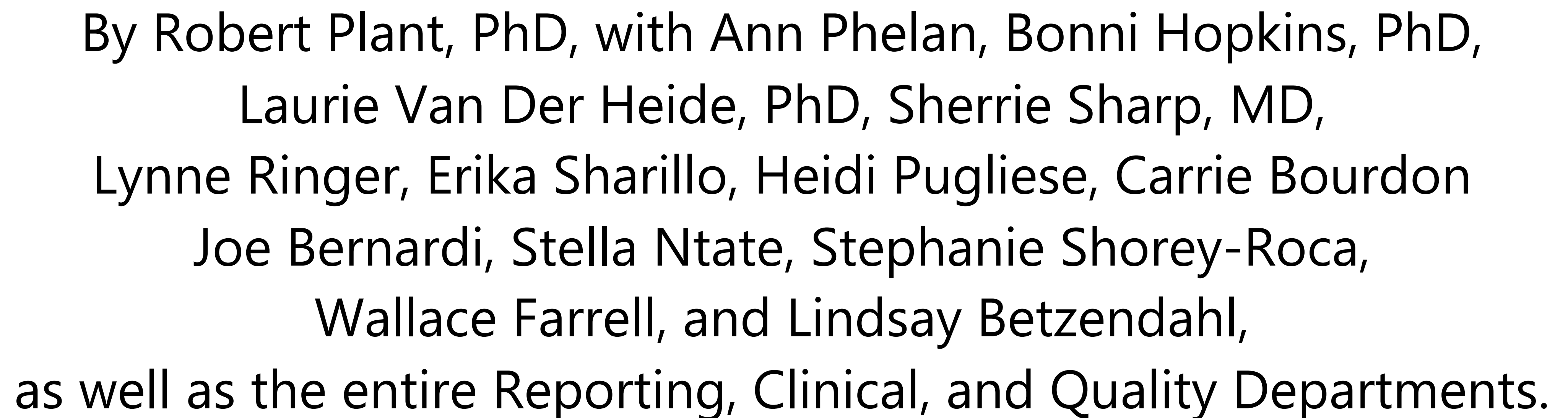
UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Calendar Year 2016: January-December 2016 - Submitted March 1, 2017



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For any inquiries, comments, or questions related to the use of Tableau, or the interactive features within this report, please contact Lindsay Betzendahl at Lindsay.Betzendahl@beaconhealthoptions.com.

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

UTILIZATION REPORT FOR ADULT MEMBERS

Calendar Year 2016: January-December 2016

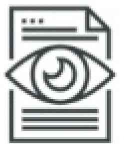
General Overview

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 most recent two quarters, but may include the past four if there is information necessary to review that had not been analyzed previously.

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

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

Hover for List of Reports Used



Methodology

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

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

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

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

UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Calendar Year 2016: January-December 2016 - Submitted March 1, 2017

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Days/1,000
Average Length of Stay

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Admits/1,000
Days/1,000
Average Length of Stay

Inpatient Detoxification: Freestanding
Admits/1,000
Days/1,000
Average Length of Stay

Home Health Services
Admits/1,000
Medication Administration Frequency
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Outpatient Enhanced Care Clinics (ECC)
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Access Standards

For this report, the following utilization data points have been placed in the Appendix and are not discussed:

Mental Health Group Home
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Intensive Outpatient
Admits/1,000

Ambulatory Detox
Admits/1,000

Methadone Maintenance
Admits/1,000

Outpatient Services
Admits/1,000

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Adult Medicaid Membership

Total Membership Volume

Total Unique Membership

Members: 1000K, 800K, 600K, 400K, 200K, 0K

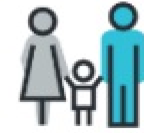
2011, 2012, 2013, 2014, 2015, 2016

- All Members with Duals
- All Members without Duals
- Adult Members with Duals
- Adult Members without Duals

Select to View Totals
Multiple values

Select to Show Table or Text

Membership Count Methodology



Dual Eligibility Information

Total Membership

Total Medicaid membership (with duals) for CY 2016 declined by 1.74%. This is the first annual decline in membership since 2011. In fact, all four membership cohorts displayed in the chart above show this same decline in annual membership over the last year.

Data Refresh

The data refresh rate in Q2 ’16 was 0.86% and 0.80% in Q3 ’16. This is the third consecutive quarter where the refresh rate was at or below 0.86%. This perhaps signals a change in the underlying processing of adult Medicaid applications. These are quarterly refresh rates less than half the magnitude of historic rates and more in line with youth refresh rates.

Refresh Percent Change by Quarters
All Benefit Groups - Duals Removed

	Q4 '13	Q1 '14	Q2 '14	Q3 '14	Q4 '14	Q1 '15	Q2 '15	Q3 '15	Q4 '15	Q1 '16	Q2 '16	Q3 '16	Q4 '16
Original	325,868	355,844	392,991	412,481	427,909	433,091	449,320	463,489	437639	444774	445262	451345	451,107
Refresh One Quarter Later	331,992	382,207	403,166	419,213	437,987	455,752	461,808	467,643	443086	448235	449078	454,969	
Percent Change	1.88%	7.41%	2.59%	1.63%	2.36%	5.23%	2.78%	0.90%	1.24%	0.78%	0.86%	0.80%	

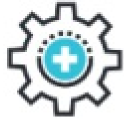
Adult Medicaid Membership

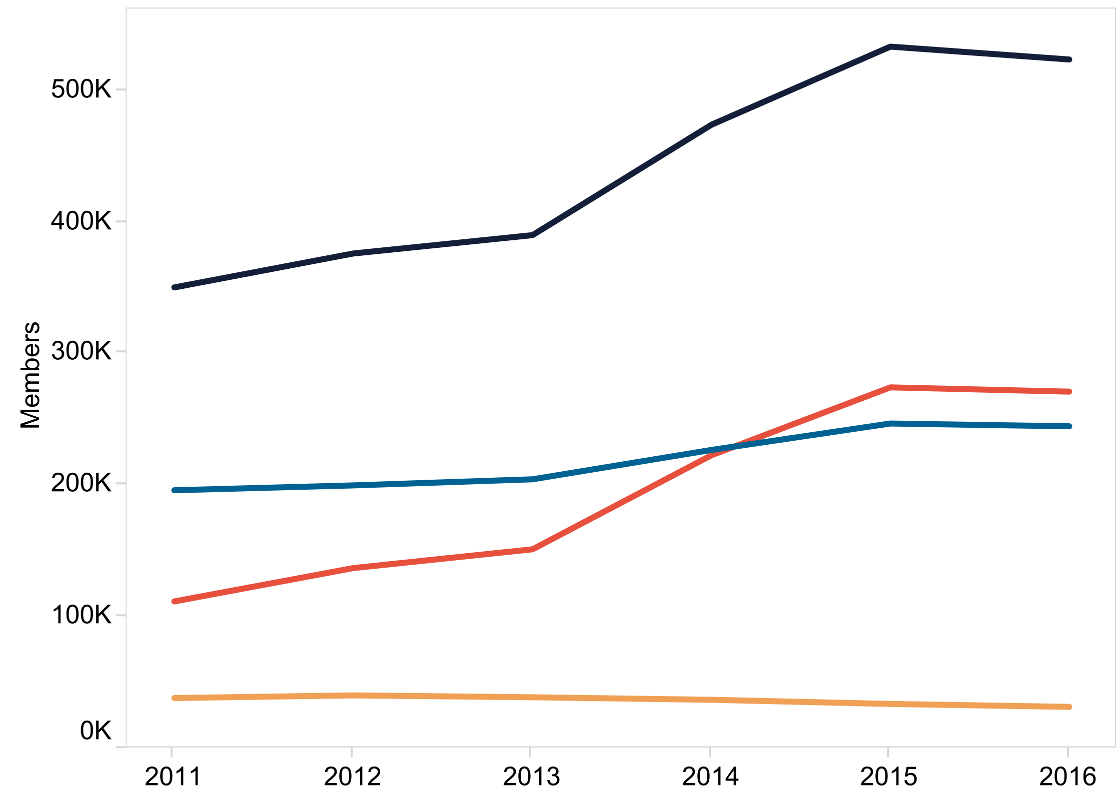
Membership by Benefit Group

Select Benefit Group Type
All

Select Individual Benefit Types
Multiple values

Select to Show Table or Text





Overview

The adult membership continues to be comprised largely by two benefit groups, HUSKY D (MLIA) and HUSKY A (Family Single). While these two groups had essentially the same number of members at the end of CY 2014, MLIA became the larger group during CY 2015 and continued to have about 26,000 more members throughout CY 2016. After increasing each year since 2012, this was the first year that membership declined for both groups.

Three of the HUSKY C benefit groups (ABD/Other Single, LTC Single, LTC Dual) have decreased in size each year since 2013.

In CY 2016, use of Outpatient services increased for every benefit group compared to CY 2015. HUSKY C (ABD/Other Single) continues to have the highest Admits/1,000 rate of inpatient psychiatric services (excluding State-run) while HUSKY D (MLIA) had the highest Admits/1,000 of all other levels of care, except Outpatient.

Select Measure
Admits/1,000

Select Time Period
CY '16

Note: For the table below, the lower levels of care are not conducive to the Days/1,000 and Average Length of Stay (ALOS) measures available. For example, because Outpatient authorizations are given for one year at a time, ALOS may not reflect the true length of time members tend to stay in Outpatient.

Admits/1,000 by Level of Care

0.00 – 29.29	Inpatient Psychiatric Facility (Excl. State-Run)	Inpatient Detoxification: Hospital	Inpatient Detoxification: General	Inpatient Detoxification: Freestanding	Partial Hospitalization (PHP)	Intensive Outpatient (IOP)	Ambulatory Detox	Methadone Maintenance	Outpatient
HUSKY A (Family Single)	0.83	0.12	0.00	0.57	0.26	1.45	0.02	0.41	15.02
HUSKY C (ABD/Other Single)	5.78	1.01		1.36	0.80	3.51	0.03	0.92	23.92
HUSKY C (LTC Single)	1.83	0.06						0.11	29.29
HUSKY D (MLIA)	2.66	1.05		3.78	1.23	5.55	0.07	1.92	25.00
All Members without Duals	2.02	0.62	0.00	2.16	0.76	3.54	0.04	1.17	20.41

Adult Medicaid Membership

Demographic Composition by Benefit Group

Overview

In CY 2016, all age groups decreased in size except the 55-64 year olds while the 65+ group remained the same size. Members ages 25-34 continue to be the largest age group of the adult Medicaid population accounting for 27.5% of the Adult Members without Duals group in CY 2016.

Both males and females decreased in size in 2016 by about 5,000 members. Females continue to be the majority in the Adult Members without Duals population. White members are the majority of this population (52%), followed by Hispanic members (26%) and Black members (17%).

Choose Demographic
No Demographic Breakout

Demographic Selection
■ All

Select Group Type
Total Groups

Select Benefit Groups
All

Composition of Adult Membership by Benefit Group
No Demographic Breakout

Adult Members with Duals | Adult Members without Duals | Adult Members Duals Only

Members

600K
500K
400K
300K
200K
100K
0K

2011 2012 2013 2014 2015 2016 2011 2012 2013 2014 2015 2016 2011 2012 2013 2014 2015 2016

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Inpatient Psychiatric Facility (Excl. State-Run)

Click for Summary

Group Type
- All Members without Duals
- HUSKY A (Family Single)
- HUSKY C (ABD/Other Single)
- HUSKY D (MLIA)

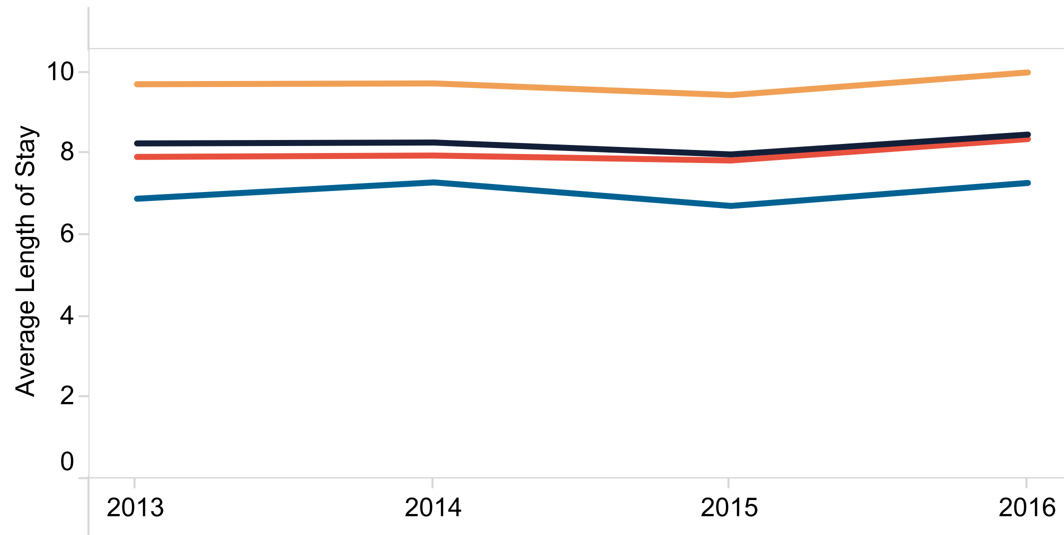
Service Class
Inpatient Psychiatric Facility..

