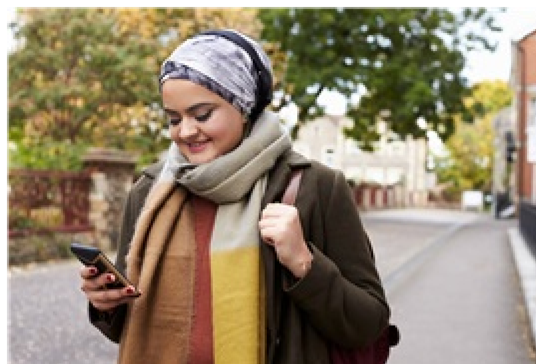
UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Calendar Year 2019: January-December 2019 - Submitted March 2, 2020



Submitted by:
Lori Szczygiel, MA, President, CT Market
Robert Plant, PhD, SVP of Analytics & Innovation
Carrie Bourdon, LCSW, Chief Administrative Officer
Erika Sharillo, LCSW, SVP of Clinical Operations
Sandrine Pirard, MD, PhD, MPH, Chief Medical Director

Prepared by:
Margarita Lovinska, MS, Quality Research Analyst
Lynne Ringer, LCSW, AVP of Utilization Management
Daniel Langless, LMFT, Director of Regional Network Management
Stella Ntate, LCSW, LADC, Regional Network Manager
Paige Fanolis, LMFT, Regional Network Manager
Mollie Greenwood, MBA, Regional Network Manager
Laura Kolpa, LMFT, Clinical Supervisor, Home Health
Stephanie Shorey-Roca, MPH, Quality Research Analyst
Kendra Carr, MPH, Quality Research Analyst
Joseph Bernardi, MS, Quality Research Analyst
Michael Cullen, MBA, Quality Research Analyst
Jennifer Gagnon, Quality Research Analyst
Paulo Correa, MD, Medical Director
Jennifer Lombardi, LCSW, Director of Quality Management
Cynthia Petronio-Vazquez, MS, LPC, NCC, AVP of Quality
Bill Kania, LMFT, AVP of Clinical Services
Christa Mullen, LPC, Clinical Supervisor
Kila Hunter, LCSW, Clinical Supervisor
Liz Downing, LCSW, Clinical Supervisor
John Lombardo, MA, LPC, Clinical Supervisor
Christopher Bory, Psy.D., AVP of Advanced Analytics & Data Visualization
Jay Palica, Director of Quality Analytics & Data Visualization
Kris Noam, Ph.D., Health Research Scientist
Elizabeth McOsker, MPH, Health Research Scientist
Susan Donovan, Director of Reporting
Wallace Farrell, SQL Developer
Michael Barron, SQL Developer
Kyra Lorde, Project Manager
as well as the entire Reporting, Clinical, and Quality Departments

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

A Beacon Health Options-CT Dashboard

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

UTILIZATION REPORT FOR ADULT MEMBERS

Calendar Year 2019: January-December 2019

Reports Used:

General Overview

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

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

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

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

Methodology

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

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

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

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

EXECUTIVE SUMMARY FOR ADULT MEMBERS

Calendar Year 2019: January-December 2019

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 benefits 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.

Total Membership

In 2019, the Connecticut Medicaid membership, including dually eligible members, increased 1.2% and reached 992,890 members, the highest volume reported to date. However, membership without duals, declined by 0.6% to 914,955 members, slightly less than the membership volume seen in 2018. Adults continued to account for the majority (64%) of the total Medicaid population including dually eligible members.

Adult members without duals decreased in 2019 by 1.1% to 555,011, while adults including dually eligible members increased by 1.7%, ending 2019 with 632,945 members.

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

Membership Demographics

Adult membership, excluding duals, slightly decreased for females by 2.3% from 313,136 (55.8%) in 2018 to 306,028 (55.1%) in 2019. Male membership, excluding duals, on the other hand slightly increased by 0.4%, with a total volume of 248,983 (44.9%) in 2019.

Age group demographics were stable, with 25-34 year olds remaining the largest age group at 27.7% of the adult non-dual population. The 35-44 age group continued to increase and remain the second largest group at 20.0%, followed closely by 18-24 year olds at 19.8%. The 65+ age group showed a sharp decrease of 48.2% in 2019, where they now encompass just 2.0% of the Adult non-dual population. The relatively large decrease in the adult non-dual population for ages 65+ from 2018 to 2019 is likely related to corrections and reassignments of dual-status that occurred in 2018 resulting in more accurate categorization in the recent numbers.

Racial and ethnic demographics continue to change. As noted in prior deliverables, modifications to the ImpaCT system used to manage member eligibility led to a significant increase in members identifying as "Unknown" race/ethnicity. The Unknown race/ethnicity group continued to increase among adults, excluding duals, up nearly 5% since 2018. In CY 2019, more than one quarter of the adult Medicaid population (28.2%) is categorized as Unknown race/ethnicity. Beacon's investigations indicate that this is a true unknown, as members are not required to choose a race/ethnicity when applying for Medicaid. It is difficult to identify which race/ethnicity groups this Unknown category includes. 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. According to the 2018 Connecticut Medicaid adult population data, of the 221,274 adults classified as Unknown, 31.1% (68,747 members) identified as Hispanic. Beacon understands that our state partners share our concerns and are seeking solutions as a recent Executive Orders 5 & 6 call out the need for improved health equity reporting within Medicaid. Additionally, Beacon is currently taking efforts to break out Hispanic ethnicity from race in many of our reports.

In CY '19, White members continued to be the largest racial/ethnic group for adults without dual membership at 33.1%. The Hispanic and Black membership remained stable, at 19.1% and 14.9% of the adult Medicaid population without duals, respectively. Members identifying as Asian (3.0%) and Other Races (1.8%) remained unchanged and represent a small portion of the non-dual Medicaid population.

Benefit Membership

HUSKY D continued to be the largest benefit group for adult Medicaid members without dual eligibility (56.9%), increasing by 5.2% since 2018 (329,828 in CY '19). Over the same time, HUSKY A membership, the second largest benefit group among adults without dual eligibility, decreased 1.7% since 2018 and accounted for 38% in CY '19. HUSKY C (ABD/Single) decreased by 37.7% from 2018 to 2019. Beacon hypothesizes that this change is also related to the aforementioned eligibility reporting issue that was resolved in 2018[1]. These trends have important implications for utilization, as HUSKY D and HUSKY C (ABD/Single) tend to be higher utilizing groups.

[1] Beacon consulted with DSS and learned from CHN via DSS that Deloitte was not consistently sending over the most recent third party liability information on members. This issue was resolved in September 2018.

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 1st, 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. In addition to the potential impact of enrollment patterns, it is also possible that the decline in unemployment and thus improvement in financial wellbeing that the state has experienced may also be a factor.

HUSKY D continued to be the largest single benefit group overall and among most demographic groups. Approximately 72% of adult males without duals and 60% of White adults had HUSKY D in 2019. HUSKY D was the largest benefit group for nearly every age group except 35-44 (which had mostly HUSKY A), and 65+ (which had mostly HUSKY C (ABD/Other Single)). Despite overall declines in its membership, HUSKY A still covered 50.4% of females and, 56.7% of 35-44 year-olds. HUSKY A is the top benefit group for females ages 25-34 and 35-44, suggesting that HUSKY A continues to provide essential medical coverage for mothers and their children.

