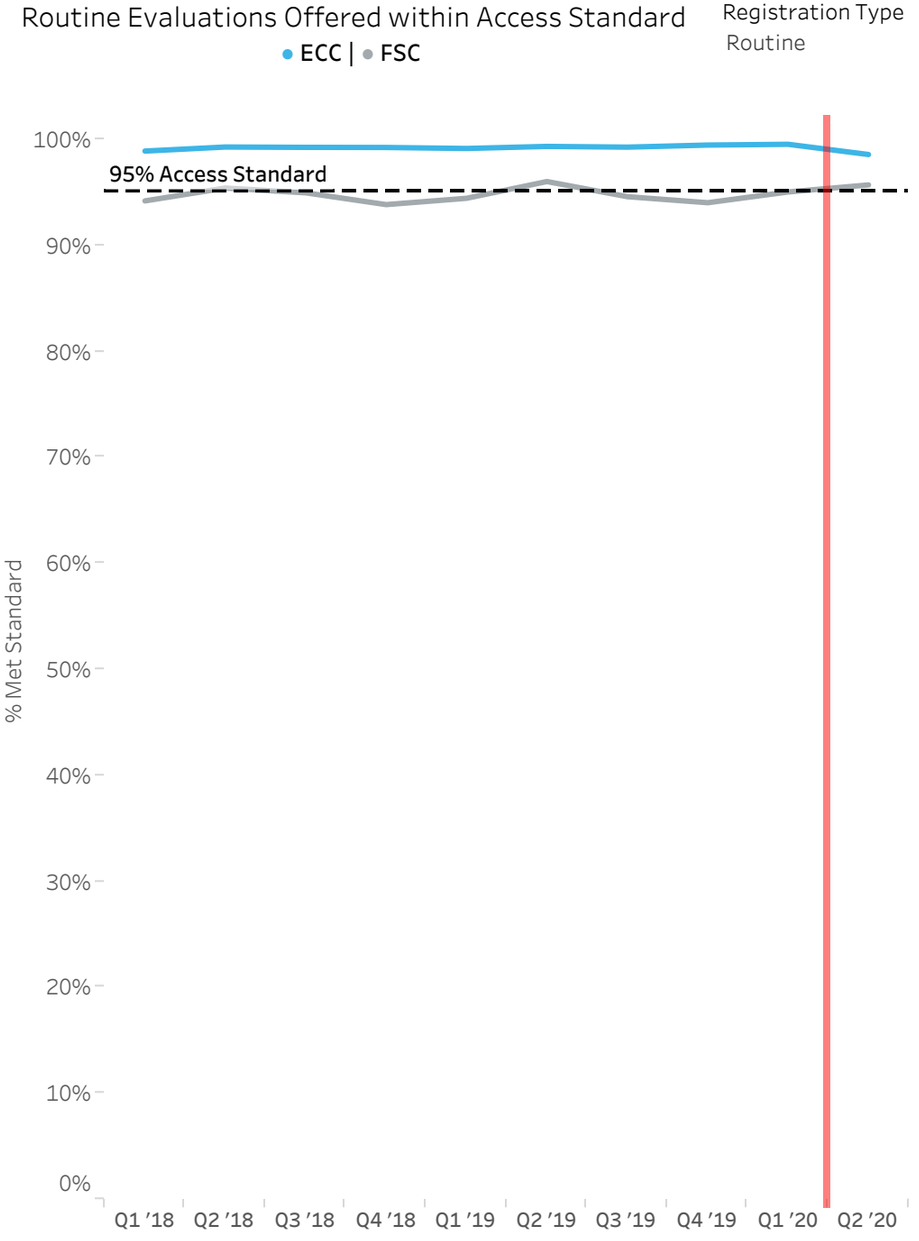
Volume of Registrations Required to Meet ECC Access Standards and Volume of Exempt Registrations ECC and Non-ECC



Number Evaluations Required to Meet Access Standard ECC and Non-ECC Free Standing Clinics (FSC)



Routine Evaluations Offered within Access Standard



Note: The red line indicates the start of the impact of COVID-19.

Enhanced Care Clinics (ECC)

Appendix Summary: January-June 2020

Summary includes analysis of both adults and youth
Due to the COVID-19 pandemic, ECC standards were relaxed, invalidating the results for Q2 '20 and will not be included in the 2020 Annual Measure.

Provider Compliance for Q1 '20

Routine Access compliance with the 14-day standard for the ECCs fell into the following categories:

1. Met the access standard of 95%: 32
2. ECCs falling below the 95% Routine Standard:
   - Clifford Beers: 93.33%
   - Klingberg Family Centers: 90.63%
   - Yale Child Study Center: 94.74%

Urgent Access compliance with the 2-day standard for the ECCs fell into the following categories:

1. Met the access standard of 95%: 31
2. ECC falling below the 95% Urgent Standard:
   - Clifford Beers: 71.43%
   - Child and Family Agency SE CT (Groton): 33.33%
   - Village for Families and Children: 80.00%
   - Yale Child Study Center: 50.00%

Emergent Access compliance with the 2-hour standard for the 35 ECCs fell into the following categories:

1. Met the access standard of 95%: 35

Interventions and Activities

2019 Volume Exemptions: The following agencies failed a measure based on the Annualized Methodology for the year but qualified for a Volume Exemption:

- Recovery Network of Programs
- Yale Child Study
- Connecticut Renaissance Stamford

The following agencies did not qualify for a volume exemption. Therefore, upon reinstatement of PA, these agencies will go on probation with the expectation that they are required to pass the measure failed for two consecutive quarters.