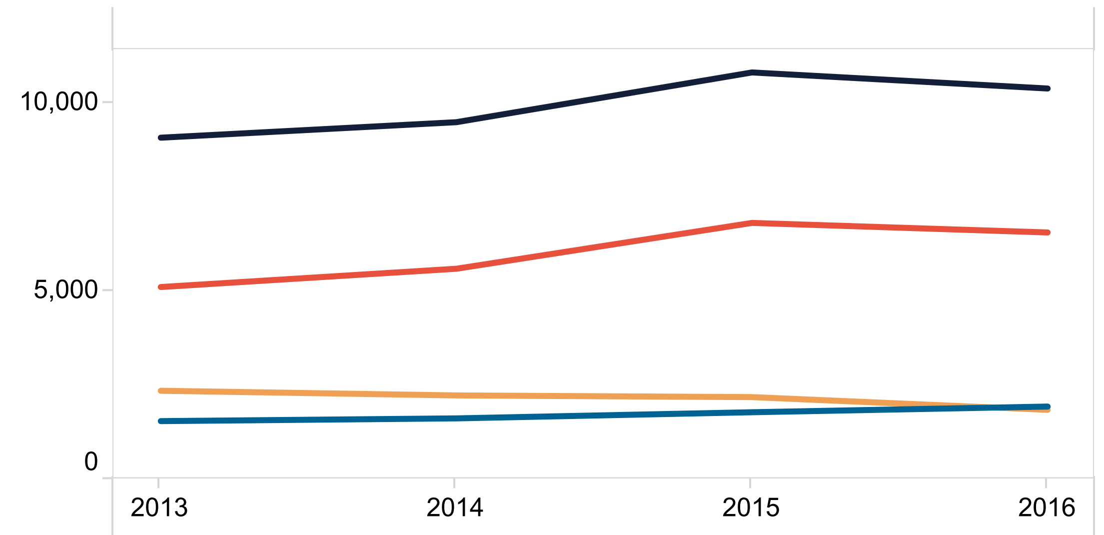
Select Membership Type
All

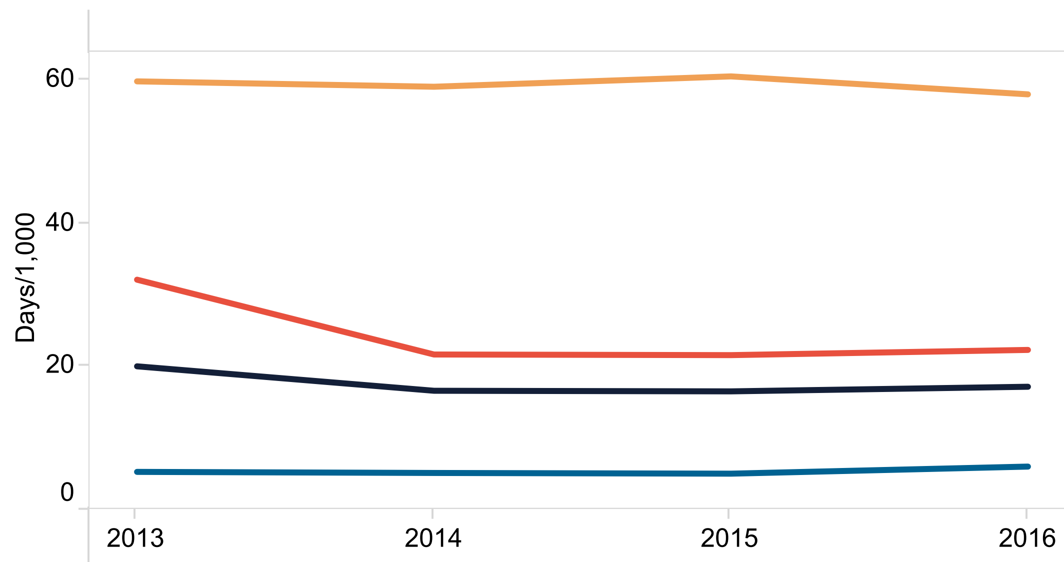
Choose Benefit Groups
Multiple values

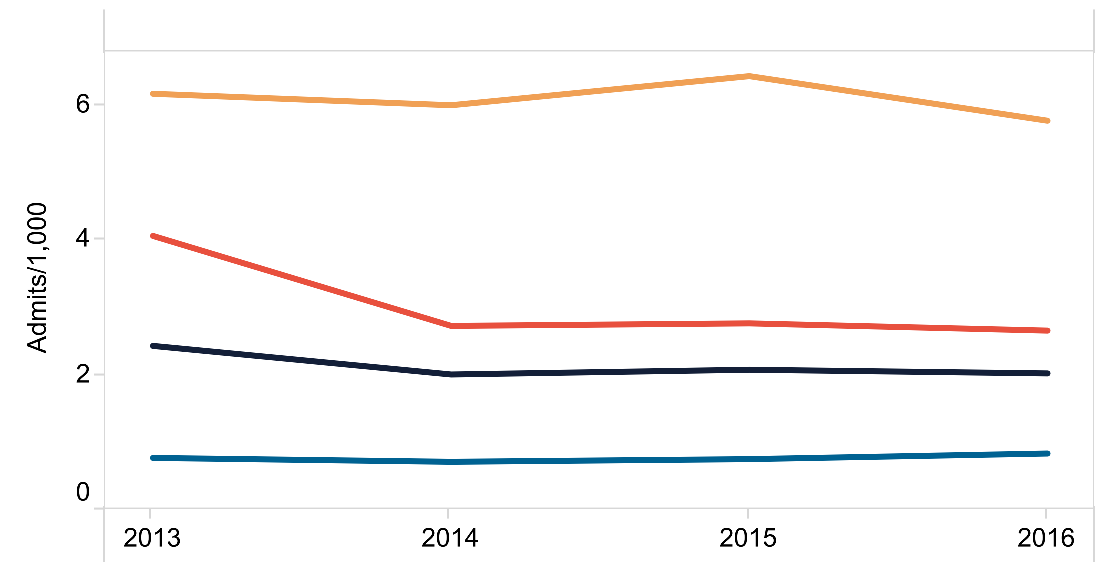
Choose Demographic
No Demographic Breakout

Admissions or Discharges (chart below only)
Admissions









Inpatient Psychiatric Facility

Summary

Overview: The Inpatient Psychiatric ALOS increased by 6.11% from CY 2015 to CY 2016. The ALOS reached a four-year high of 8.47 days, up 0.49 days from the previous year. Admissions to Inpatient Psychiatric Hospitals decreased for the first time in four years, down 427 admissions. While Admits/1,000 decreased slightly, Days/1,000 increased by 0.64 days in CY 2016. All age groups, except for 65+, experienced an increased ALOS, and adult members ages 25-34 had the largest percent increase of 8.7%, almost 0.7 days. Also, the ALOS increase was more significant for female members, who had a decrease in admissions from CY 2015 to CY 2016. Black and Hispanic members had an increase in CY 2016 of over three quarters of a day.

Conclusions

Since the ALOS increased by 0.49 days, one would expect the Admits/1,000 to decrease. ALOS continues to be monitored by UM staff and is a focus of PAR meetings. The most significant increase in ALOS was experienced by adult members ages 25-34, which will be a focus of future PAR discussions to better understand the factors related to the increased ALOS. During the previous PAR cycle providers reported homelessness and access to Substance Use Disorder Residential Treatment as a barrier to timely discharges.

Recommendations

1. Continue the Adult Inpatient Bypass Program – Determination of Bypass Program parameters will be conducted annually, and quarterly monitoring will be conducted to bring in facilities that have met the targets. Those providers who earned Bypass status but subsequently fail to meet the targets will be allowed two additional quarters to make adjustments and meet targets before being removed from the Bypass Program.

Update – Quarterly updates of Bypass status continue to be reviewed and analyzed internally to inform UM strategy. In collaboration with the Regional Network Managers (RNMs), providers are updated monthly and quarterly on their performance on the Bypass target measures and what actions are required to maintain or be included in the program. In Q3 ’16 Norwalk Hospital lost Bypass status due to the discharge form completion rate in Q1 ’16 and for exceeding the 7-day readmission rate target in Q2 and Q3 ’16. Bristol Hospital met all three targets and earned Bypass status in Q3 ’16. In Q4 ’16, Bridgeport Hospital, Griffin Hospital, and State of Connecticut-J.D. Hospital lost Bypass status due to consistently exceeding the targeted 7-day readmission rate of 6.0%. While in Q4 ’16 Bridgeport met the 7-day readmission rate target, their ALOS was greater than the target of 8.2 days. Norwalk Hospital was able to meet all targets and return to Bypass status in Q4 ’16. The Adult Inpatient Bypass Program will continue and targets will be re-evaluated to determine if changes in the behavioral health service system have impacted inpatient hospital data statewide.

Continued on next page.

Inpatient Psychiatric Facility

Summary, cont.

Recommendations, continued

2. *Continue Adult PAR Program* – Regional Network Managers (RNMs) will continue to assess gaps, barriers, and best practices amongst the psychiatric hospitals. The Adult Inpatient Workgroup presentations/discussions will begin to include performance indicators broken out by provider and by geographical region. For hospitals whose data has been stable over the long term, it may not be necessary to meet individually, but data will be reviewed and shared electronically. RNMs will target these hospitals for best practices. Those hospitals where data has been inconsistent or where trends are noted that require action, communication will be on a regular basis and meetings will occur at a minimum of biannually.

Update – In Q3 and Q4 2016, the RNMs met with the inpatient psychiatric hospital providers in a continued effort to improve access to care and quality of care for Medicaid adults. Clinical and Medical Affairs staff from Beacon joined the RNMs when applicable to participate in PAR discussions. During the PAR meetings, data was shared on measures including ALOS, 7-day and 30-day readmission rates, and discharge form completion rates. New measures such as the length of stay for members awaiting state beds and HEDIS Follow Up After Hospitalization for Mental Illness were also introduced.

The RNMs and other Beacon staff continued to have discussions with individual hospitals about their performance, including barriers and best practices for achieving and/or maintaining an efficient length of stay. These conversations provide an opportunity to better understand the varied clinical philosophies and approaches of the treatment teams across hospitals and to facilitate progress by sharing hospital comparisons to the statewide group. Hospitals often cited homelessness, access to residential rehab beds, and access to state psychiatric beds as barriers to a reduced ALOS. This became the focus of the winter 2016 workgroup. As a result of participating in conversations about clinical barriers to care progression, Beacon was able to work with the State Partners and hospitals, when appropriate, to enhance communication between community entities to facilitate relationships necessary to improve smooth discharge planning.

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Inpatient Detoxification: Hospital-Based

Summary

Overview: The ALOS for All Members without Duals decreased for the second consecutive year, reaching 5.30 days in CY 2016. The ALOS for each benefit group trended down except for HUSKY A (Family Single) which increased slightly in CY 2016. While ALOS decreased, admissions continued to trend upwards. Days/1,000 and Admits/1,000 followed similar upward trends.

