UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

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

Connecticut BHP
Supporting Health and Recovery

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A Beacon Health Options-CT Dashboard

Reports Used:

UTILIZATION REPORT FOR YOUTH MEMBERS

Calendar Year 2019: January-December 2019

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 that drive the trends and associated programmatic responses taken by Beacon Health Options to impact, mitigate or support the trend. Beacon also presents recommendations to address remaining challenges and reports progress related to these recommendations. The areas of focus for this deliverable are listed on the following page.

Methodology

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

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

The methodology for calculating age has changed, resulting in a slight shift in adult and youth membership totals. Previous to this report, counts for adults and youth were based on if a member met that age criteria during the time period. This meant that youth who were both 17 and 18 years old in a quarter were counted in both the adult and youth totals. In order to allow for the drill-down of demographic and age information, it was required that members be counted in only one group during a time period. Age group is now based on the age that a member was for the majority of the time period (quarter or year). Other 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 YOUTH MEMBERS

Calendar Year 2019: January-December 2019

Introduction

This summary and analysis of Youth 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.

Membership

In 2019, the Connecticut Medicaid membership, including members with dual eligibility, 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 the prior year. Adults continued to account for the majority (64%) of the total Medicaid population including dually eligible members.

Total youth membership ages 0-17 remained very stable, ending 2019 with 359,945 members. Only four youth members were dually eligible during the year.

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.

The adult HUSKY A population declined in both 2018 and 2019, but youth membership remained stable, suggesting that single male and female adults lost or left HUSKY A, but adults with children were largely unaffected by the decrease.

Benefit/DCF Membership

The majority of youth Medicaid members in Connecticut continued to be part of the HUSKY A Family Single benefit group (343,162 members in 2019). The adult HUSKY A population declined in both 2018 and 2019, but youth membership remained stable, suggesting that single male and female adults lost or left HUSKY A, but adults with children were largely unaffected by the decrease. The second largest benefit group for youth was HUSKY B (27,596 members in 2019). In 2019, the youth Medicaid membership remained stable by age group—mostly 3-12 year olds (55.3%), followed by 13-17 year olds (26.2%) and 0-2 year olds (18.5%). Gender demographics were also stable over the past four years, with slightly more male (51%) than female (49%) youth members.

Today, more than one third of the youth Medicaid population's (36%) race and ethnicity is unknown.

As noted in prior deliverables, changes to the ImpaCT system, used to manage member eligibility, led to a significant increase in members identifying their race/ethnicity as "Unknown."

The Unknown group continued to rise in 2019, up 9% from 2018. Today, more than one third of the youth Medicaid population's (36%) race and ethnicity is unknown. Beacon's investigations suggest that this is a true unknown, as members are not required to choose a race/ethnicity when applying for Medicaid. Having such a large unknown category will hinder efforts in tracking utilization and outcomes by race/ethnicity, which enable Beacon's ability to analyze health disparities in the Connecticut Medicaid population. We cannot know if the unknowns are evenly distributed among racial and ethnic groups, or if certain groups are more likely than others to opt out of responding. According to CY 2018 Connecticut Medicaid Population data, of the 173,211 youth members between the ages of 0-17, approximately 29% identified as Hispanic. Beacon hypothesizes that many members opting out of selecting a race/ethnicity are from minority groups who felt reluctant to answer due to fear of how the data would be used, or they did not see themselves represented in the available options. This belief is anecdotally supported by Beacon's experience in meeting with the CFAC membership and a separate group of provider executives as part of the 2018-19 Health Equity Study. Many, predominantly individuals from a minority group, who participated in the CFAC meeting opted not to answer questions related to race/ethnicity while nearly all of the predominantly white provider representatives were willing to self-identify on race/ethnicity. Beacon understands that our State Partners share our concerns and are reviewing potential solutions. Additionally, Beacon is currently taking efforts to separate Hispanic ethnicity from race in many of our reports.

After Unknown, the next largest racial/ethnic groups were Hispanic (23.5%), White (22.4%), and Black (13.4%). Other Races (2.7%) and Asian (2.5%) members continued to make up a small portion of the youth membership. All racial/ethnic groups continued to decrease in membership since 2017, with the exception of the Unknown category. While the large Unknown population makes it difficult to compare the Medicaid population with Connecticut's overall population, Hispanic youth appear to be overrepresented in the Medicaid population at 16.5% of the total state population and at least 23.5% of the Medicaid youth population.[1]

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[1] US Census Bureau (2018). "Quick Facts: Connecticut." Retrieved from census.gov/quickfacts/ct

"DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs. In order to identify youth that are In-Home Child Welfare and Out-of-Home Committed, Beacon used a combination of the D and I/O identifiers as requested by State Partners. Please note that there are exceptions to the "Out-of-home Committed" status, however, the majority of youth with this status are out-of-home.