HUSKY C (ABD/Other Dual) remained the largest dual benefit group, accounting for 68.2% of all adult dual members in 2019. The adult dual population continues to be older (63.5% were 65+), female (65.7%), and White (62.1%). Demographic trends were stable, showing all demographic groups decreased in dual membership consistently, with the exception of the "Unknown" race/ethnicity group, which saw a 48.2% increase in HUSKY C (ABD/Other Dual), and a 77.8% increase in HUSKY C (LTC Dual) since 2018.

Inpatient Psychiatric Hospital Utilization

Discharge volume from inpatient psychiatric hospitals (in- and out-of-state, but excluding State facilities) remained consistent from 2016 to 2018, before decreasing 5.5% from 10,627 discharges in 2018 to 10,040 discharges in 2019 for all members without duals.

As seen in prior years, 25-34 year-olds continued to have the most discharges in 2019 (2,835, 11.2%), although discharge volume among this age group is lower than the volume observed in 2018. White adults had the most discharges of all racial and ethnic groups (39.2% of discharges in CY '19). Males also continued to have more than half of discharges (54.9% for males vs. 45.1% for females), and continued to remain disproportionately overrepresented in inpatient stays, as males represented 44.1% of the adult Medicaid non-dual population.

HUSKY D members continued to have the highest volume of discharges of adult non-dual members (7,329), followed by HUSKY A (1,545) and HUSKY C (ABD/Single) (1,135).

In addition to the decline of IPF discharge volume in 2019, the ALOS increased by 0.4 days to 9.8 days in 2019, the highest ALOS to date. The ALOS increased in 2019 for both males and females, however, this change was greater among males (from 9.6 days to 10.1 days) compared to females (9.4 days to 9.6 days).

In that time, more than one third (33.3%) of these [inpatient psychiatric] discharges came from the three largest facilities: Yale New Haven Hospital (1,246 discharges), Hartford Hospital (1,139 discharges), and St. Vincent's Medical Center (872 discharges).

The ALOS remained fairly similar for members between 18 and 54 years of age, ranging from 8.9 days (ages 33-44) to 10.2 days (ages 18-24) in CY '19. However, older groups tended to have longer lengths of stay (ages 55-64 at 11.7 days and ages 65+ at 17.7 days), likely due to age-related medical comorbidities and overall duration of psychiatric diagnoses, among other factors.

In 2019, the ALOS was steady for most racial and ethnic groups. The ALOS for the Asian adult population remains higher than other racial or ethnic groups. As mentioned in prior submissions, Asian members consistently have low behavioral health utilization including inpatient care (111 IPF discharges in 2019), which may indicate that they had fewer prior services before an inpatient stay and therefore need a longer length of stay to stabilize. All other racial and ethnic groups have an ALOS between 8.6 days (Other Races) and 10.1 days (Black).

In-state Provider Analysis and Reporting (PAR) Program hospitals, which excludes the Hospital for Special Care, Prospect Rockville Hospital's eating disorder unit, and Sharon Hospital, accounted for approximately 9,800 discharges in 2019. In that time, more than one third (33.3%) of these discharges came from the three largest facilities: Yale New Haven Hospital (1,246 discharges), Hartford Hospital (1,139 discharges), and St. Vincent's Medical Center (872 discharges).

The ALOS for in-state PAR hospitals was 9.7 days in 2019, which is an increase of 0.3 days from the year prior. Yale New Haven Hospital and Hartford Hospital, the two largest discharge volumes in 2019, also showed an increase in ALOS. In 2019, Yale New Haven Hospital has an ALOS (13.3 days) that is 3.6 days greater than the statewide average, while Hartford Hospital has an ALOS (12.4 days) that is 2.7 days greater than the statewide average. Hartford Hospital continues to report an increase in member acuity as a driver of the acute LOS. As such, several members were identified as needing a longer inpatient stay beyond the acute portion of the stay and were subsequently referred to the state hospital for ongoing treatment. For CY 2019, Hartford Hospital had 18 discharges awaiting placement for a state bed for an average of 48.8 days. With Hartford Hospital and Yale New Haven Hospital removed, the statewide ALOS drops one full day to 8.7 days in 2019. It is also worth noting that the ALOS for both Hartford Hospital and Yale New Haven Hospital increased in Q3 of 2019 but returned to more historic levels in Q4 of 2019.

Yale New Haven Hospital and Hartford Hospital, the two largest discharge volumes in 2019, also showed an increase in ALOS.

The ALOS was stable in 2019 for most of the other providers. The Hospital of Central Connecticut saw a decrease in length of stay in 2019 to 11.6 days, a reduction of five days, consistent with the increase of discharge volume. Likely, this reduction in ALOS is in part due to the Hospital of Central Connecticut becoming part of the Hartford Healthcare system where the focus has been on increasing capacity and throughput from the Emergency Departments.

In 2019, Prospect Waterbury's ALOS increased nearly two days from 10.9 to 13.1 days. Waterbury hospital continues to struggle with attaining an efficient length of stay. This has been attributed to turn over of staff across disciplines; timely access to state beds and stabilization of members with schizophrenia/psychotic disorders. The assigned Regional Network Manager has worked with hospital leadership, local community providers and the LMHA to support strategies that lead to timelier discharge for members who present with SMI.

Per the data shared with providers as part of the PAR program, the statewide 7-day readmission rate decreased slightly from 2018 to 2019 (4.8% to 4.5%).[2] In addition, the statewide 30-day readmission rate also decreased slightly from 2018 to 2019 (15.7% to 14.9%). The volume and percentage of readmissions within 7 days post IPF to detox has increased for each of the last three years, from 55 (10.9%) in 2017 to 68 (16.0%) in 2019). The four providers with notably long ALOS in 2019 (Hartford Hospital, Yale New Haven Hospital, The Hospital of Central Connecticut, and Prospect Waterbury) had lower than average 7- and 30-day readmission rates, with the exception of Prospect Waterbury with a 7-day readmission rate of 5.0% and a 30-day readmission rate of 18.8%.

In the prior semiannual submission, it was stated that Beacon has begun to track the reasons for adult members remaining in the hospital beyond the acute portion of their stay. This was expected to allow the CT BHP to better understand where the waits are occurring within the system in order to strategize how to best address the barriers. A potential impact of this increased focus resulted in a decrease in the ALOS for members that were awaiting recommended services from 67 days in CY '18 to 43.3 days in CY '19.

In 2019, discharges awaiting placement for residential rehabilitation had varying ALOS among quarters, ranging from 15.2 days to 20.9 days. The portion of the stay that was awaiting a State inpatient bed had a sudden spike in Q3 '19 at 80.3 days, whereas all of the other quarters in 2019 averaged around 65 days.

From 2017 to 2019, both seven-day and thirty-day readmissions trended down.

Inpatient Intermediate Duration Acute (IDA) beds are an alternative to a state hospital bed for members who require longer treatment and stability, but likely can return to the community. Discharge volume from IDA is relatively low, with 26 discharges in 2019. Admission to this level of care is more difficult, as stable housing and weekly contact with an outside provider is needed. All 26 discharges in 2019 were from St. Vincent's Medical Center.[3] Since these are 30-45 day beds, higher ALOS is expected. In 2019, the ALOS decreased to 27.4 days from 34.5 days in 2018. In 2019, IDA was split between males and females (50%/50%) who were mostly White (46.2%) with HUSKY D membership (80.8%).

[2] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.
[3] St. Vincent's Medical Center is the only provider of IDA services.