All age groups had a decline in ALOS in CY 2016 except the 45-54-year-old cohort which increased by 0.25 days. Admissions increased by 20% for All Members without Duals. Days/1,000, and Admits/1,000 increased for all age cohorts except the young adults ages 18-24 and members 65+. In CY 2016, the ALOS increased for females by 0.29 days while decreasing the same amount (0.28 days) for males. The ALOS is trending downward for White and Black members while remaining flat for Hispanic members.

Conclusions

Beacon continues to work with Inpatient Hospital Detoxification providers to obtain authorizations for members when the admission is primarily related to detox. This may account for the continued increase in Admits/1,000. The increase in ALOS for members age 45-54 is to be expected as total years of use has led to more significant health issues requiring medical management. The emerging adults ages 18-24 continue to be best served in non-hospital settings as they are less medically compromised and can receive therapeutic services while withdrawing from substances.

Recommendations

1. Increase communication and collaboration with Hospital-Based Detoxification providers – RNMs and clinical supervisors will continue to schedule and attend meetings with the hospital-based inpatient detoxification providers. Initial meetings will be used to clarify processes and protocols related to detox authorizations and aftercare planning. Subsequent meetings will offer the opportunity to promote real-time UM process communication, review ALOS and readmission data, devise innovative strategies to resolve barriers to discharge, identify gaps in services and expedite connect-to-care initiatives. Meeting attendees will include Beacon RNM and clinical manager, inpatient detoxification hospital-based administration, direct treatment providers, discharge planners, and utilization review personnel (specific to each hospital). Meetings will be offered at least twice a year for ongoing data review and collaboration with all hospitals.

Update – The Regional Network Managers (RNMs) and Clinical Supervisors continued to meet with the inpatient medical detoxification hospital providers during the second half of 2016. Measures reviewed include ALOS, discharge volume, 7- and 30-day readmission rates, and discharge completion rates. Through the PAR meetings, the providers identified several challenges impacting readmission rates. These barriers include a lack of timely, appropriate resources available at discharge, significant medical comorbidities, lack of transportation and individuals either leaving AMA or refusing services at discharge. Additionally, the knowledge of and relationships with local community providers varies greatly across the medical detox providers. As needed, the RNMs and Clinical Supervisors have increased provider awareness of available traditional and non-traditional community resources, encouraged participation in CCT meetings when appropriate, and facilitated connect to care meetings when barriers in continuity of care were identified. The Clinical Supervisors emphasized Beacon UM staffs' role to assist providers in developing primary and secondary discharge plans as well as the role of Clinical Liaisons for aftercare follow up outreach. Lastly, Beacon staff continue to encourage the medical detox providers to enter discharge completion forms to support Beacon's connect to care efforts post discharge. Connect-to-care will continue to be a focus in 2017.

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Inpatient Detoxification: Freestanding

Summary

Overview: The ALOS for Freestanding Detoxification has increased slightly for the past three years, but remains around four days. The 25-34 age group continues to have the largest number of admissions (up 6% from CY 2015) and the highest Days/1,000 and Admits/1,000 rate for this level of care (also up from CY 2015). Males continue to have about two-and-a-half times the number of admissions as females. White members continue to make up the vast majority of admissions to this level of care.

Conclusions

These results are to be expected given a protocol driven service and no increase in the bed capacity within this level of care. Some freestanding providers have discussed the need for a longer opiate treatment protocol for individuals who are using higher potency opiates. The ALOS will continued to be monitored to see if the changes to protocol for high opioid dependency leads to an increased ALOS, a reduction in readmission rates, and/or a reduction in members leaving AMA.

Recommendations

1. Collaborate with freestanding detox providers to develop OTP/MAT materials. Beacon will hold meetings with the seven freestanding providers to develop a curriculum for their staff to educate members on the multiple pathways to recovery. This would include resources available in the local community. Beacon will present the CTBHP MAT website and other materials available to support the providers on this project.

Update – Beacon staff met individually with all seven freestanding providers and began discussions related to medication assisted treatment (MAT) and a desire to develop a curriculum that can be shared and offered at all Freestanding Detoxification facilities. This curriculum will offer consistent education to Medicaid members related to MAT services available to them in addition to therapy and nontraditional resources. Several of the providers offered to participate in the development of such materials and a willingness to partner on this project. Over the next 6 months Beacon will hold initial meetings and review current materials in order to develop a universal curriculum that will be offered to all Freestanding Providers. Beacon was able to inform providers of the CTBHP MAT website and several providers have utilized the MAT map locator and provided updates for the map locator to Beacon to accurately reflect services provided at their facilities.

Inpatient Higher Levels of Care Table

Showing: Admits/1,000

How to use the interactive tables: 1. The "Level of Care" filter allows you to compare the three higher levels of care (Inpatient Psychiatric, Inpatient Detox: Hospital-Based, and Inpatient Detox: Freestanding). 2. Change the "Select Measure" filter to see the data in the table below. Available Measures include Admits/1,000, Admissions, Days/1,000, ALOS, and Discharges. 3. Filter to view and compare the benefit group types (totals, duals, singles). 4. Finally, filter by benefit group to adjust the table's output. Note that the color indicates the range from lowest value (white) to highest value (blue) within the table. The corresponding graphs can be found on page 4. Additionally, some cells may be blank, which indicates that there were no members in that benefit group that utilized the level of care selected.

Level of Care	Select Measure	Select Group Type	Choose Benefit Groups
Inpatient Psychiatric Facility (Excl. S..	Admits/1,000	Multiple values	All

Showing Adult (18+) Medicaid Admits/1,000

		2013	2014	2015	2016
HUSKY A (Family Single)	Inpatient Psychiatric Facility (Excl. State-Run)	0.77	0.71	0.75	0.83
HUSKY A (Family Dual)	Inpatient Psychiatric Facility (Excl. State-Run)	0.87	0.96	1.02	1.01
HUSKY B	Inpatient Psychiatric Facility (Excl. State-Run)	1.65	1.52	0.96	1.79
HUSKY C (ABD/Other Single)	Inpatient Psychiatric Facility (Excl. State-Run)	6.18	6.01	6.44	5.78
HUSKY C (ABD/Other Dual)	Inpatient Psychiatric Facility (Excl. State-Run)	1.00	0.84	0.92	0.90
HUSKY C (LTC Single)	Inpatient Psychiatric Facility (Excl. State-Run)	1.78	1.92	1.65	1.83
HUSKY C (LTC Dual)	Inpatient Psychiatric Facility (Excl. State-Run)	0.39	0.24	0.33	0.17
HUSKY D (MLIA)	Inpatient Psychiatric Facility (Excl. State-Run)	4.06	2.73	2.77	2.66
Charter Oak	Inpatient Psychiatric Facility (Excl. State-Run)	0.45			

Range

0.17 6.44

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Home Health Services

Admissions & Admits/1,000

Select Group Type
All

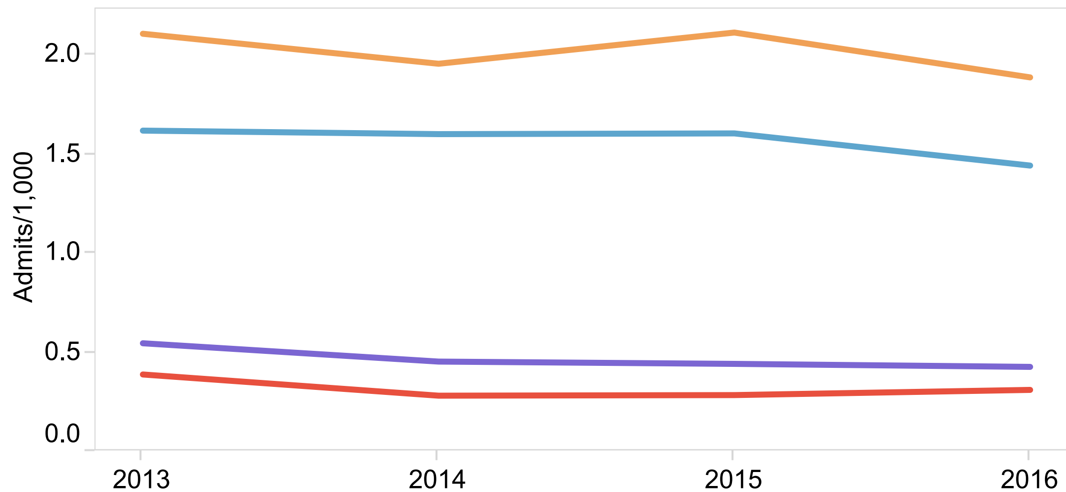
Service Class
Skilled Nursing

Choose Benefit Groups
Multiple values

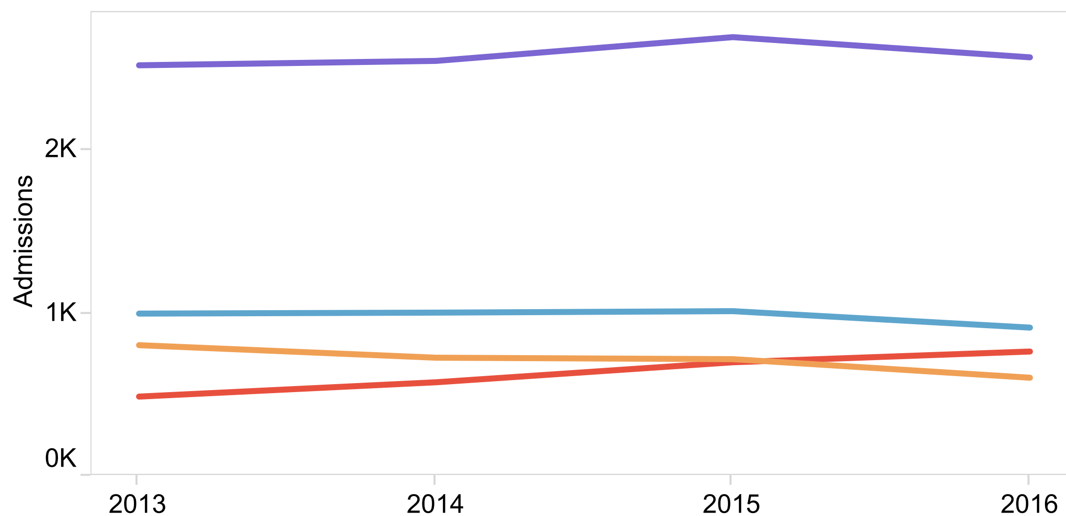
Group Type
- All Members with Duals
- HUSKY C (ABD/Other Single)
- HUSKY C (ABD/Other Dual)
- HUSKY D (MLIA)

Overview: For All Members with Duals the Admits/1,000 for Skilled Nursing trended downward for the third consecutive year. HUSKY C (ABD/Other Single) and HUSKY C (ABD/Other Dual) had a decrease in CY 2016 of just over ten percent. Total admissions were down slightly in CY 2016. HUSKY D (MLIA), however, had an increased for the third consecutive year, increasing 56.9% since 2013. For Medication Administration, Admits/1,000 and Admissions were essentially unchanged in CY 2016 for All Members with Duals. For HUSKY D (MLIA) the admission volume has increased 58.0% since 2013.