As reported in previous semi-annual deliverables, anomalies in the eligibility file related to DCF status were identified in 2017 and fixed as of January 1, 2018, so while comparisons cannot be made to 2017, DCF information can be reported for 2016, 2018, and 2019. DCF involvement increased slightly by 3.5% to 15,038 members in 2019. Approximately 4% of the youth Medicaid population was DCF-involved at any point during the year. In 2019, DCF-involved youth membership consisted of mainly 3-12 year olds (52.9%) with an even split between males and females (50.7% vs. 49.3%, respectively). For DCF involved youth Unknown race/ethnicity had the highest membership (35.1%), followed by White (24.9%), Hispanic (20.5%), and Black (15.5%) youth. Most DCF-involved youth were a part of In-Home Child Welfare, followed by Out-of-Home. Most DCF groups had similar gender, age, and racial/ethnic demographic breakdown. Due to sHB 5041, an act concerning the transfer of juvenile services from DCF to the Court Support Services Division (CSSD) of the Judicial Branch effective July 1, 2018, data collection for these DCF groups was discontinued.

Inpatient Utilization (Excluding Solnit)

In 2019, there were approximately 120 total in-state pediatric acute psychiatric hospital beds available between six hospitals (excluding two non-acute hospitals: Albert J. Solnit Children's Center, also known as Solnit, and the Hospital for Special Care). Collectively, the in-state hospitals account for the vast majority of discharges each year. Out-of-state inpatient utilization of psychiatric care takes place primarily at Four Winds Hospital, an in-network facility just over the Connecticut border in New York State.

These factors, namely increased acuity, as well as fewer and declining numbers of PRTF beds for young children, contributed to an increase in the ALOS for this population.

Discharge volume for in-state inpatient psychiatric hospitals, excluding Solnit, continued to decrease to 2,330 discharges in 2019 while the average length of stay (ALOS) increased to 13 days, a 3.6% increase from 12.5 days in 2018. As seen in previous years, females continued to have more discharges (53.5%) while males stayed longer on average (13.8 days vs. 12.2 days). In addition, 13-17 year olds continued to have more discharges (66.8%) than 3-12 year olds, while 3-12 year olds stayed longer. The ALOS was similar between the two age groups from 2016 to 2018; however, in 2019, the ALOS for 13-17 year olds decreased slightly by 1% to 12.1 days while the ALOS for 3-12 year olds increased 12% to 14.6 days. We have continued to see an increase in acuity and complexity of behavioral issues including suicide attempts, self-harming behaviors and behavioral dysregulation following national trends. In Connecticut, there are fewer PRTF beds available for 3-12 year olds than for 13-17 year olds and there was a further reduction in PRTF bed capacity for 3-12 year olds that occurred at the end of 2018. These factors, namely increased acuity, as well as fewer and declining numbers of PRTF beds for young children, contributed to an increase in the ALOS for this population.

Most racial and ethnic groups saw a decrease in inpatient discharges or were stable with the exception of Hispanic youth, which rose from 22.5% in 2018 to 24.7% in 2019. Discharges from White youth decreased in both 2018 and 2019, but this group continued to have the most discharges (719, 30.9%). While Unknown race/ethnicity increased in the youth Medicaid population (35.5%), IPF discharge volume among Unknown members was relatively stable, representing 25.5% of IPF discharges. Discharges by Black youth have been decreasing since 2017, representing 13.5% of discharges (315). Discharges by Asian members were consistently low (27 in 2019) and their ALOS varied more than other groups given their lower volume. The ALOS for the race/ethnic groups ranged from 11.4 days (Asian) to 14.2 days (White) in 2019. Per the data shared with providers as part of the Youth PAR program, the primary diagnosis in 2019 was depressive disorders, accounting for 76.4% of youth IPF discharges.

DCF-involved youth continued to have a disproportionate volume of inpatient stays, as they constitute roughly four percent of the youth population and had nearly 20% of the youth inpatient discharges in 2019.

In-state inpatient discharges for non-DCF-involved youth decreased 6.2% in 2019 (1,873 discharges), while discharges for DCF-involved youth increased 7.5% in that time to 457 discharges.[2] Despite lower discharge volume, DCF-involved youth continued to have a disproportionate volume of inpatient stays, as they constitute roughly four percent of the youth population and had nearly 20% of the youth inpatient discharges in 2019. DCF-involved youth also consistently had longer ALOS compared to non-DCF-involved youth. The ALOS for DCF-involved youth increased in both 2018 and 2019 to a high of 17.3 days, while the ALOS for non-DCF-involved youth was relatively stable in that time, ending 2019 at 11.9 days, nearly 5.5 days less than DCF-involved youth.

[2] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs. In order to identify youth that are In-Home Child Welfare and Out-of-Home Committed, Beacon used a combination of the D and I/O identifiers as requested by State Partners. Please note that there are exceptions to the "Out-of-home Committed" status, however, the majority of youth with this status are out-of-home.