Recommendation 1: Continue Adult Inpatient PAR Program

In CY 2019, Regional Network Managers met with the adult inpatient psychiatric hospitals in continued efforts to improve access and quality of care for Medicaid adults. Clinical and Medical Affairs staff also participated in PAR discussions as needed. These conversations provided an important forum to understand the varied clinical philosophies, community resources, treatment approaches, and cultural influences at each hospital and within each community. Understanding a provider's performance within this context furthers our ability to shape provider practice via the PAR program.

As noted in previous semi-annual reports, variation in ALOS and readmission rates across the state continue. Through the lens of the new bypass metrics, Regional Network Managers continue to encourage conversations specific to hospital practice, treatment philosophy, and/or local provider resources. From 2017 to 2019, both seven-day and thirty-day readmissions trended down. Over the past three years, seven-day readmissions have declined from 5.0% in 2017 to 4.5% in 2019. Comparatively, thirty-day readmissions also decreased during this same time period from 15.8% 14.9%. Despite this system improvement, medication non-adherence and co-occurring substance use disorders were identified as factors adversely impacting readmission rates.

Medication non-adherence and co-occuring substance use disorders were identified as factors adversely impacting readmission rates.

While readmissions remain on a downward trajectory, the average length of stay has increased from 8.8 days in CY 2017 to 9.7 days in CY 2019, with notable variation across the provider network. Therefore, PAR discussions in CY 2019 continued to focus on barriers and best practices for attaining and/or maintaining an efficient length of stay.

Factors influencing ALOS are consistent with previous PAR cycles and remain as follows: staffing shortages across disciplines; use of locum tenens; breakdown in adherence to internal workflows; timely access to state, intermediate and residential beds; homelessness; probate hearings; electro-convulsive therapy (ECT); diagnosis of schizophrenia/psychotic disorder and older age. Member acuity was also reported as a driver of ALOS, adversely impacting milieu dynamics and contributing to an escalation in staff injuries.

Factors influencing ALOS are consistent with previous PAR cycles and remain as follows: staffing shortages across disciplines; use of locum tenens; breakdown in adherence to internal workflows; timely access to state, intermediate and residential beds; homelessness; probate hearings; electro-convulsive therapy (ECT); diagnosis of schizophrenia/psychotic disorder and older age.

A major component of the CY 2019 PAR meetings focused on implementation of the new Bypass program and its varied impact on hospital performance. As expected, hospitals fluctuated widely in their ratings within the three-tiered case-mix model. While six hospitals maintained a tier one rating (Bridgeport, Bristol, Griffin, Charlotte Hungerford, Lawrence & Memorial, and Middlesex), the other hospitals varied in tier status.

Another focus of the adult IPF PAR program was hospital performance on the prescription fill rate post discharge from an inpatient psychiatric stay. During the 2019 PAR cycle, best practices to improve member's adherence to medication post an inpatient stay were reviewed. As an example, Lawrence & Memorial Hospital implemented a system where the on-site pharmacy visits the inpatient psychiatric unit for member consultation prior to discharge to discuss the benefits of medication adherence. At Griffin Hospital, the use of courier services is now utilized to assure timely delivery of member medications post an inpatient stay. The use of Long-Acting Injectable medications was also promoted to improve adherence. For January through June of 2019, prescription fill rates were at 71.7% after 7 days and 75.3% filled after 14 days. As such, this will remain a focus of discussion during CY 2020 PAR program to further support performance improvement along with the dissemination of best practices pertaining to medication adherence across the hospital network.

Hospital providers frequently identify the state bed waitlist as having an adverse effect on ALOS. Since 2017, the total average length of stay for members identified as awaiting placement for a state bed increased from 61.7 days in CY 2017 to 69.3 days in CY 2019. As described under recommendation 4, Beacon adjusted the Provider Analysis and Reporting dashboard for adult inpatient psychiatric facilities to include other levels of care and/or programs contributing to an extended hospital stay such as residential rehab. This data will be reviewed in PAR meetings and with the state partners to better inform the discussion about perceived barriers.

The total average length of stay for members identified as awaiting placement for a state bed increased from 61.7 days in CY 2017 to 69.3 days in CY 2019.

Recommendation 2: Implement and Monitor Impact of Modified Inpatient Bypass Program
As mentioned in the mid-year submission of the semi-annual reports, the prior Bypass Program which evaluated providers performance on three measures was maintained for the first half of the year. The new Bypass Program was initiated August 5, 2019, after much planning and preparation with providers. Providers were informed of their performance on the metrics (see grid below) based on Q1 '19 data due to the need for a claims lag. Providers were also notified of the corresponding tier (see grid below) that had been earned based on their performance and authorization parameters that would be granted for initial authorization between August 5 and November 3, 2019.

	Measures	Youth		Adult	
		Standard	Pts.	Standard	Pts.
1	7-Day Readmit	5%	1	6%	1
2	Discharge Form Completion	90%	1	90%	1
3	Behavioral Health ED Visit within 7-Days of Discharge	9%	1	13.5%	1
4	Length of Stay Difference (in days)	>= -0.5 >= -1.5 < -1.5	2 1 0	>= -0.5 >= -1.0 < -1.0	2 1 0
5	Length of Stay Improvement or Maintenance • Improvement • Maintenance	-- >= 1.0 >= 0	1	-- >= 1.0 >= 0	1
6	Bed Tracking	90%	1	90%	1

Table 1: IPF Bypass Measures, Standards, and Points

During Inpatient PAR meetings occurring in the latter part of the year, Bypass information was reviewed, and questions were answered to ensure that all the providers were knowledgeable and understood the metrics and their corresponding performance. Q2 '19 performance was sent out to providers in late October with an effective date of November 4, 2019 for any changes based on performance. Individual hospital performance will continue to be reevaluated every three months and authorization adjusted accordingly. The length of stay will be monitored closely to assess for potential impact of the new bypass.

Tier	Point Range	Requirements	Authorization Process
Tier 1	5 – 7	• At least 1 point must come from the Length of Stay Difference measure **and** • At least 1 point must come from the 7-Day Readmit measure	Auto approval based upon the facility's average predicted LOS based on discharges within the previous quarter
Tier 2	3 – 4	• At least 1 point must come from the Length of Stay Difference **or** the Length of Stay Improvement/ Maintenance measure	7 units auto approved for initial requests
Tier 3	1 – 2	--	3 units auto approved for initial requests
Non-Bypass	0	--	No auto-approval

Table 2: IPF Bypass Tier Requirements and Authorization Process

The Higher Level of Care team uses the length of stay difference information to identify providers in need of targeted clinical assistance in moving their identified target. Beacon continues to share data with providers about members that are at greater risk of having longer lengths of stay based on risk factors (e.g., homelessness, previous episode with awaiting services and total number of medical ED visits within the past year) utilized within our predictive modeling.

Recommendation 3: Increase Focus on Readmissions and Changing Pathways
As previously mentioned, with the increase in re-admissions to detoxification post mental health inpatient stays, concentrated efforts need to be made to address both mental health and substance use disorder (SUD) needs during the treatment episode and in the discharge planning process.

The Clinical team will work with hospitals to ensure that releases of information are obtained and documented to allow Beacon clinicians to share prior SUD history and inquire if medication assisted treatment has been offered and encouraged for members with an SUD history. The sharing of information will also assist in improved discharge planning.