- Charlotte Hungerford – Adult
- Charlotte Hungerford – Child

Data Entry Errors: All agencies that did not meet the 95% access standard for the urgent or emergent measure in Q1 '20 were asked to review their data to verify whether those failures were data entry errors. No Q2' 20 data entry errors will be reviewed as previously indicated.
The following agencies had data entry errors approved for Q1 '20:

- Child and Family Agency (New London)
- Yale Child Study Center
- Clifford Beers Clinic
- The Village for Families and Children

2020 Mystery Shopper Program: The following agencies were mystery shopped early **in Q1 '20. In M**arch 2020, Mystery Shopper calls were suspended due to COVID. The announcement of this suspension was made and disseminated in CTBHP Provider Bulletin – **PB 2020-19**. As a result of the temporary suspension of Mystery Shopper calls, no calls were completed in Q2 '20.

- Mid Fairfield Child Guidance Clinic – Passed
- United Services – Passed

Ongoing Follow Up Calls from Q3 & Q4 19

- BH Care Shoreline – Passed
- Intercommunity – Failed
- Klingberg Family Services – Passed
- Connecticut Renaissance Bridgeport – Failed

Intercommunity and Connecticut Renaissance Bridgeport failed the first follow up call as noted above and have one pending follow up call. Since Mystery Shopper calls are suspended, they will receive their second follow up call once the public health crisis is declared over.

Enhanced Care Clinics (ECC)

Appendix Summary: January-June 2020

Change in Agency ECC Designation:

The following agencies opted to give up their ECC designation bringing the total number of ECCs to 33 at the end of Q1 '20:

- **Southern CT Child Guidance:** In January 2020, Southern CT Child Guidance merged with the Community Health Center, Inc. (CHCI) and as a result opted out of keeping their ECC designation since their three sites now fall under CHCI's scope as a Federally Qualified Health Center.
- **Catholic Charities Norwich:** Effective June 30, 2020, Catholic Charities Norwich will cease to provide behavioral health services and therefore has opted out of their ECC designation.

ECC Provider Conference Call: This call addressed the challenges ECC providers faced when transitioning to telehealth in response to the public health crisis. A brief summary of the highlights from the call are detailed below:

- Providers experienced up to a 60% decrease in volume as they transitioned to telehealth.
- Agencies adopted many different telehealth platforms to provide telehealth along with audio only sessions.
- Identified segments of the population found it difficult to adapt to telehealth making the audio option critical to continuing services.
- Providers reported a financial impact when moving to the telehealth platform that required the purchase of laptops along with required HIPAA compliant and VPN licenses.
- Providers expressed concerns around the uncertainty of telehealth continuing after the public health crisis is declared over and questioned in what format it will be retained.
- Some telehealth best practices demonstrated by providers were identified as:

a) The adoption of a virtual call center with access to all open slots so that appointments can be booked immediately.

b) The creation of 'virtual rooms' on site where members can come in and use technology for telehealth appointments.

c) The creation/design of a telehealth team as a part of a holistic approach to care. This team consists of a recovery coach, therapist and an MD or nurse. This ensures that a member's social determinants of health, clinical/therapeutic and medical needs are addressed using an interdisciplinary team approach.

ECC Agency/State Agencies Activity in Q1 and Q2 '20:

- **PB 2020-19 CMAP COVID-19 Response - Enhanced Care Clinic Access Requirements:** This provider bulletin was developed by Beacon and the state agencies in order to address what ECC measures and expectations were to be temporarily suspended as a result of the COVID-19 public health crisis.
- **Relaxation of Annual Methodology for Q2 '20:** As a result of the temporary relaxation of the ECC access measures as cited in the above bulletin and the temporary relaxation of the Prior Authorization requirement (**PB 2020-33**), Q2 '20 will be excluded from Annual Measure calculations for 2020.

Q1 and Q2 '20 Meetings

ECC Operations: The standard monthly meetings were held as well as additional ad hoc meetings to address the following ECC issues:

- Moves, merges, and adding or closing of ECC locations
- Changes in ECC designations
- Billing Issues
- Mystery Shopper Calls and Corrective Action Plans
- Data Entry Errors
- Creation of ECC Provider Bulletin to address temporary changes in expectations around provider performance
- ECC Contingency Plans
- ECC Provider Conference Call – agenda items and debriefing of call
- Current ECC capacity deliverable item in SUD grant
- Annual Measure and Volume Exemptions