Skilled Nursing - Adults
Admits/1,000



Skilled Nursing - Adults
Admissions



Select Time Period
CY '16

Skilled Nursing - Adults: CY '16
Admissions

Group	Age	Admissions
All Members with Duals	18 - 24	302
	25 - 34	483
	35 - 44	429
	45 - 54	669
	55 - 64	549
	65+	140
HUSKY C (ABD/Other Single)	18 - 24	48
	25 - 34	113
	35 - 44	83
	45 - 54	178
	55 - 64	160
	65+	21
HUSKY C (ABD/Other Dual)	18 - 24	28
	25 - 34	120
	35 - 44	145
	45 - 54	247
	55 - 64	252
	65+	119
HUSKY D (MLIA)	18 - 24	132
	25 - 34	189
	35 - 44	125
	45 - 54	198
	55 - 64	120
	65+	0

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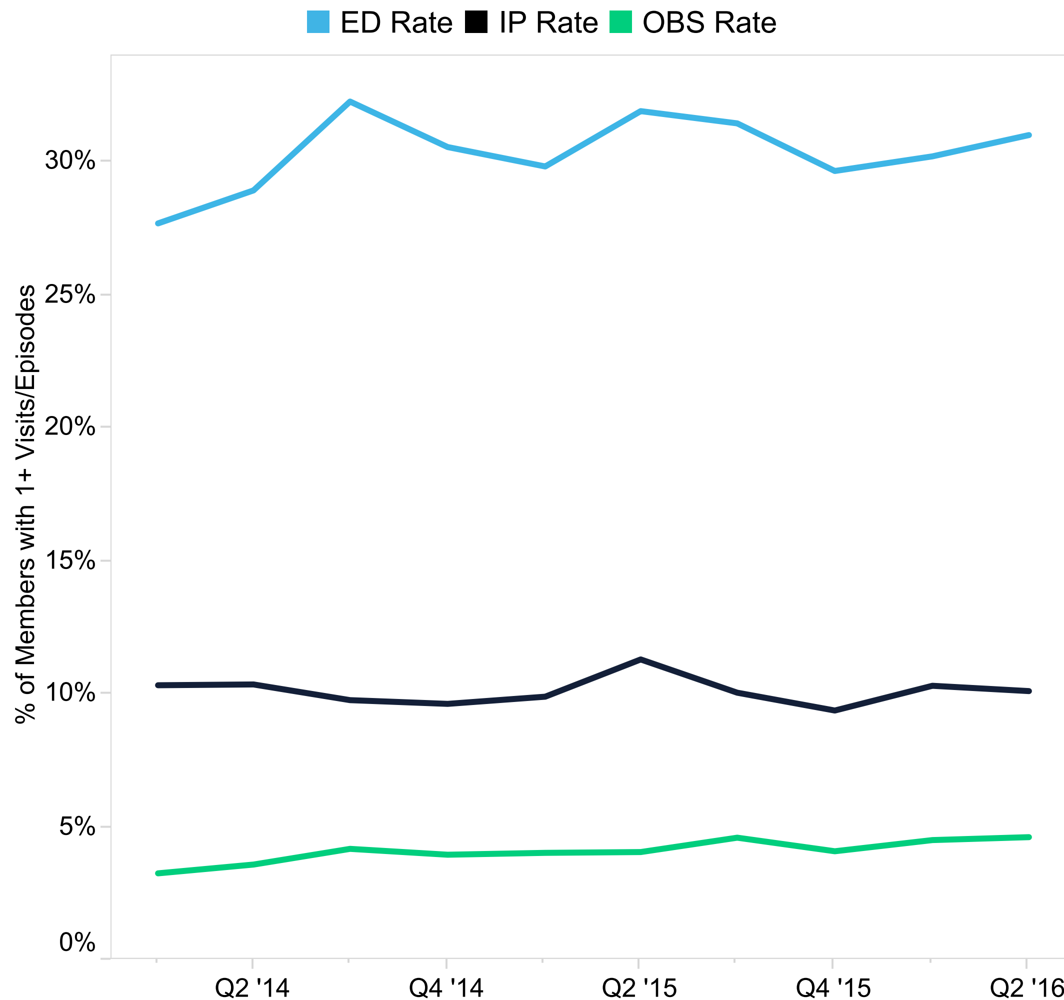
Home Health Services

Medication Administration & Utilization (ED/IP/OBS) Claims

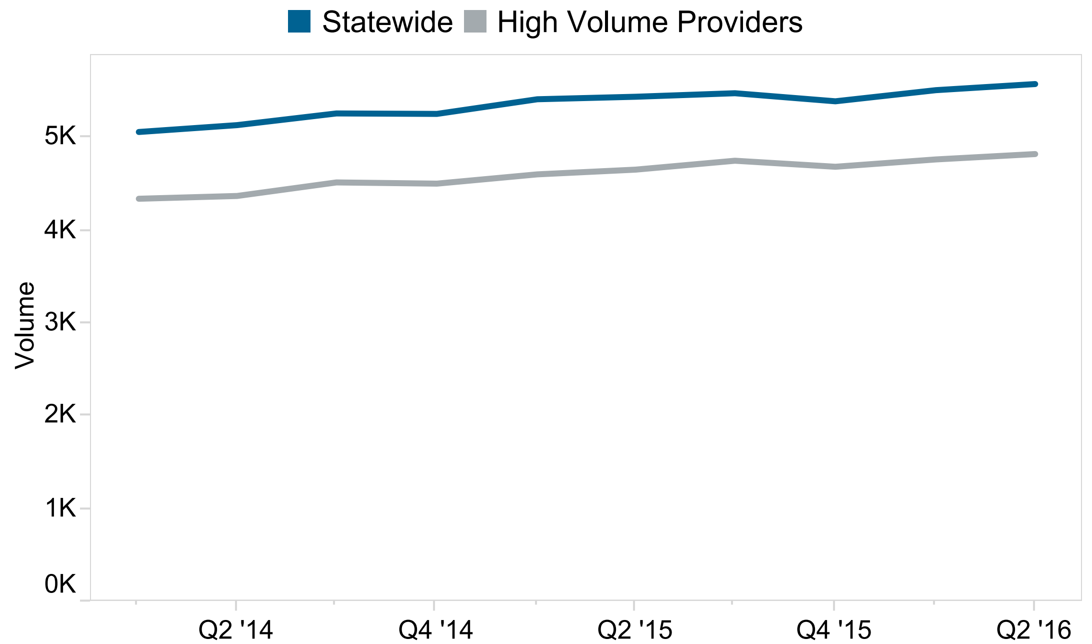
Overview
The volume of members receiving Medication Administration services has trended up in Q1 ‘16 and Q2 ’16 for both statewide and the high volume providers. The BID rate decreased for the fourth consecutive quarter reaching 14.20% in Q2 ’16.

The statewide emergency (ED) and inpatient (IP) and observation rates rose slightly in Q1 ’16 and Q2 ’16 reaching 31.0%, 10.1% and 4.6%, respectively.

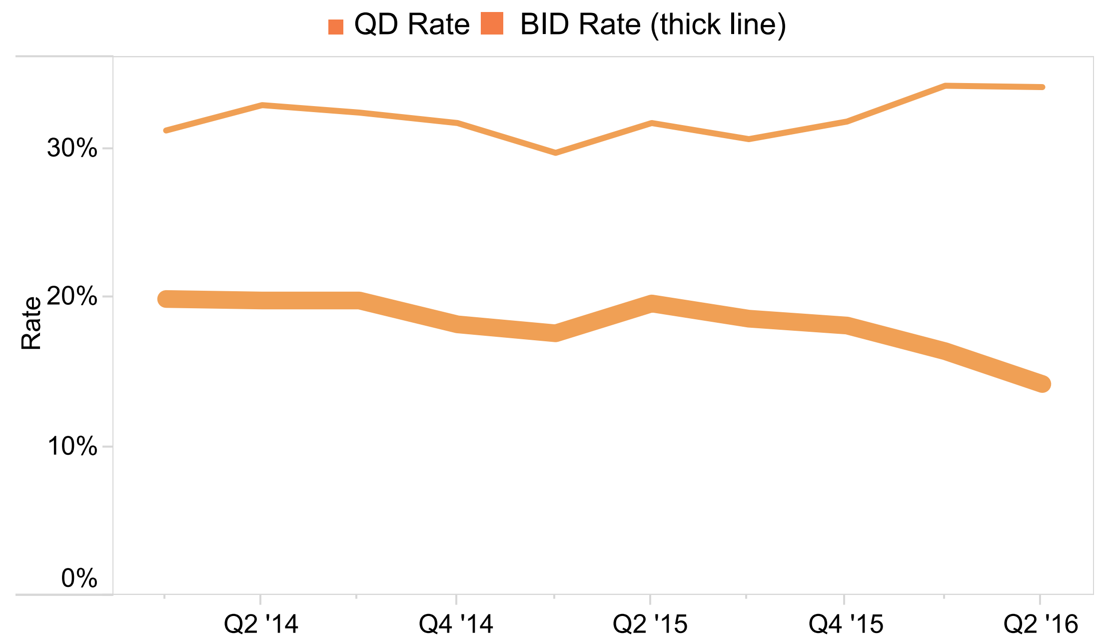
Statewide Emergency Department, Inpatient Hospitalization and 23-Hour Observation Bed Utilization Rates



Medication Administration Volume



Statewide Medication Administration QD vs. BID Rates



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Home Health Services

Summary

Recommendations

1. Continue planned focus on claims data analysis – Beacon will continue to provide analysis of the relationship between reduction in Medication Administration frequency, re-hospitalization rates, and connection to other community services for members to ensure that further reductions in medication administration frequency are not causing an increase in utilization of those other services. Beacon will continue cohort tracking of members receiving BID medication administration service to refine our knowledge and understanding of utilization patterns. Beacon will continue to engage providers in exploration of the variances in frequency reduction rates and hospitalization/OBS and ED rates through semiannual group and individual meetings with the 13 high-volume providers.

Update – Beacon has continued to utilize a Bypass Program for home health agencies. The bypass program provides administrative relief for both Beacon and home health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The Bypass eligibility criteria includes achievement of a BID medication administration target rate. The volume of agencies on the Bypass Program has increased this year as more agencies have met the target BID utilization rate. The agencies on Bypass are authorized for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. Beacon has continued to work with those providers not meeting the Bypass standards to achieve this goal.

Beacon has continued to collaborate with providers regularly to review and monitor their status within the Bypass Program and discuss the tools to support the reduction of the BID rate. This year, home health agencies have increased their utilization of the Home Health Prompting tool which has supported the reduction in the BID rate.

2. Increased collaboration with CHN. To promote the efficient and appropriate use of Home Health services, it is necessary for the respective Administrative Service Organizations to collaborate on State initiatives and goals.

Update – Beacon has continued to meet with leadership from CHN to discuss home health authorizations, level of care guidelines and cases to develop parallel efficiencies in operational process, communication and criteria for Home Health services. This recommendation has been achieved, is now monitored on an ongoing basis, and has become standard operating procedure. This recommendation will therefore be concluded.

3. Discuss and review home health agency data and reviewer findings, with a focus on providers whose frequency of visits has increased or remains above the statewide average.

Update – In February 2016, the Department of Social Services (DSS), Department of Mental Health and Addiction Services (DMHAS), the Department of Public Health (DPH), Beacon, and CHN held a statewide Home Health meeting with the goal of familiarizing providers with the aggregate utilization and expenditure trends, services covered by Medicaid that help support medication administration reductions, the methodology to track future utilization and cost trends and an encouragement to providers to attend small group sessions that would be held at Beacon in collaboration with CHN. These smaller group meetings afford providers an opportunity to review their individual agency level data on utilization and cost trends as well as the opportunity for peer to peer sharing and learning from those who have already made great strides in medication administration decreases.

This recommendation has been achieved, is now monitored on an ongoing basis, and has become standard operating procedure. This recommendation will therefore be concluded.

Continued on next page.

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Home Health Services

Summary, continued

Recommendations, continued

4. Work with the DSS to implement home health aide medication prompting. Utilization of certified home health aides to perform medication prompting for a cohort of Medicaid members has the potential to be an efficient process to reduce overdependence on skilled nursing for the sole purpose of Medication Administration.

Update – The use of Home Health Aide Prompting Medication Administration was implemented in Q3 '15. The utilization of home health prompting has increased this year and has supported the reduction of the BID rate. In addition, Beacon has continued to offer Medication Administration Training (MAT) to home health agencies and residential care homes. The goal of the MAT program is to train certified Home Health Aides (HSAs) in medication parameters to develop a knowledgeable and safe workforce that compliments and supports the skills of Registered Professional Nurses. To further promote MAT training to HHAs, Beacon has expanded MAT training to offer onsite training to home health and RCH agencies. Beacon will continue to provide MAT training and monitor the volume of Home Health aide prompting services. This recommendation has been achieved, is now monitored on an ongoing basis, and has become standard operating procedure. This recommendation will therefore be concluded.