To further support this effort, Beacon has encouraged inpatient providers to adopt evidence-based practices (EBPs) to treat SUD and in particular MAT induction for members with OUD during inpatient episode. Saint Francis Care Behavioral Health Mount Sinai Campus was formally invited to participate in the Changing Pathways Pilot. The kick-off meeting provided an opportunity to review the Changing Pathways pilot and re-visit the rationale for expanding this model from two freestanding withdrawal management facilities to an inpatient psychiatric unit. In addition, time was devoted to discussing specific protocols for a warm hand-off at discharge. While partnerships with local and statewide OP MAT providers existed for the ED, comprehensive meetings were held by the Regional Network Managers to establish and/or solidify referral pathways for supporting the warm transfer from the inpatient setting to community MAT providers across the network.

As such, the Peer role will be pivotal to supporting this practice change. While embedded on the unit, the Peer will function as a resource for improving member engagement and help to facilitate and bridge members to treatment post the inpatient stay. As a person in recovery, the Peer will be available to support members choosing MAT inductions, addressing barriers that negatively impact adherence to MAT 90 days after inpatient stay. In 2020, Beacon will continue to provide education about MAT induction for members with co-occurring OUD and promote adoption of this EBP by inpatient providers.

Recommendation 4: Continue to Track Adult Awaiting Recommended Services and Address Identified Barriers
The enhanced tracking of recommended services that adult members are awaiting while on an inpatient unit has been in place since early 2019. Improvements continue to be made in order to more accurately identify system throughput issues and to strategize around opportunities to resource other levels of care to reduce length of stay and costs associated with overstay. With enhanced tracking, the Adult Higher Level of Care team has been able to set up regular phone calls with individuals at the LMHAs to discuss the members awaiting state inpatient beds. During these discussions, diversionary opportunities are explored with the intent to assist the member into the community if possible. The waiting time for residential rehabilitation for further SUD treatment has been an area of focus during the Adult Operations meetings in order to jointly strategize about ways to address the barriers. Beacon will continue to work with the State Partners on identifying and addressing barriers to admission to the next recommended service.

Inpatient Detoxification – Hospital Utilization
Discharge volume and admissions per 1,000 for Inpatient Detoxification in the Hospital (IPDH), excluding state facilities, both decreased in 2019, with 3,645 discharges made by approximately 2,160 unique members, indicating many repeat utilizers.[4] These trends appear driven largely by White males in the HUSKY D benefit group.

As expected, due to the greater medical risks involved with alcohol detoxification, hospital detoxification discharges were mostly for alcohol use (94.6%)[5]. Due to detoxification protocols, the ALOS was stable during 2019. As mentioned in the prior semiannual, by using member-level PAR data, Beacon discovered an error was made during the authorization process, which inflated the ALOS in CY '19.[6] With the erroneous length of stay removed, the ALOS in 2019 actually reflected 5.2 days, a 0.1 day difference. This error also had an impact on demographics, incorrectly increasing the ALOS for females, White members, the 25-34 age group, and HUSKY D membership.[7]

Due to detoxification protocols, the ALOS was stable during 2019.

The vast majority of IPDH discharges are coming from HUSKY D members, accounting for 3,208 discharges in CY '19. Discharges from this benefit group increased since 2018 and is overrepresented with 56.9% of the adult non-dual Medicaid population and 88% of IPDH discharges. Males are also overrepresented, as they make up 44.9% of the adult Medicaid non-dual population and 71.3% of IPDH discharges.

IPDH discharges were stable among all race/ethnic groups, with more than half coming from White members, who are also disproportionally overrepresented as they make up 33.1% of the adult non-dual Medicaid population and 55.6% of IPDH discharges. The ALOS was also stable among most race/ethnic groups, clustered between 4.9 days (Black) and 5.6 days (Other).

IPDH discharges were stable among all race/ethnic groups, with more than half coming from White members, who are also disproportionally overrepresented as they make up 33.1% of the adult non-dual Medicaid population and 55.6% of IPDH discharges.

Discharges decreased among all age groups from 2018 to 2019, except for 55-64 and 18-24 year olds. The majority of discharges are from adults aged 45-54 years-old and are disproportionally overrepresented in the Inpatient Detoxification—Hospital service class, as they represent 16.6% of the total adult Medicaid population and 33.8% of the IPDH population. Most age groups saw a slight decrease in ALOS with the exception of 25-34 age group, which increased by 0.7 days from 2018 to 2019.

[4] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.
[5] Note: this data comes from the Adult Inpatient Data Dashboard. The data feeding this dashboard is updated weekly, and data updates may impact prior weeks' numbers as well, so any numbers reported from the Adult Inpatient Data Dashboard in this deliverable may differ slightly from the numbers currently shown on the dashboard.
[6] The member's admission date was entered as 2018 instead of 2019, resulting in a LOS of 369 days instead of the four days the member actually stayed. In order to fix, claims would need to be recouped and provider was unwilling to do so.
[7] With the erroneous 369 LOS removed, the actual ALOS in 2019 for females was 5.2 days (vs. 5.6 days), age group 25-34 was 4.8 days (vs. 5.4 days), White was 5.3 days (vs. 5.5 days), HUSKY D was 5.2 days (vs. 5.3 days), and Danbury Hospital was 5.7 (vs. 7.8 days).

Of the 3,645 IPDH discharges in 2019, 3,597 (98.7%) were from in-state hospitals in 2019. Yale New Haven Hospital (714 discharges) and St. Francis Hospital (527 discharges) were the top two providers for IPDH, accounting for 34.5% of in-state discharges. Yale saw a 10.3% reduction in discharge volume from 2018. St. Francis Hospital, however, saw a 13% increase in 2019. Those numbers should be interpreted with caution however as requests for authorization for inpatient stays for members in need of detoxification are reviewed by either Beacon or the medical ASO (CHN) depending on whether the primary problem is determined to be behavioral health or medical.

From the data shared in the PAR program, the total 7-day readmission rates for all in-state IPDH providers (excluding state facilities) increased from 2018 to 2019 (9% to 11%), higher than in previous years. On the other hand, the 30-day readmission rate decreased slightly in this time (29.5% to 28.8%). For both 7- and 30-day readmissions, slightly more than half readmitted to the same provider.

Recommendation 5: Continue Hospital-Based Detoxification PAR Program with High-Volume Facilities
PAR meetings were held in the second half of 2019 with the two highest volume providers, St. Francis and Yale. The focus of the PAR meetings was on increasing utilization of Medication Assisted Treatment (MAT) for both Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD).

In 2018, Beacon began to assist in developing relationships between new specialist staff and regional treatment experts at both Yale and Saint Francis to encourage connections to care. In 2019, Beacon continued to support the establishment of referral pathways to outpatient treatment. Although Yale's addiction medicine consultation service is well networked to a variety of outpatient recovery providers, this expertise is not yet shared among all social work staff. One finding from a 2019 PAR meeting with Yale was that there was a disconnect in communication between utilization management staff and social work staff, which has contributed to challenges connecting to aftercare. As a result, leaders at Yale are working to identify new workflows to support improved communication and connections to care for all members hospitalized for withdrawal management at Yale.

In 2020, Beacon will continue to promote the adoption of MAT for both AUD and OUD by inpatient providers across the network. Efforts to improve discharge planning and connect to care will also be carried forward.

Inpatient Detoxification – Freestanding Utilization
Like IPDH, Inpatient Detoxification at Freestanding Facilities (IPDF) continued to be utilized mainly by White males in the HUSKY D benefit group. However, IPDF serves a younger population than IPDH which is to be expected since the rate of medical comorbidities and severity of the disease tend to worsen with age. In 2019, discharges decreased very slightly by 1.6% (from 11,263 in 2018 to 11,084 in 2019) and were mainly for alcohol (51.9%) or opioid (44.4%) detoxification. Given that most facilities usually operate at full capacity, it is not surprising that discharges have remained steady despite the ongoing opioid epidemic. The ALOS was unchanged in 2019, at 4.3 days. The ALOS was 4.0 days for opioid withdrawal (with a 25.3% Against Medical Advice (AMA) rate), and 4.4 days for alcohol withdrawal (with a 19% AMA rate).[8]

HUSKY D continued to account for the vast majority (88.4%) of discharges from IPDF. Consistent with the prior year, ALOS was nearly identical across benefit groups at 4.2 to 4.3 days.

By gender, discharges were steady in 2019, with males having more discharges (71.6%) than females, which is again a disproportional overrepresentation of males in the adult non-dual Medicaid population (44.9%). The ALOS for males and females was nearly identical in 2019, with 4.3 for Males and 4.2 for Females. Discharges remained stable across racial and ethnic groups, with White members having approximately half of IPDF discharges in 2019 (50.1%)—again, a disproportional overrepresentation compared with White members' proportion of the total population (33.1%).

In 2019, providers with the lowest length of stay, Cornell Scott-Hill Health (3.7 days), Intercommunity (3.8 days), and Rushford Center (4 days), all had the highest rates of induction onto Medication Assisted Treatment (MAT) for members with OUD among the freestanding detox facilities.

Discharges remained fairly stable across age groups in 2019. Consistent with prior years, members in the 25-34 year-old age group had the most discharges (34.0%) in 2019. The ALOS remained stable across age groups, clustered around four days, with the exception of the 65+ age group with 5.3 days (note this was based on 22 discharges in 2019).

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

Consistent with prior years, there were seven in-state inpatient freestanding detox providers, accounting for 11,080 discharges in 2019. The largest IPDF provider continued to be Intercommunity Recovery Center, which had 2,533 discharges in 2019, approximately 23% of all IPDF discharges during that time. Recovery Network of Programs had the second highest number of discharges (1,891, or 17% of the total), followed by Stonington Behavioral Health (1,663, 15%). Because treatment is protocol driven, there is little variance among providers for ALOS which ranged from 3.7 days to 5.0 days.

AMA rates for members with opioid related disorders was considerably lower for induction (10.3%) versus detoxification (28.0%) in 2019.

In 2019, providers with the lowest length of stay, Cornell Scott-Hill Health (3.7 days), Intercommunity (3.8 days), and Rushford Center (4 days), all had the highest rates of induction onto Medication Assisted Treatment (MAT) for members with OUD among the freestanding detox facilities. Cornell Scott-Hill Health had an induction rate of 41.7%, Rushford at 25.5%, and Intercommunity at 25.4%. Shifts in practice change to induct members with an Opioid Use Disorder on MAT with a warm-handoff to community providers may attribute to lower lengths of stay, compared to providers who are continuing to practice traditional detox to zero protocols, requiring longer lengths of stay to ensure an adequate withdrawal management process. In addition, AMA rates for members with opioid related disorders was considerably lower for induction (10.3%) versus detoxification (28.0%) in 2019.

For members with an opioid related disorder, the readmission rates were considerably lower for induction versus detoxification, with a 7-day rate of 3.3% versus 5.3% and a 30-day rate of 12.4% versus 19.6% in 2019.

From the data shared in the PAR program, the 7-day readmission rates for all in-state freestanding detoxification providers increased in 2019 to a high of 5.8%.[9] In addition, the 30-day freestanding detox readmission rate slightly increased from 19.8 to 20.0%. The majority of discharges (77.8% of 7-day readmissions and 64.3% of 30-day readmissions) readmitted to a different provider. For members with an opioid related disorder, the readmission rates were considerably lower for induction versus detoxification, with a 7-day rate of 3.3% versus 5.3% and a 30-day rate of 12.4% versus 19.6% in 2019.

Recommendation 6: Continue Provider Workgroup Meetings and PAR Program

Throughout CY 2019, Beacon continued to meet with freestanding detoxification facilities to collaboratively discuss Provider Analysis & Reporting (PAR) measures from the Inpatient Withdrawal Management Tableau dashboard. Historically these metrics comprised of ALOS, readmissions, AMA and connect to care rates. With the expansion of the Changing Pathways model, newly added measures have been folded into PAR conversations that include: MAT induction and adherence rates, the efficacy of MAT education along with connection to MAT post an inpatient stay.

CY 2019 PAR and workgroup meetings provided an effective platform to advance the shift in practice from traditional protocols where members are detoxified to zero vs. alternative withdrawal management involving initial induction and then maintenance on medication for opioid use disorder. Sharing of the PAR data remains a transparent process, allowing for meaningful discussions pertaining to system variability and the challenges incurred with adopting MAT induction as an evidence-based practice in the treatment of Opioid Use Disorder (OUD).

With the expansion of the Changing Pathways model, newly added measures have been folded into PAR conversations that include: MAT induction and adherence rates, the efficacy of MAT education along with connection to MAT post an inpatient stay.

The impact of this practice change has resulted in a seismic shift across the withdrawal management provider network (ASAM 3.7 level of care). To date, the outcomes demonstrate an unprecedented upward trend in induction rates, and improved AMA rates, readmission rates, and connect-to-care rates for members who were inducted versus those who were detoxed to zero during a withdrawal management episode.

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

While all seven freestanding detox facilities are at different stages of implementation, providers have been generally receptive to feedback regarding adoption of the changing pathways model. Figure 1 displays the percentage of members with an OUD diagnosis who were inducted onto MAT during CY 2019. There continues to be an upward trend in induction rates demonstrated by the statewide average of MAT inductions, increasing from 14.8% in Q1 and Q2 2019 to 23.8% in Q3 and Q4 2019. Providers have also reported MAT education as an essential precursor to MAT induction.

Core Provider Analysis and Reporting (PAR) measures such as AMA and readmissions rates also continue to support the effectiveness of MAT. In 2019, new data metrics were introduced that compare members who were inducted on MAT to those who engaged in a traditional detox protocol. Figure 2 demonstrates that MAT induction contributes to lower 7 and 30-day readmission rates, as well as lower AMA rates when compared to the detox cohort. With the promising upward trend in MAT inductions, this data further leverages the efficacy of adopting this critical practice change.

To date, the outcomes demonstrate an unprecedented upward trend in induction rates, and improved AMA rates, readmission rates, and connect-to-care rates for members who were inducted versus those who were detoxed to zero during a withdrawal management episode.