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Inpatient Psychiatric Facility (Excl. State-Run)

Benefit Group
- All Members without Duals
- HUSKY A (Family Single)
- HUSKY C (ABD/Other Single)
- HUSKY D (MLIA)

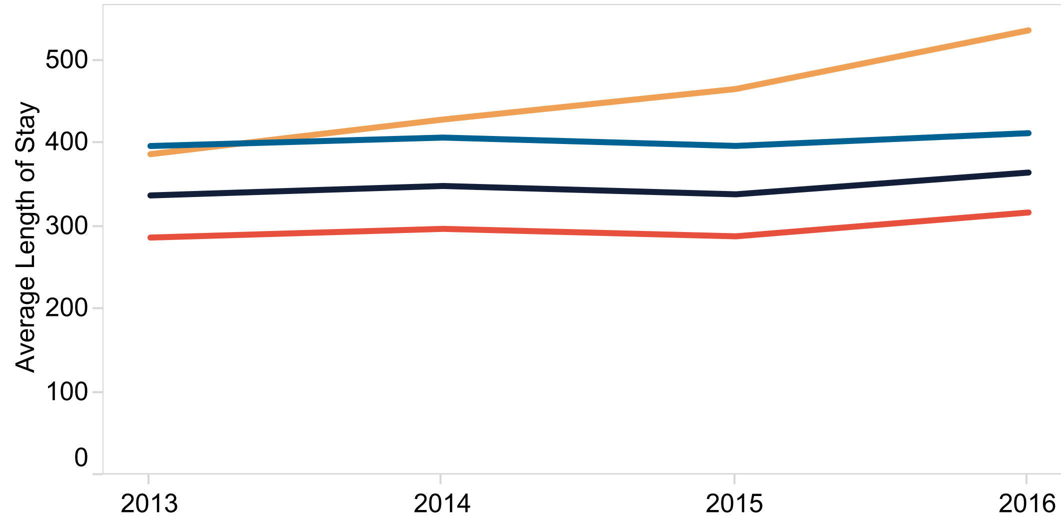
Service Class
All

Select Group Type
Multiple values

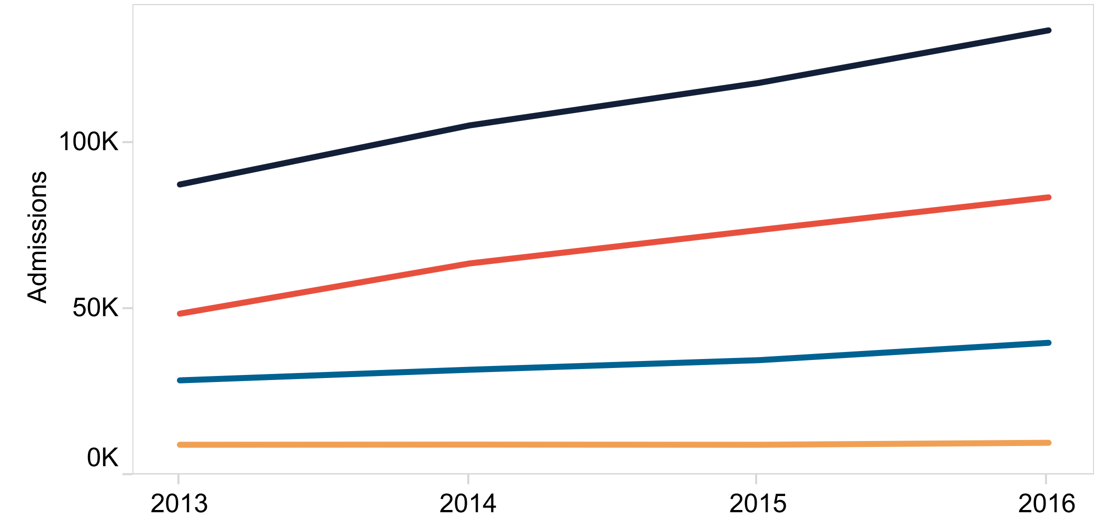
Choose Age Group
All

Choose Benefit Groups
Multiple values

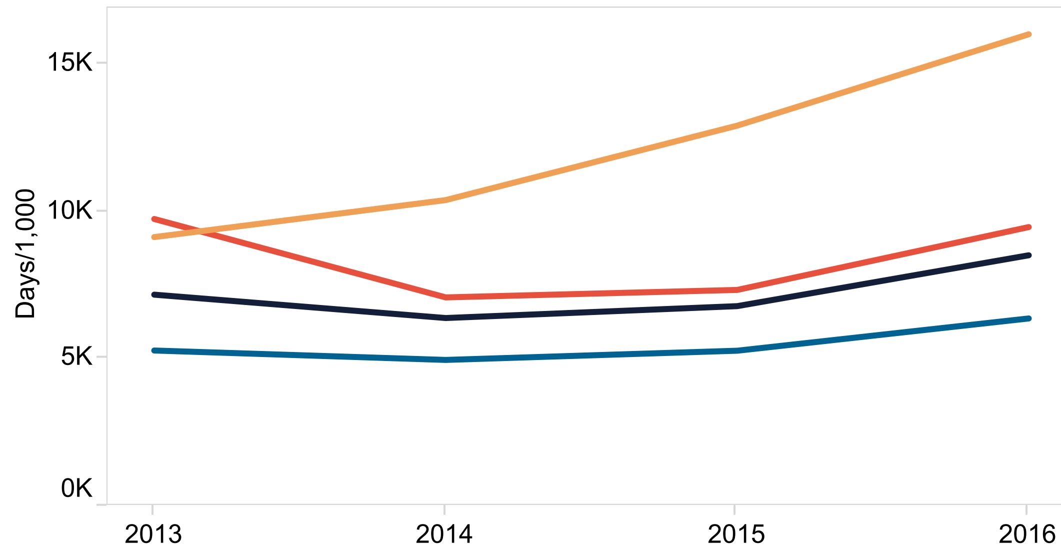
All - Adults: Ages All
Average Length of Stay (ALOS)



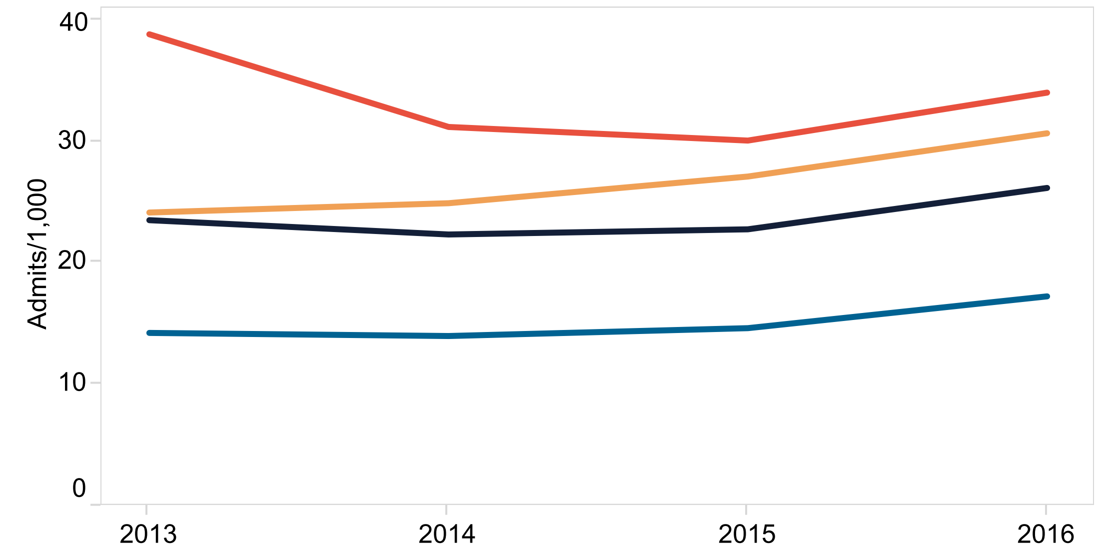
All - Adults: Ages All
Admissions



All - Adults: Ages All
Days/1,000



All - Adults: Ages All
Admits/1,000



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Methadone Maintenance

Recommendations

Recommendations

Note: The data for Methadone Maintenance can be found in the Lower Level of Care Utilization graphs on the previous page via the drop down filter, along with the other lower levels of care.

1. Identify members receiving Methadone Maintenance who can benefit from services closer to their residence. Logisticare is sending transportation requests for members with complex needs and who are traveling more than 15 miles for Methadone Maintenance to Beacon's clinical staff for clinical review and recommendations. Staff proactively outreach to providers to assist in transferring members to the closest methadone provider so that treatment is not interrupted. When transferring to a closer clinic is not feasible, alternative modes of transportation are explored and/or providers are asked if take home doses can be considered.

Update – Beacon continues to receive referrals from Logisticare when members are traveling greater than 15 miles via livery to methadone maintenance treatment to address any barriers in receiving services within their local community. Beacon met with several Methadone Clinics for ongoing collaboration and to understand continued challenges the clinics and our Medicaid members face when there is a need for a change in provider or transportation method. Beacon continues to attend the DMHAS Methadone Directors Roundtable for ongoing collaboration and to be informed of any regulation changes and/or areas of focus as presented by the State Opiate Treatment Authority.

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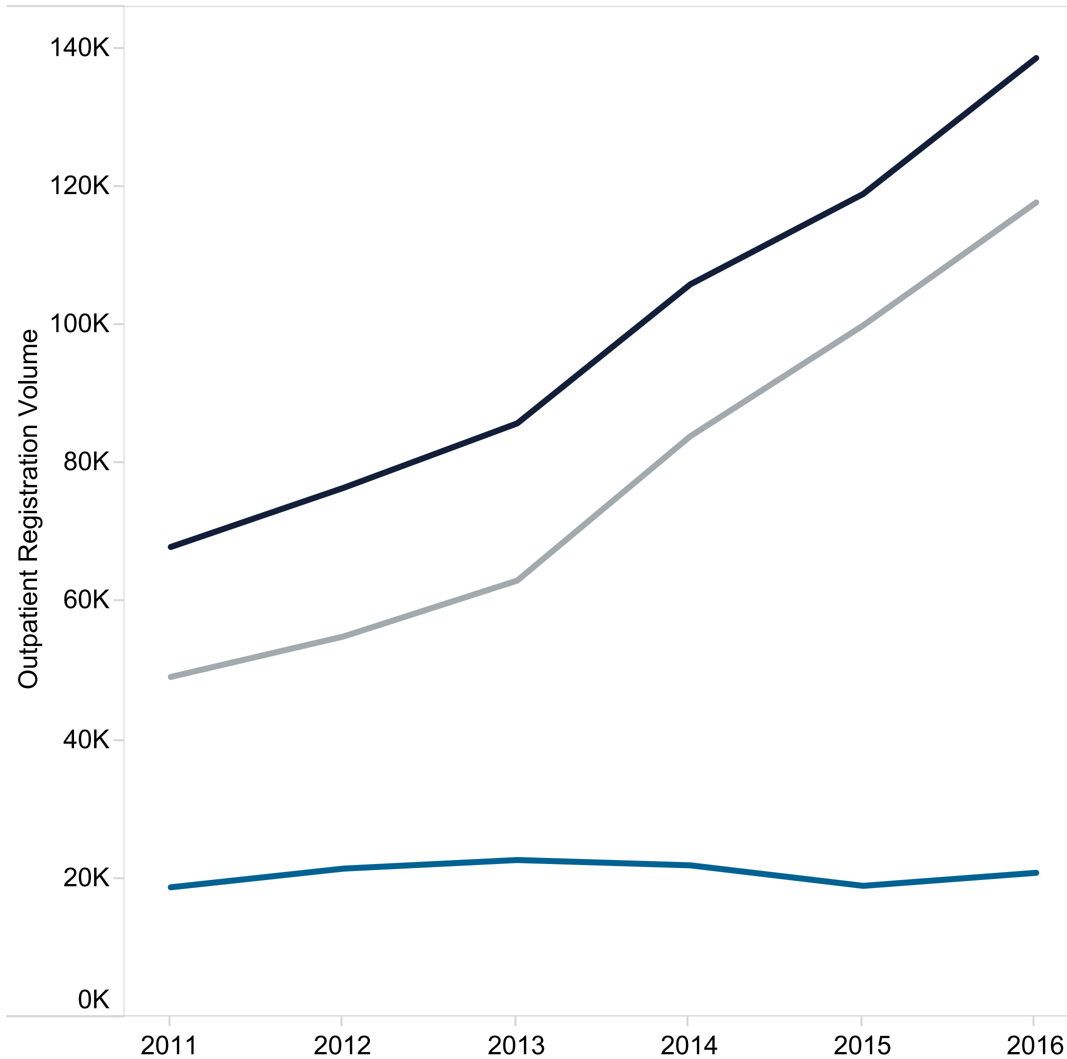
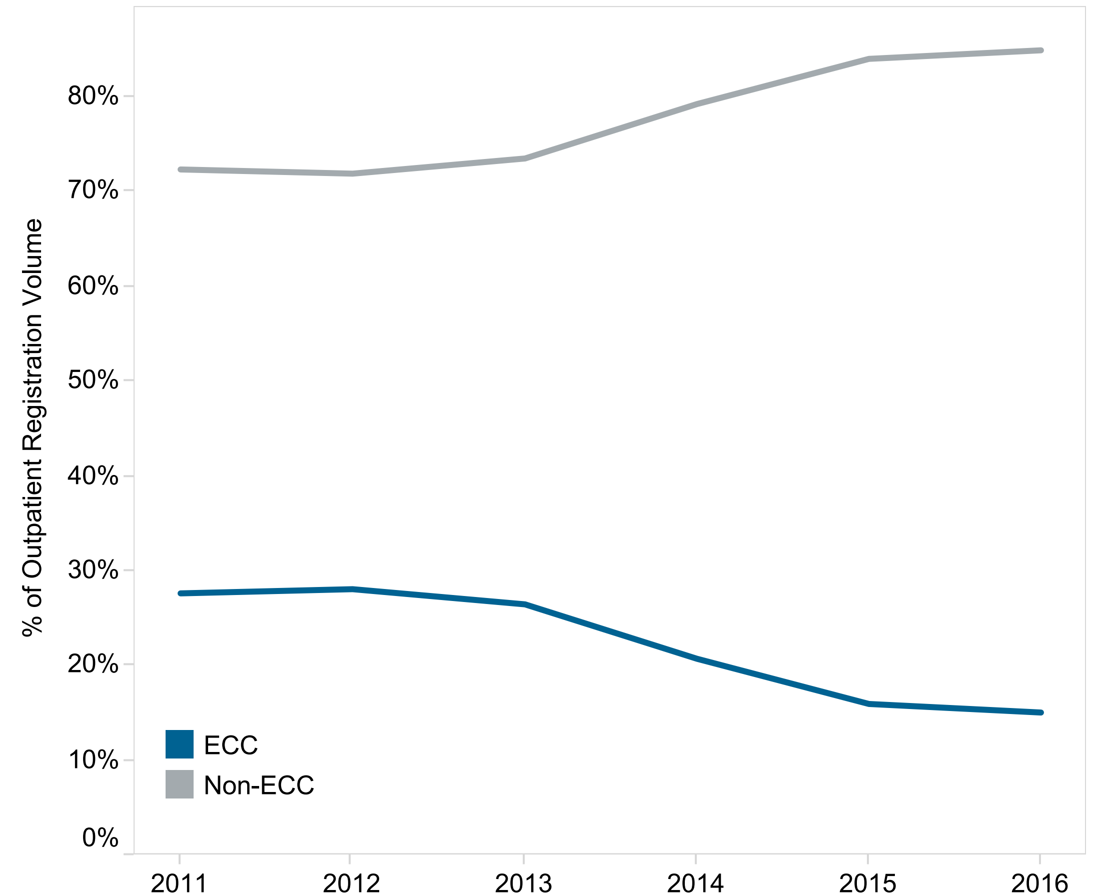
Outpatient Registration Volume