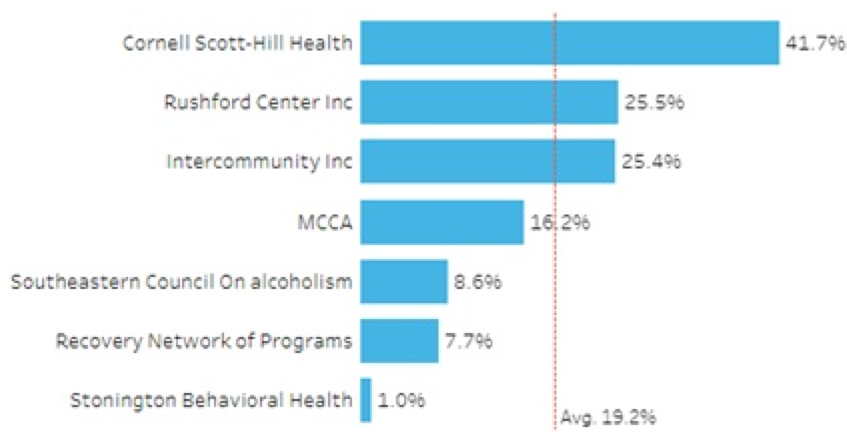


Figure 1: Percent of OUD Discharges Inducted on MAT by Provider CY 2019

Additionally, the percentage of members connecting to MAT subsequent to a withdrawal management episode has continued to steadily increase with the statewide average growing from 24.4% in CY 2018 to 29.8% in CY 2019. While there is an overall increase in MAT medication being included as part of a discharge plan, providers have demonstrated different preferences and/or comfort levels with the available MAT options (e.g. methadone, buprenorphine, naltrexone). Although all MAT options may not be equally available in all locations, a primary goal is to for the type of MAT utilized by each program to be driven by clinical considerations and member choice vs. provider preference.

Two freestanding workgroup meetings were convened during CY 2019 to review progress and share best practice surrounding the Changing Pathways model. A focal point of the May 2019 workgroup meeting centered on optimal treatment duration and early discharge after induction. InterCommunity reported that when a member wants to leave treatment earlier than originally planned after being inducted, they typically discharge and refer to their own continuum of care to ensure a smooth transition.

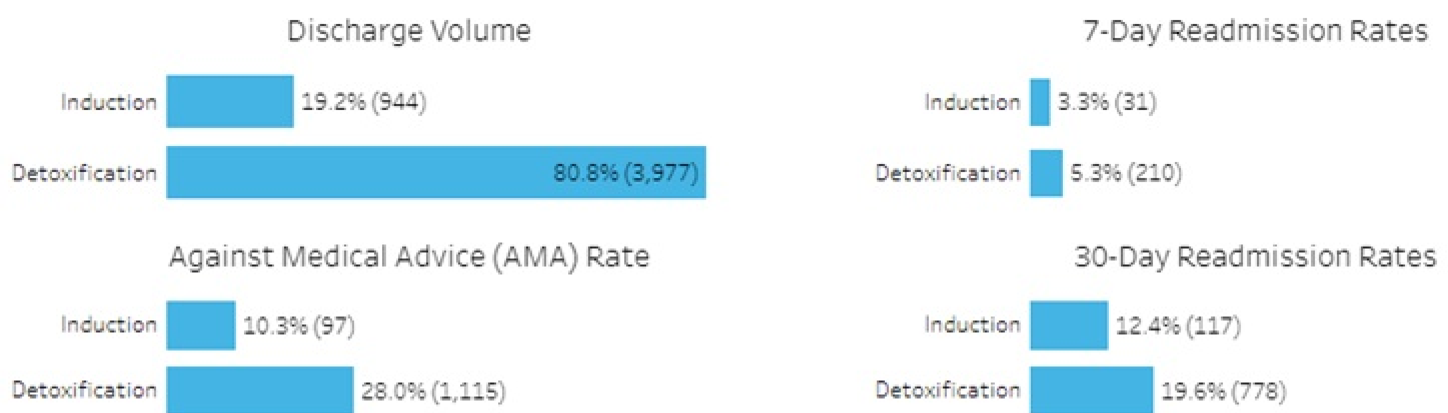


Figure 2: Percentage of Discharges Inducted on MAT Compared to Detoxification CY 2019

Stonington reported that they have found that when members are connected to their care management program to help address issues around social determinants of health, engagement in treatment is improved and they are less likely to leave AMA. Additionally, providers were shown data indicating a low percentage of providers prescribing MAT for AUD upon discharge. This presents an opportunity for further discussion at future PAR and workgroup meetings. These workgroups are instrumental in shaping the system and are thus a key part of the recommendation to continue this work overall.

During December's workgroup meeting, data was presented on the frequency of withdrawal management episodes to the "same provider" for CY 2018. Parallel data was also presented on the frequency of withdrawal management at "any provider," showing that while the percentage of withdrawal management episodes decreases over time, there still remains a high percentage of individuals with multiple withdrawal management episodes. Providers strategized how those who have their own continuum of care are less challenged with connect to care barriers which may assist in reducing readmissions to the withdrawal management level of care. Furthermore, new adherence to MAT measure was shared with providers and discussion ensued as to what factors might be driving relatively low adherence to MAT, an outcome occurring across all providers. Identified barriers that may contribute to this include social determinants of health, transportation, stigma, and other psychological factors.

Recommendation 7: Increase Focus on Readmissions and Changing Pathways
The Changing Pathways Pilot has demonstrated significant progress in highlighting MAT as a standard of care in effectively treating the growing opioid epidemic with a total of 469 MAT inductions from 10/1/18-10/1/19. Prior to October 2018, Intercommunity and Rushford reported that they very rarely inducted clients in their withdrawal management programs. At Intercommunity, the induction rate increased from 5.2% in October 2018 to a peak of 47.7% in October 2019. This represents an 817% increase in inductions from October 2018 to October 2019. At Rushford, the induction rate increased from 7.6% in October 2018 to 32.4% in October 2019. This represents a 326% increase in inductions from October 2018 to October 2019.

A deeper dive into the data from Year 1 of the Changing Pathways Pilot demonstrates a number of positive outcomes that are summarized in the MAT Performance Target End of Year Summary. For example, aside from the growing induction rates and consistency with implementing MAT education to our members, both InterCommunity and Rushford saw a 36% increase in connection to MAT post-discharge from Q2 2018 to Q3 2019. A new "Adherence to MAT" measure was also created to show the number of those that remain adherent to MAT 90 days post discharge using an 80% adherence rate standard. Across the two pilot sites, nearly 40% of inducted members were adherent to their MAT for the 90 days following discharge. This is about 2.5 times the rate of non-inducted members. Members who were adherent in this group also had significantly less Behavioral Health Emergency Department (BH ED) visits when compared to the non-adherent group. Additional significant findings from year one of this initiative include members who were inducted at the pilot sites having more decreases in higher level of care utilization when compared to the non-inducted cohort. These positive outcomes confirm the success of the Changing Pathways Pilot and support the continued promotion of this shift in practice to providers across the behavioral health system.

Replication of the Changing Pathways model to the non-pilot Freestanding Withdrawal Management facilities continues to occur with differing effect. During the May 2019 workgroup, Intercommunity and Rushford shared their lessons learned with the other freestanding detox providers and a collaborative discussion ensued about the critical components for adopting this practice change. A follow up discussion occurred during the December 2019 workgroup, during which each of the providers shared their successes and challenges with implementing MAT inductions. Beacon and the State Partners have begun discussions about next steps for expansion of the pilot within the freestanding level of care.

While the Changing Pathways Pilot has demonstrated great success in addressing components of the opioid epidemic, continued efforts are needed to focus on addressing the large and growing alcohol use disorder (AUD) population.

An essential feature of the Changing Pathways model has been the Peer Specialist (PS) role. Peers are able to leverage their knowledge of the service system to facilitate an informed discussion, educating members on the resources that may be available to them. This is especially helpful when members are struggling to decide between MAT induction and traditional medical detoxification. In addition to the support provided during their inpatient stay, the Peers have been able to become part of the discharge process. This occurs through direct conversation with the clinicians and the members, informing each of the multiple pathways to recovery and that each member has a right to be part of the decision-making process. Establishing these early connections encourages members to ask the Peers questions related to MAT, as well as aftercare choices. Furthermore, being present during the discharge process increases the likelihood of remaining connected. This engagement extends through the warm hand-off in the form of meeting members at their outpatient MAT appointments. These activities have proven effective with supporting outcomes related to member connect to care, MAT adherence, and reduced readmission rates. As such, Intercommunity and Rushford have made changes in their organizational structure for the provision of Peer/Navigator like activities to be included as part of their service delivery for the Freestanding level of care.

While the Changing Pathways Pilot has demonstrated great success in addressing components of the opioid epidemic, continued efforts are needed to focus on addressing the large and growing alcohol use disorder (AUD) population. As such, greater awareness into the effectiveness of MAT for treating AUD will be a priority at upcoming PAR and workgroup meetings during the 2020 calendar year.

Home Health Utilization
Admissions (authorization initiations) for Medication Administration increased by 27.8% for adults with dual memberships only and was unchanged for adults without dual membership in 2019. Within the Dual Benefit Groups, HUSKY C (ABD/Other Dual) had a 28.7% increase for admissions in 2019, with adults ages 55-64 having the most admissions (225). For non-dual members, HUSKY D (MLIA) has the highest admission volume with 1,012 admissions. This benefit group increased by 26.7% in Q1 '19 (from 206 admissions in Q4 '18 to 261 admissions in Q1 '19) and remained steady onward. Similarly, within the IPF demographic, HUSKY D members between 25-34 years of age had the highest volume of Medication Administration, continuing the observed shift in the population receiving this service, which had been largely members with HUSKY C (ABD/Other Dual) between the ages of 55-64 in prior years. However, HUSKY C (ABD/Other Single) consistently had the highest admissions per 1,000 each quarter.

The twice daily (BID rate) for Medication Administration has steadily increased for most of the last six quarters reaching 16.1% in Q1 '19, and dropped slightly in Q2 '19 to 15.8%. The rate had dropped considerably several years ago under the PT and following an adjustment to the Bypass program. Providers are reporting an increase in the acuity of their members as well as increased risk of overdosing due to the opioid crisis and are thus inclined to keep a "closer eye" on a larger portion of their members. Additionally, prescribers taking on new members for medication management are frequently more conservative and more likely to prescribe BID at initiation. One factor to note is that despite the uptick in BID, the majority of the largest volume providers continue to meet the bypass as in most cases the rate is within the bypass guidelines. The once daily (QD) administration rate remained higher than BID, slightly increasing in both Q1 '19 (38.0%) and Q2 '19 (38.8%). The emergency department (ED) rate slightly increased in the first two quarters of 2019, (29.0% and 29.6%, respectively). The inpatient rate was steady around 9% from Q3 '18 to Q2 '19 while the 23-hour observation rate had a slight jump from 4.5% in Q1 '19 to 5.2% in Q2 '19.

Utilization for Start of Care/Resumption of Care for members including duals was 766 admissions in 2019, however, all groups saw a decrease from 2018 to 2019, except for HUSKY D (MLIA), which increased by 12% from 2018. Since Start of Care/Resumption of Care is authorized in conjunction with Medication Administration, the trends by benefit and age group are the same as for Medication Administration.

Similarly, 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 8: Continue Home Health Bypass Program
Beacon continued the Bypass and Bypass Plus Program for home health agencies in 2019. The Bypass Program provides administrative relief for Home Health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The agencies on bypass are authorized for longer periods of time, thus allowing providers who demonstrate strong performance more time to work with HUSKY Members instead of engaging in UM activities. The Bypass Program eligibility criteria continues to be achievement of a BID medication administration target rate and emergency department visit rate.

Beacon held a Statewide Home Health Provider Meeting mid-year and shared the Bypass performance data. In Q1 '19, the Statewide BID rate was 15.9%, the ED rate was 28.9%, and the QD rate was 36.9%. Five of the nineteen providers are on Bypass Plus (26.3%), while eight of the nineteen providers are on Bypass (42.1%). Three providers remain off the bypass this quarter. The Q1' 19 home health bypass evaluation concluded with thirteen of the nineteen (68.4%) providers receiving the administrative benefits provided by the bypass program.

The Q2'19 home health bypass evaluation concluded with eleven of the sixteen (68.8%) providers receiving the benefits provided by the bypass program.

And for Q2 '19, the Statewide BID rate was 15.8%, the ED rate was 29.6%, and the QD rate was 38.8%. Three of the sixteen providers are on Bypass Plus (18.8%), while eight of the sixteen providers are on Bypass (50.0%) Five providers remain off the bypass this quarter, with no providers at risk. The Q2'19 home health bypass evaluation concluded with eleven of the sixteen (68.8%) providers receiving the benefits provided by the bypass program. Two providers were removed from the Bypass display of performance due to having a consistent volume of under 40 members for the previous year.

The UM/QM Committee continues to review the Home Health Bypass programs annually and assess for any enhancements that would improve the quality of the service offered. During the next six months, Beacon plans to take a closer look at the population of members receiving BID to identify factors that may be contributing to the increase in BID utilization. Pending that analysis, Beacon will consider adjusting the bypass program, particularly the threshold for the BID rate, as a means to address the upward trend. The shift to an automatic authorization based on Provider Bypass performance similar to the process for the inpatient bypass program allows the Clinical staff to target their clinical assistance to the providers that are not achieving the metrics. Close monitoring of the Home Health care agencies performance will occur to ensure that there is not an increase in the measured rates. Additionally, the claims lag for home health was recently reevaluated and it appears that the lag time has shortened to 3-4 months, which will allow for monitoring closer to real time.

Lower Level of Care Utilization

Outpatient admissions and admissions per 1,000 continued to represent the vast majority (79.5%) of all non-dual adult admissions to Lower Levels of Care. From 2018 to 2019, there was a 0.3% decrease in Outpatient admissions (from 118,944 to 118,627).

Although an outpatient session is a relatively low-cost intervention, based on the recently submitted PMPM dashboard the frequency of the use of this level of care results in the highest PMPM expenditure when compared to other behavioral health levels of care.

Recommendation 9: Convene a meeting with the state partners of the CTBHP to consider revisiting the methods currently used to manage the outpatient level of care. Although an outpatient session is a relatively low-cost intervention, based on the recently submitted PMPM dashboard the frequency of the use of this level of care results in the highest PMPM expenditure when compared to other behavioral health levels of care. This suggests that this level of care may deserve more attention than it has received and that there may be opportunities to better manage this highly utilized service via alternative payment models, performance improvement methodologies, or other innovative approaches.

Beacon's retrospective record reviews, IOP clinical study, data analytics, and UM experience, have demonstrated that there is notable variation in how this service is delivered across the network.

Intensive Outpatient continued to be the second largest service with 20,289 admissions in 2019, making up nearly 14% of admissions. Partial Hospitalization (PHP) saw a 4.3% decrease in 2019 (4,634 admissions). Methadone Maintenance saw the opposite trend, with an increase of 3.7% (5,555 admissions).

Recommendation 10: Develop an Intensive Outpatient Provider Analysis and Reporting (PAR) Program

In the summer of 2019, Regional Network Managers (RNMs) spent time in their respective regions visiting Intensive Outpatient Treatment Providers (IOP). This was in an effort to gain a system wide perspective of the IOP level of care and the scope of treatment programming offered at each individual site. More importantly, meetings were utilized to strengthen existing partnerships across the network to support a successful launch of the anticipated IOP PAR program. In addition, RNMs utilized this time to solicit provider feedback as to the types of metrics and data that would be most meaningful toward understanding their performance in relationship with other similar programs.