Adult and Youth





	2011	2012	2013	2014	2015	2016
ECC	18,783	21,486	22,725	21,959	18,993	20,877
Non-ECC	49,191	55,046	63,116	83,969	100,008	117,773
Total	**67,974**	**76,532**	**85,841**	**105,928**	**119,001**	**138,650**

Registration Volume

The "Total Outpatient Registration Volume" measure captures the overall volume of newly registered Medicaid members, including those evaluations excluded from meeting the ECC access standards. From 2011 to 2016, the total outpatient registration volume greatly increased from year to year. Most recently, the total outpatient registration increased 16.51% from CY 2015 to CY 2016.

Over the past six years, the total ECC registration volume remained rather constant, while non-ECC volume continued to increase, therefore expanding the gap between ECC and non-ECCs with each passing year. In CY 2016, ECCs accounted for approximately 15% of the total outpatient registration volume, while non-ECCs accounted for approximately 85%.

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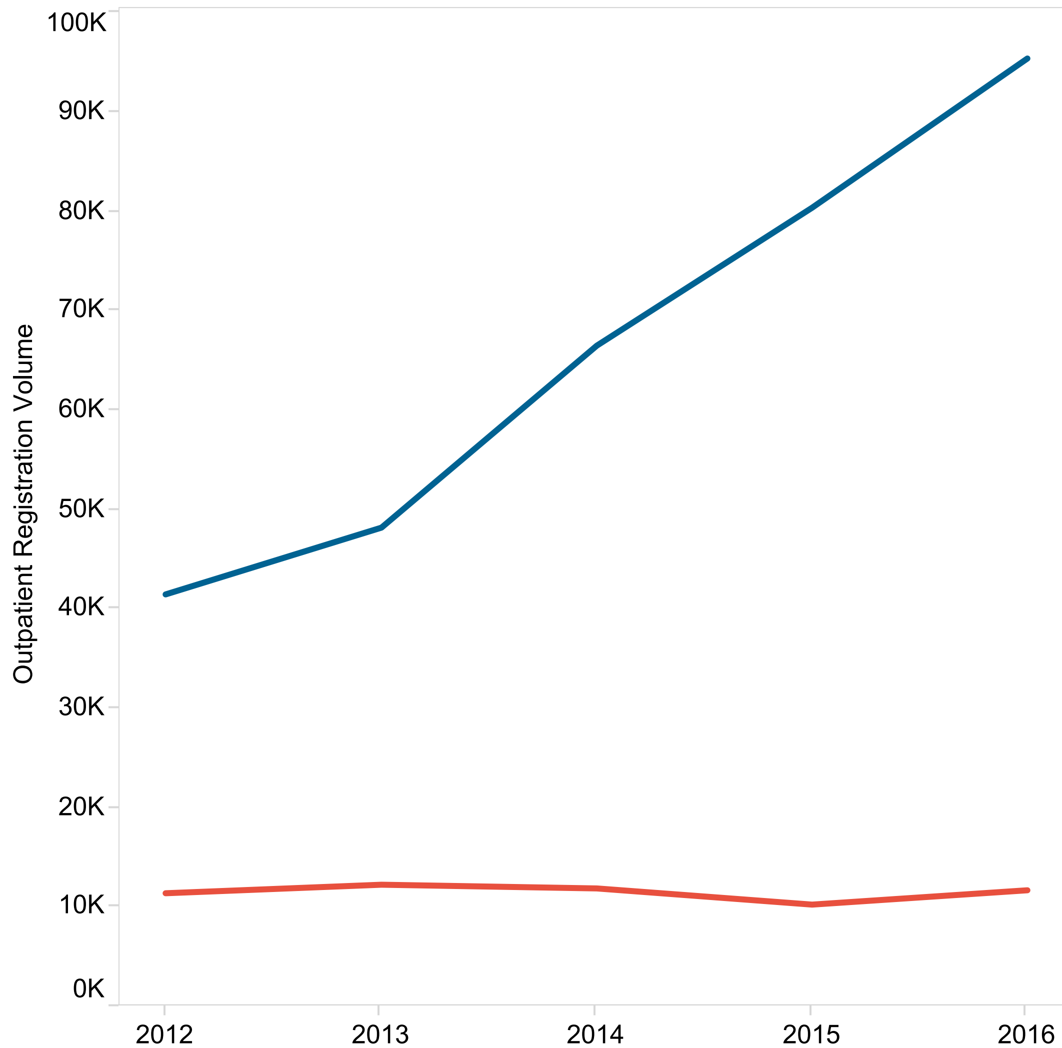
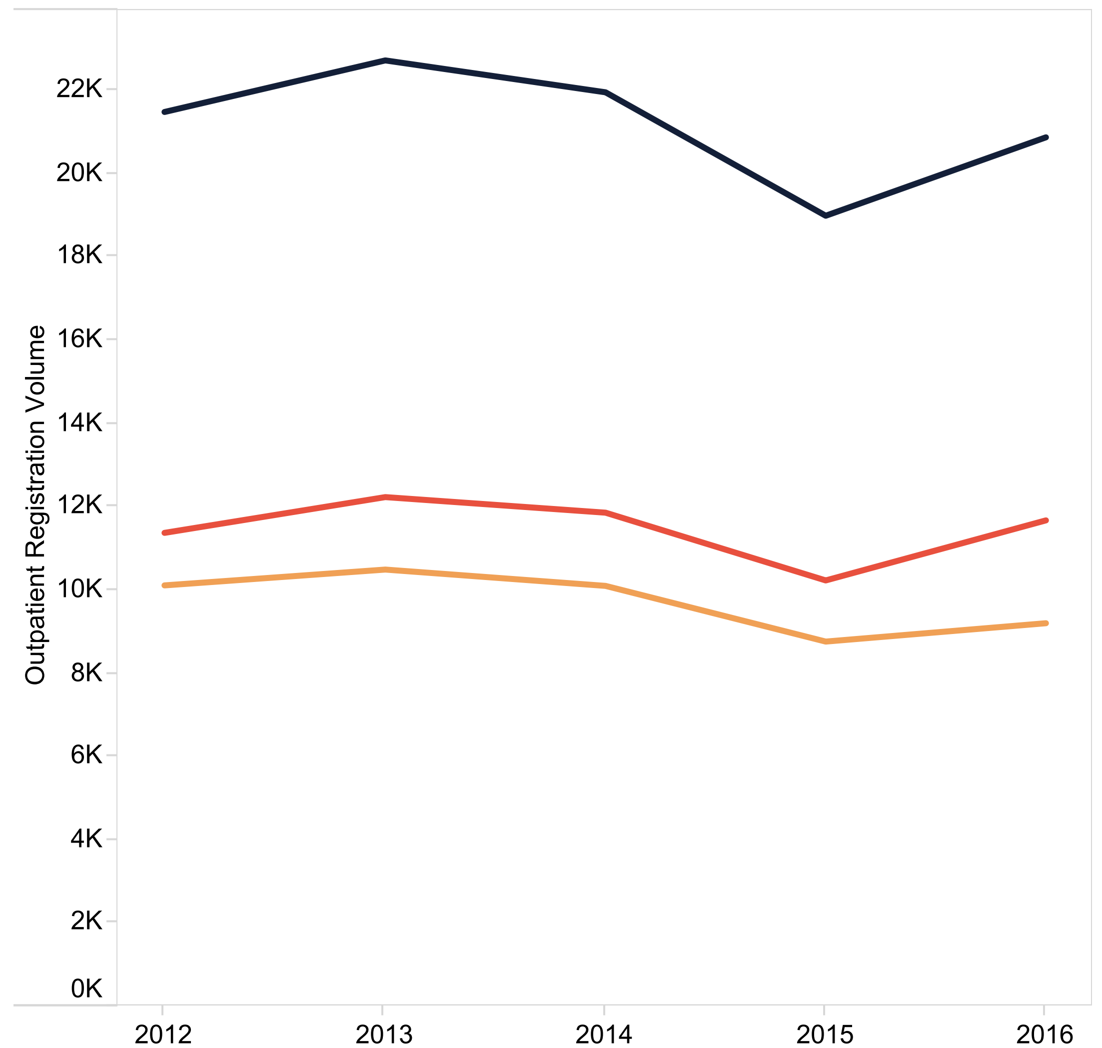
Adult ECC and Non-ECC Outpatient Registration Volume

Type of Care (Age grp)
Adult Measures





Overview

Non-ECC adult registrations have been trending upward since CY 2012, and accounted for approximately 89% of adult outpatient registration volume in CY 2016. ECC adult registrations have remained fairly consistent and accounted for approximately 11% of adult outpatient registration volume in 2016.