Beacon's retrospective record reviews, IOP clinical study, data analytics, and UM experience, have demonstrated that there is notable variation in how this service is delivered across the network. To reduce unwanted variation in care delivery and further the collaborative work noted above, adult and pediatric IOP workgroups were convened in September 2019. Providers were given an overview of other CTBHP PAR programs to show examples of how this platform has enhanced quality improvement and access to services across the CT behavioral health delivery system. During this meeting, an overview of the Methodology and Draft Proposed Measures for the IOP PAR were introduced including the following:

- Engagement in IOP Care
- Extended Stays in IOP Care
- Emergency Department Utilization During Care
- Emergency Department Utilization Post Episode End (7 and 30 days)
- Higher Level of Care Utilization During IOP Care
- Higher Level of Care Utilization Post Episode End (7 and 30 days)

Following the workgroup meetings with providers, the dashboard went into development going through several iterations to sharpen its functionality for a more user-friendly provider experience. With the dashboard now in production, RNMs started to schedule IOP meetings within their respective regions. Given the high volume of IOP providers, the frequency of PAR meetings will vary based on provider performance and volume.

Enhanced Care Clinics (ECCs)

The ECC and non-ECC total registration volume for both youth and adult members continued to increase over time, reaching 167,688 registrations. In 2019, non-ECC adult registration represented 92.5% of the total adult outpatient registration volume, reaching a high of 119,388 registrations. Meanwhile, adult ECC volume saw a 2.4% increase in 2019 with 9,664 registrations.

The 95% access standard was consistently met for all three access types for adult ECCs (Routine at 99.3%, Emergent at 98.2%, and Urgent at 97.8%). Across all adult outpatient evaluations in 2019, ECCs continued to have higher rates of meeting the 95% access standard than non-ECC clinics. This was expected, due to the level of attention given to the access standards by the ECCs.

In 2019, non-ECC adult registration represented 92.5% of the total adult outpatient registration volume, reaching a high of 119,388 registrations.

Recommendation 11: Reassess ECC initiative

Over 2018 and early 2019, there were many meetings held to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, incorporation of value-based payment methodologies, and opportunities to broaden the initiative. Beacon did develop a draft of a preliminary proposal to redesign the way in which outpatient services, inclusive of the ECCs, are authorized, managed, and incentivized to address primary issues that impact the delivery and quality of outpatient care. The scope of the proposal regarding application to ECCs, non-ECCs, and/or non-clinic solo or small group practices remains under consideration.

Discussions are ongoing and feedback from providers on the ECC Redesign is welcome.

ECC Appendix Summary
Summary includes analysis of both adults and youth

Provider Compliance for Q3 and Q4 2019

The total number of ECC agencies went down by one in Q4 19 due to the loss of their ECC designation. This means that in Q3 19 there were a total of 36 agencies while in Q4 19, there were a total of 35 agencies. An additional ECC agency lost their designation effective 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% in **Q3**: 32
2. Met the access standard of 95% in **Q4**: 33
3. ECC falling below the 95% Routine Standard:
- Charlotte Hungerford (Adult): 88.00% in **Q3 '19**
- Charlotte Hungerford (Child): 90.00% in **Q3 '19**
- Klingberg Family Centers: 94.87% in **Q3 '19**
- Yale Child Study Center: 91.43% in **Q3 '19**
- Charlotte Hungerford (Adult): 93.94% in **Q4 '19**
- Klingberg Family Centers: 93.42% in **Q4'19**
- Yale Child Study Center: 91.94% in **Q4 '19**

Urgent Access compliance with the 2-day standard for the ECCs fell into the following categories:
1. Met the access standard of 95% in **Q3**: 35
2. Met the access standard of 95% in **Q4**: 33
3. ECC falling below the 95% Urgent Standard:
- Yale Child Study Center: 57.14% in **Q3 '19**
- Child and Family Agency SE CT (Essex): 50.00% in **Q4 '19**
- Yale Child Study Center: 42.86% in **Q4 '19**

Emergent Access compliance with the 2-hour standard for the 37 ECCs fell into the following categories:
1. Met the access standard of 95% in **Q3**: 35
2. Met the access standard of 95% in **Q4**: 34
- Charlotte Hungerford (Adult): 0.00% in **Q3 '19**
- Clifford Beers: 0.00% in **Q4 '19**

Interventions and Activities

Annualized Measure: Although the formal measurement period has been annualized, ECCs continue to receive data on a quarterly basis. This includes both quarterly and year-to-date totals for each access standard.

2019 Volume Exemptions: This will be addressed in the Q1 and Q2 '20 semi-annual report in order to allow enough time for the Q4 '19 data entry errors to be addressed.

Data Entry Errors: All agencies that did not meet the 95% access standard for the urgent or emergent measure in Q3 '19 were asked to review their data to verify whether those failures were data entry errors. Q4'19 approved data entry errors will be reviewed in the Q1 & Q2 '20 semi-annual report. The following agencies had data entry errors approved during 2019 through **Q3 '19**:
- Child and Family Agency (New London)
- Yale Child Study Center
- McCall Foundation
- Mid Fairfield Child Guidance Clinic
- Catholic Charities Norwich

2019 Mystery Shopper Program: The following agencies were mystery shopped in **Q3 '19 and Q4 '19**:
- BH Care Shoreline: Failed
- Catholic Charities - Waterbury: Failed
- Community Health Resources: Passed
- Connecticut Renaissance Bridgeport: Failed
- Intercommunity: Failed
- Yale Child Study: Failed
- Charlotte Hungerford (Adult): Failed
- CMHA: Failed
- Recovery Network of Programs: Failed

Some agencies failed for one reason while others failed for multiple reasons. Overall, the reasons for failure were:
- No triage
- Poor triage quality
- Presenting problem not asked
- No call back within 24 hours
- Other administrative issues

Agencies that failed the Mystery Shopper call were put on a Corrective Action plan and probation, if it was an initial call. If it was not an initial call but was instead a follow-up call that was failed, they were given 45 days to address the reasons for failure with the expectation of a follow-up call after the 45 days. Agencies in the latter category were notified of the possibility of the termination of their ECC designation if they failed the second follow up call.

Agencies on Probation/Loss of ECC Designation in 2019:

Annualized Measure:
Klingberg Comprehensive Family Centers and Hartford Hospital IOL: Both agencies were on probation for failing the 2018 annualized measure but came off probation once they passed the routine measure over two quarters.

Loss of ECC Designation:
Catholic Charities Waterbury and Torrington: Both agencies were on probation to address ongoing documentation and quality of care issues that were noted at the end of the process to obtain their permanent designation as an ECC. Catholic Charities Waterbury was also on probation for failing a Mystery Shopper call. Both agencies have since lost their ECC designation in Q4 '19.

ECC Agency Activity in Q3 and Q4 '19:
Chart Audit: A chart audit was done at Catholic Charities Torrington on October 18, 2019. The agency did not pass the chart audit.

Site Visits/Conference Calls/Emails:
BH Care Shoreline, Connecticut Renaissance Bridgeport, Catholic Charites Waterbury, Yale Child Study Center, Recovery Network of Programs, Intercommunity, CMHA and Bridges to provide support around addressing failed Mystery Shopper calls as well as address questions around adding additional secondary locations.

Q3 and Q4 '19 Meetings
ECC Operations: The standard monthly meetings were held as well as additional ad hoc meetings to address ECC issues.