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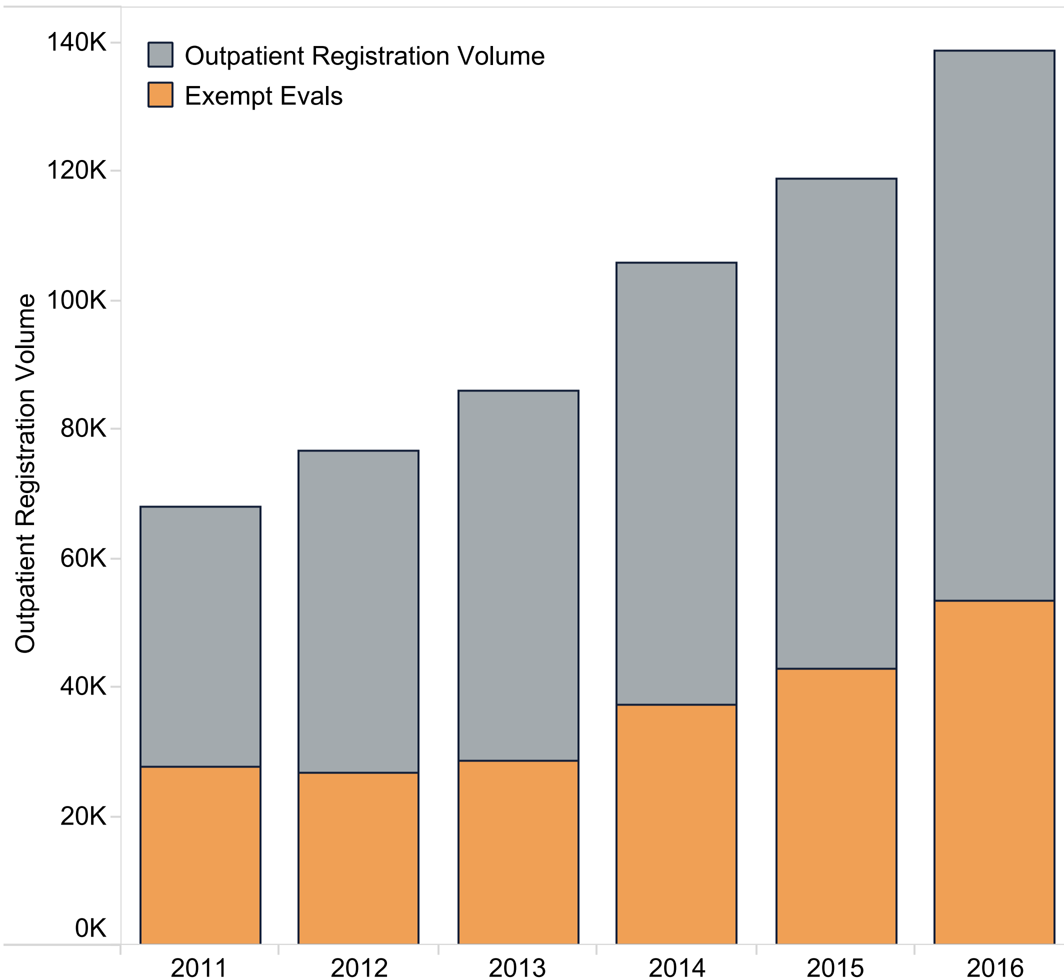
Outpatient Registration Volume

Overview

The "Registrations Required to Meet ECC Access Standards" measure captures only those evaluations that are relevant to meeting ECC access standards. Outpatient clinics are able to identify and exclude from calculation the "exempt registrations" which include: 1) those clients stepping down from a higher level of care within their agency; and/or 2) those clients who have been in treatment at the ECC but who experienced a change in insurance coverage to Medicaid. The access measures are based only on the timeliness of appointments for those members who are truly new clients in the ECCs. Total evaluations needing to meet the access standards accounted for approximately 61% in 2016. This has remained fairly constant over the reporting period, while the total outpatient registration volume has increased. When comparing ECCs vs. FSCs for adults, FSCs have consistently had a higher number of evaluations, and have been slightly trending upward over time. ECCs have remained consistent.

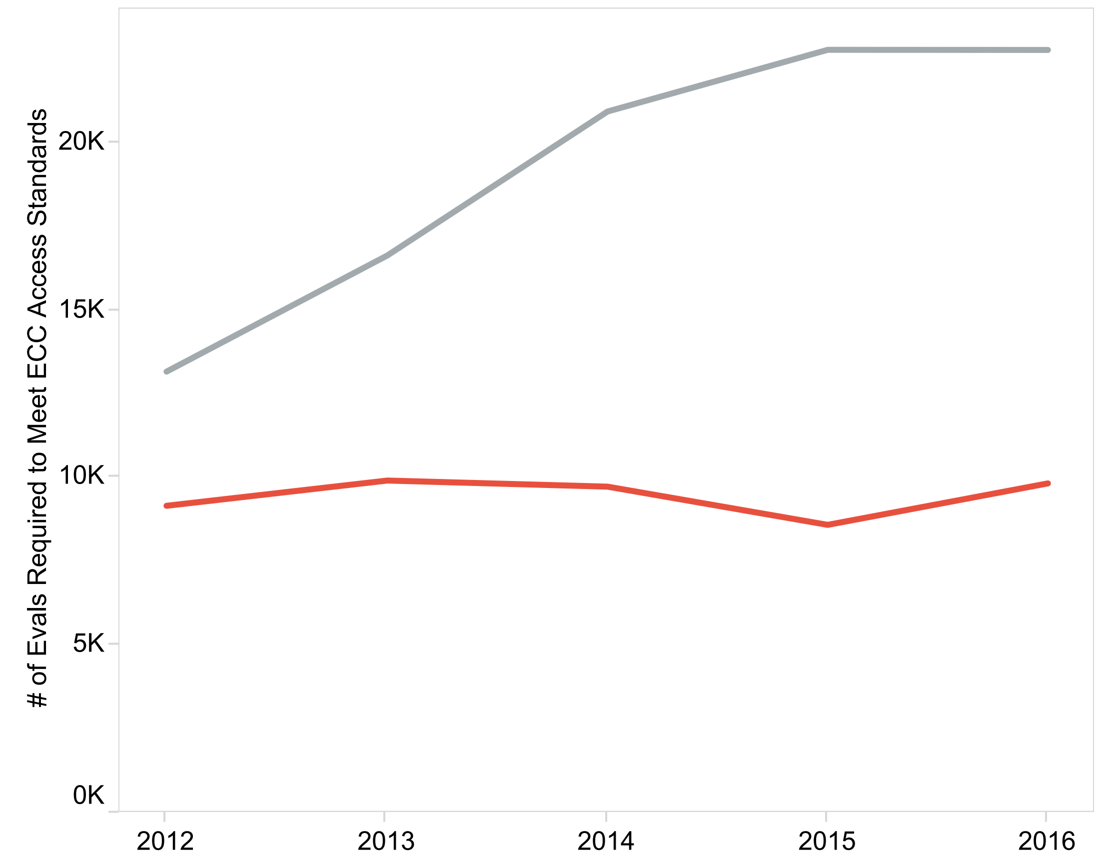
Total Outpatient Registration Volume: Volume of Registrations Required to Meet ECC Access Standards and Volume of Exempt Registrations ECC and Non-ECC



Select Group
Adult Measures

ECC Adult
FSC Adult

Total Number of Evaluations Required to Meet ECC Access Standards: ECC and Non-ECC Freestanding Clinics (FSC)



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Adult Outpatient ECC Access Standards

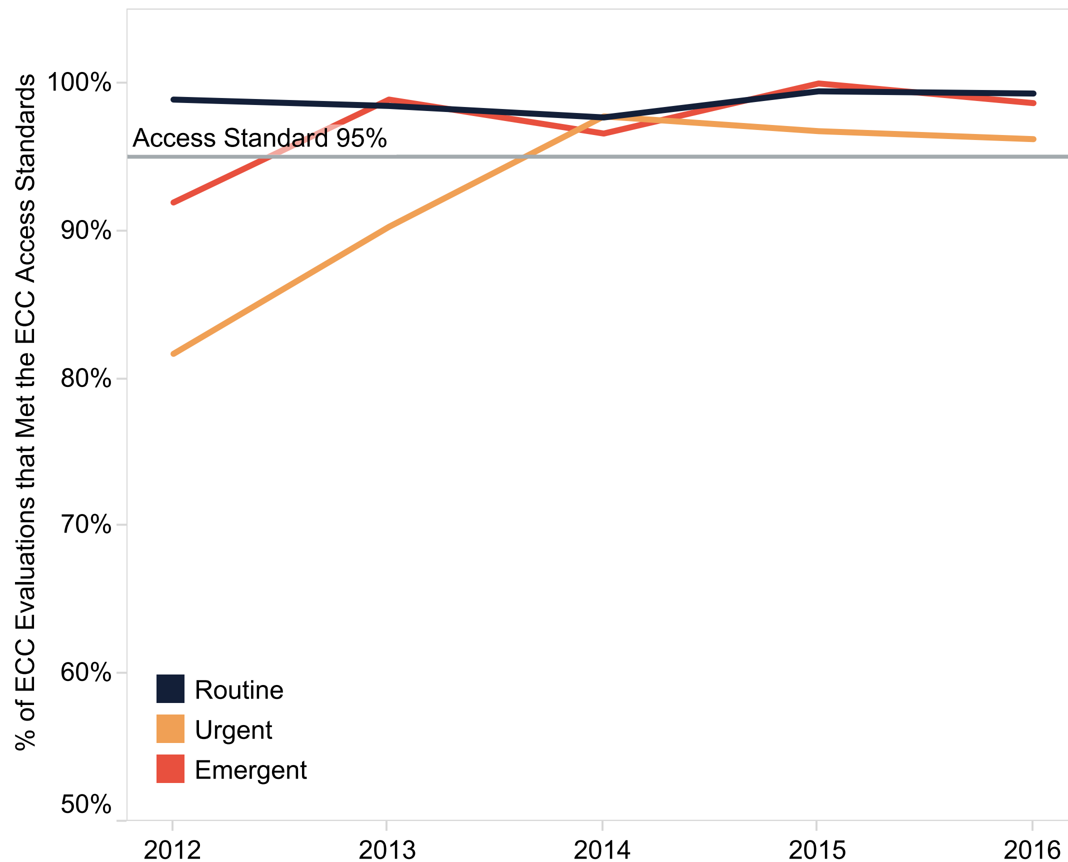
Routine, Urgent and Emergent Registrations

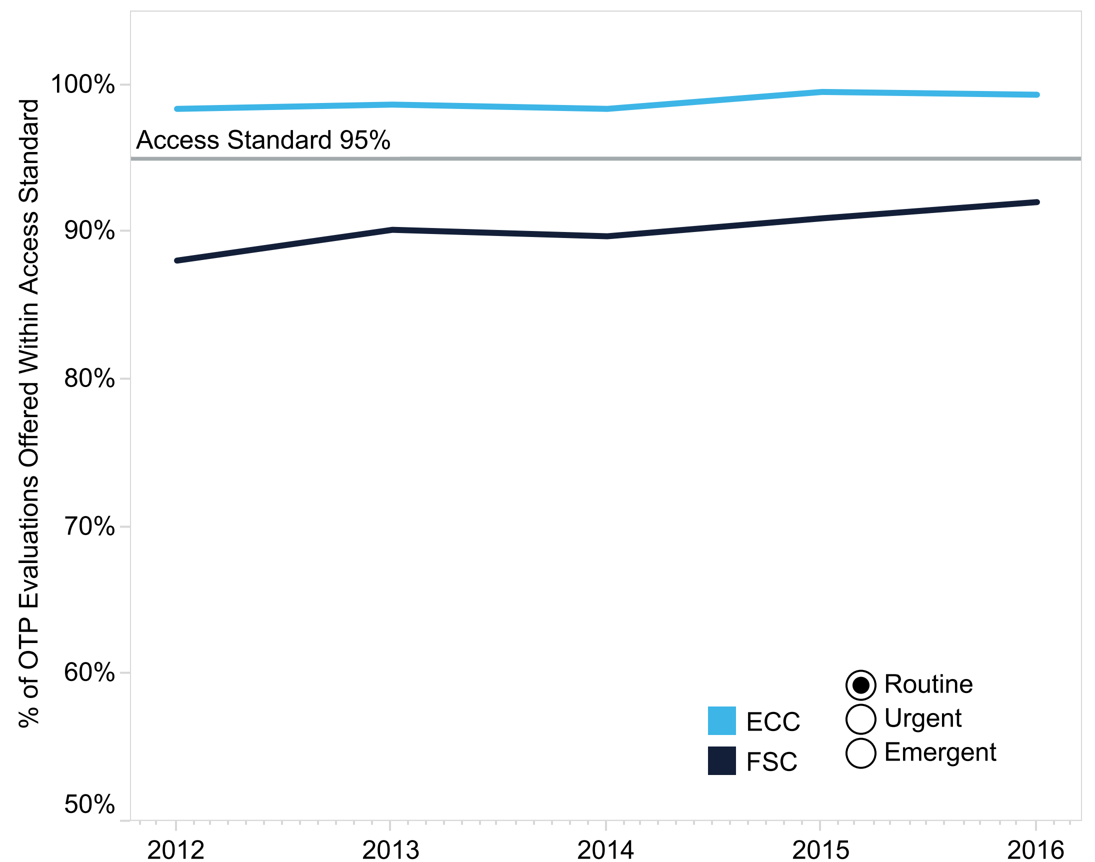
Access Standards

Emergent evaluations for adults were below the 95% access standard in CY 2012, but increased the following year and remained above the access standard from 2013 through 2016. Urgent evaluations for adults were also below the access standard in CYs 2012 and 2013, but increased in 2014 and has remained above 95%, although trending downward. Routine evaluations have consistently remained above the access standard from CY 2012 through CY 2016.

The percent of total outpatient evaluations offered within the ECC access standard have been consistently met by ECCs for routine and emergent. From CY 2013 to CY 2014, total urgent evaluations increased and was able to rise above the 95% access standard. Urgent continued to meet the access standard from CY 2014 through CY 2016, although it has been trending downward.

Both routine and urgent evaluations have been consistently unmet by FSCs, although urgent dramatically increased 22.5 percentage points from 2015 to 2016. Emergent met the access standard in CY 2014 at 95.2% but dipped below the 95% access standard the following year and continued to trend downward in 2016.





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Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities

Compliance

Provider Compliance for CY '16

Routine Access compliance with the 14 day standard for the 38 ECCs fell into the following categories:
1. Met the access standard of 95%: 35
2. ECC falling below the 95% Routine Standard for at least one quarter:
   Hartford Hospital (IOL): 92.31% in Q1 2016 and 94.12% in Q2 '16; **CY 2016: 94.87%**
   Catholic Charities (Torrington): 91.30% in Q4 '16; **CY 2016- 93.75%**
   Connecticut Renaissance (Bridgeport): 90.34% in Q3 '16 and 94.67% in Q4 '16; **CY 2016: 92.54%**

Urgent Access compliance with the 2 day standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Urgent volume during the year: 33
2. Met the access standard of 2 days: 27
3. ECC falling below the 95% Urgent Standard:
   Charlotte Hungerford (Adult): 50% in Q1 2016 (vol. of 2); **CY 2016: 88.89%**
   Clifford Beers: 33.33% in Q1 2016 (vol. of 3); **CY 2016: 33.33%**
   Community Health Resources: 33.33% in Q2 2016 (vol. of 3); **CY 2016: 25.00%**
   Catholic Charities (Torrington): 75.00% in Q3 2016 (vol. of 4); **CY 2016: 83.33%**
   Connecticut Renaissance (Bridgeport): 66.67% in Q3 2016 (vol. of 3); **CY 2016: 66.67%**
   Connecticut Renaissance (Norwalk): 50.00% in Q4 2016 (vol. of 2); **CY 2016: 50.00%**

Emergent Access compliance with the 2 hour standard for the ECCs fell into the following categories:
1. Number of ECCs that reported Emergent volume: 13
2. Met the access standard of 2 hours: 9
3. ECC falling below the 95% Emergent Standard:
   Central CT Child Guidance: 0% in Q4’16 (vol. of 1); **CY 2016: 0%**
   Family and Children’s Aid: 0% in Q4’16 (vol. of 1); **CY 2016: 0%**
   The Village for Families and Children: 50.00% in Q3 2016 (vol. of 2); **CY 2016: 60.00%**
   Yale Child Study: 0% in Q2’16 (vol. of 1); **CY 2016: 0%**

Continued on the next page.

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Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities

Interventions and Activities

Interventions to address ECC performance on Access Standards:

Although the formal measurement period has been annualized, ECC's continue to receive data on a quarterly basis. This includes both quarterly and year to date totals for each standard. Those agencies below 95% for any measure will be required to submit a Corrective Action Plan (CAP) with one exception. The seven new ECC locations will not be required to submit a CAP since they currently have a provisional designation and any performance on access standards below the 95% is currently not being counted until their designation becomes permanent.

Community Health Resources, Clifford Beers, Charlotte Hungerford and The Village have all indicated that the percentages received on the urgent or emergent measures where they did not meet the 95% access standard were a data entry error and have sent in paperwork currently being reviewed. Family and Children's Aid and Yale Child Study have also been given the opportunity to present paperwork to support their missing the emergent measure in Q2 and Q4 2016. All paperwork submitted will be presented at the ECC Operations meeting for review.

Catholic Charities Norwich which had been on probation for not meeting the Routine Access standard in Q3 2015 and the Urgent Access standard in Q4 2015 came off probation in Q3 2016.

Activity Around New ECC Locations in Q3'16 and Q4'16:

The seven ECC locations have been going through an orientation process as follows:
- On 6/28/2016 – the first orientation meeting was held at CTBHP and covered general information about being an Enhanced Care Clinic.
- On 10/11/2016 – a follow up to the initial orientation meeting was held and covered information about what to expect as part of the process of the Onsite Survey which all new ECC locations will go through as a part of moving from a provisional designation to a permanent designation. In addition, clinics were offered the opportunity to have any documents that they had ready reviewed. Connecticut Renaissance and Recovery Network of Programs submitted documents for review. Clinics were also informed that the Onsite Surveys would occur in Q1 2017.
- In December 2016, the clinics were asked to submit charts for review that could be used as a part of the Inter-rater Reliability process in preparation for the Onsite Surveys. Those charts were reviewed and each clinic received feedback in January 2017.

**Wellmore had been approved as an additional adult location withdrew just before the 7/1/2016 start date.*

Continued on the next page.

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Outpatient Enhanced Care Clinics

Compliance, Interventions, & Activities, continued

Interventions and Activities, continued

Mystery Shopper Program:

In Q3 2016, Catholic Charities – Torrington, Connecticut Renaissance – Norwalk, and Recovery Network of Programs were mystery shopped. All three agencies are part of the seven new ECC locations. Calls were made in both Spanish and English in Q3 2016 and the results were as follows:

- There were issues with no Spanish speaking staff available in some cases and no initial calls answered or voicemails responded to over a 24-hour period. This information/feedback was communicated to the agencies in October 2017.

In Q4 2016, Charlotte Hungerford (Adult), Intercommunity, and United Services were mystery shopped. All three agencies met the mystery shopper standard. As a follow up to Mystery Shopper calls done in Q2 2016 with Hartford IOL, a meeting was held on August 17th, 2016 to address their triaging process. Since the initial meeting, the clinic has submitted several iterations of a Triage Tree and more than one phone conference has been held with the clinic to address the modifications. They have now eliminated one step of their initial process and modified their screening tool to more easily identify a member in crisis at the beginning of the triage process. Their final iteration and triage protocol were forwarded to the state partners on 2/9/2017.

Percentage of Members Requesting Later Appointment Even Though They Have Been Offered Appointment Within Required Time Frame

This information was shared with providers along with the Q3 2016 ECC results and clinics were contacted to try and get a better understanding of the data. In most cases the clinics reported that even though members may have requested a later appointment than what was offered, they were often still seen within the 14 days. This is supported by the data when we look at what the statewide average was for members receiving appointments outside of the 14-day window; 4.83% in both Q3 2016 and Q4 2016. (Tableau – Offered vs. Accepted)

ECC Operations: There were ongoing meetings throughout Q3 ’16 and Q4 ’16.

ECC Provider Workgroup on Capacity and Access: Did not meet in Q3 ’16 and Q4 ‘16.

Activities Going Forward:

1. Continue monitoring access data on a quarterly basis within the context of annualized methodology
2. Continue the Mystery Shopper program to ensure effective triage and screening
3. Complete the Onsite Surveys of the seven new ECC locations

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Global Recommendations

Updates

1. Support Regions in the development of Community Care Team (CCT) Meetings – RNMs will continue to support each region/hospital in the planning, development and continuation of established CCTs. ICMs will participate in follow-up meetings and continue to facilitate the CCTs while working with the hospital and community providers to identify additional staffing resources.

Update – The RNMs have been actively involved in supporting the ongoing development of the CCT meetings at various hospitals across the state. In preparation for the reallocation of Beacon's ICM and Peer resources from the Frequent Visitor to the NGA Initiative, Beacon staff worked collaboratively with the Hartford and South Central CCTs in the fall of 2016 to develop and implement CCT transition plans. Additionally, the RNMs continued to provide support, technical assistance, and help with provider engagement to other CCTs across the state, including two newly established CCTs at the Hospital of Central Connecticut and a joint CCT between Waterbury Hospital and St. Mary's Hospital. The ICMs and Peers continue to participate in CCTs across the state when members they are working with as part of the NGA intervention are being discussed.

2. Increase coordination with CHN – Clinical managers/administrators from CHN and Beacon meet biweekly to review protocols and procedures related to authorizations and shared cases. As we move towards an integrated health model we will further develop communication plans and member specific interventions that reflect our shared efforts to provide quality care and support for Medicaid members.

Update – Beacon and CHN continue to meet with Medical Detoxification providers to clarify authorization processes. This joint effort will continue to further reduce duplicate authorization requests and increase the hospitals understanding of the importance of discharge planning to support ongoing recovery in the community and a reduction of rapid recidivism. Clinical management from Beacon Health Options and CHN continue to meet on a monthly basis to further clarify inpatient referrals for co-management and have refined the referral criteria. The weekly complex member collaborative meeting continues in addition to the monthly community based co management meeting to provide member updates and offer feedback and suggestions for next steps. Beacon is partnering with the medical ASO in scheduling meetings with hospital detox providers to further clarify authorization procedures and which ASO should be contacted based on case presentation. These efforts will continue as needed.

3. Establish an ASO Behavioral Health Systems Committee (ABH/DMHAS) whereby systems of care (e.g. residential rehab) that fall outside the scope of Beacon's existing provider network of care work together to identify, problem solve, and address systemic barriers. Several Connect to Care meetings have been held in the New Haven area to discuss coordination amongst inpatient providers (IPD and IPF) and statewide residential rehabilitation programs. The following recommendations for improved access were identified:
a. Examine residential rehabilitation level of care capacity to adequately serve three distinct populations identified 1) SA 2) Co-occurring 3) Co-morbid
b. Examine utilization of DMHAS Recovery Houses (e.g. step-up versus step-down)
c. Examine the potential of developing a standardized referral form and centralized access

Update – Beacon held an Inpatient Workgroup meeting with facilities and invited DMHAS to present on residential rehab services available to members. Providers continued to question the ability to have a centralized referral form or process. One suggestion was to pilot a centralized process in a region to determine if that would help streamline the referral process and increase access to residential rehab services as the current process can be labor intensive for the referring party. DMHAS reported underutilization of this service based on census data, Providers questioned whether there was a need for increased capacity for dually diagnosed individuals as this is the population most often referred from Inpatient Hospital to residential rehab. These two items will be brought to the Substance Use Disorder Workgroup for discussion and potential next steps as the group has representation from Beacon, DSS, DMHAS, ABH, CHN and DCF.

Recommendations continue on the next page.

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Global Recommendations

Continued

4. Develop a comprehensive Medication Assisted Treatment continuum of care.
a. Identify current MAT providers and develop an inclusive document that identifies which medicated assisted treatment is available through specific providers/facilities.
b. Identify current openings/capacity for new Medicaid referrals into these programs. Develop a provider resource list to encourage higher level of care providers to begin MAT with members knowing which programs can provide ongoing MAT in the community.

Update – Beacon created a Medication Assisted Treatment (MAT) webpage which has provider and member resources available. Beacon also developed an interactive map that lists all known Medicaid MAT providers that is available on the MAT webpage. Beacon developed a Member and Provider toolkit that will include two brochures. One brochure focuses on MAT for Opiate Use Disorder and the other focuses on MAT for Alcohol Use Disorder. The toolkits have been reviewed and are pending final approval. Once approved they will be posted to the MAT webpage and included in member/provider folders related to the National Governors' Association initiative. Beacon will also partner with CHN to have a provider focus group with Medical Providers. The goal will be to expand the network of MAT Prescribers in CT.