Most of Connecticut youth Medicaid members access inpatient psychiatric treatment at one of the in-network PAR facilities. Currently, there are six PAR Connecticut pediatric hospitals that treat youth for psychiatric disorders, in addition to New York-based Four Winds Hospital; however, older youth may receive their treatment on an adult unit, which is also included in the in-state data. In 2019, approximately half of discharges from in-network providers occurred at two in-state hospitals: Yale New Haven Hospital (714 discharges) and Natchaug Hospital (552 discharges). Despite continuing as highest volume providers, Yale and Natchaug (in addition to St. Francis Hospital) reported intermittent temporary reductions in bed capacity during 2019 due to unit acuity and staffing needs. While these beds were offline for a brief period of time, there was a likely impact on the rate of discharges, given that not all beds were able to be utilized. Beacon will continue to maintain communication with inpatient providers regarding reduction in capacity as well as unit acuity. Beginning in Q4'19 Saint Francis Hospital census increased from 12 to 16 beds. There are plans to add an additional two beds for a total census of 18 in the summer of 2020.

In-Network PAR providers (including Four Winds) had an ALOS of 12.9 days in 2019. Hartford Hospital and Four Winds notably had higher ALOS than other in-network PAR providers, approximately 3.5 days above average. In 2019, Hartford's ALOS reached 16.3 days, only slightly lower than the ALOS of 16.6 the prior year. Discharge delay was a contributing factor to this provider's ALOS, as there were 22 youth on delay in 2019. With these 22 youths removed, the ALOS for Hartford Hospital was 13.7 days, a reduction of nearly 3 days.

Hartford Hospital and Four Winds notably had higher ALOS than other in-network PAR providers, approximately 3.5 days above average.

Four Winds Hospital is the fifth largest inpatient pediatric provider for Connecticut youth, and has made up for the loss of youth inpatient beds in Connecticut as it acts as a safety net when youth are unable to access inpatient beds in-state. Discharge volume increased for each of the past four years, ending 2019 with 262 discharges. The ALOS at Four Winds is consistently higher than the in-state PAR ALOS, which may be partly explained by Four Winds accepting Connecticut youth who were "stuck" in the emergency department awaiting inpatient care.

As mentioned in prior deliverables, Hartford Hospital and St. Francis identified many factors influencing length of stay, including the increased wait for PRTF and Solnit Inpatient, increased acuity of youth, internal staffing changes, and limited congregate care (PRTF, Group Home, Residential) discharge options for youth under 12 years old. Additionally, with the realignment of hospital systems, efforts continued to centralize admissions across hospitals within a system. In 2019, both hospitals continued to serve a majority of youth outside of the Hartford Region. The change in population may have an impact on ALOS, since the hospital may be less familiar with resources outside the region. An additional barrier lending to longer lengths of stay for these youth can be difficulties with parents/guardians attending family therapy sessions aimed at re-integrating the youth into community based services. Beacon will continue to offer support in connecting to resources at both the member level (ICM) and provider level (RNM).

The ALOS at Four Winds is consistently higher than the in-state PAR ALOS, which may be partly explained by Four Winds accepting Connecticut youth who were "stuck" in the emergency department awaiting inpatient care.

The youth 7-day readmission rates remained steady over the last three years. However, the 30-day readmission rate declined from 11.6% in both 2017 and 2018 to 10.9% in 2019. The 7-day readmission rates varied among hospitals, ranging from 0.7% (St. Vincent's Medical Center) to 4.4% (Yale New Haven Hospital). Yale New Haven Hospital also had the highest 30-day readmission rate at 15.9%, while Prospect Manchester had the lowest 30-day readmission rate of 5.3%. Of youth readmitting within 7 and 30 days, the majority readmitted to the same provider (76.1% and 66.5%, respectively). For both 7-day and 30-day readmissions, females comprised approximately 56% of the readmitting cohort. In addition, approximately 77% of youth readmitted within 7 and 30 days were non-DCF-involved.

Beacon assigned a technical assistance clinician to focus on all cases with an ALOS greater than 10 days to offer increased support around discharge planning, coordination of care, and arrange for Beacon MD consultation for complex youth who have been unable to stabilize during the 10 days of acute inpatient treatment. Rounds participation also continues at Yale, St. Vincent's, and Natchaug.

Natchaug Hospital is participating in a pay-for-performance initiative and is evaluated on their ALOS (excluding outliers of stays greater than 65 days) in addition to readmissions and connections to care (C2C) post-IPF discharge for youth members. Based on their performance from February 1, 2018 to January 31, 2019, the ALOS was the only measure that did not meet either of the benchmark targets of less than 10.5 days (100% payment target) or 10.75 days (50% payment target). While under the performance initiative, this provider reduced ALOS from 13.6 days in 2017 to 11.9 days in 2018, their ALOS including outliers increased slightly to 12.1 days in 2019.

Of youth readmitting within 7 and 30 days, the majority readmitted to the same provider (76.1% and 66.5%, respectively). In addition, approximately 77% of youth readmitted within 7 and 30 days were non-DCF-involved.

Recommendation 1: Continue to Monitor Flow between EDs and Inpatient Units including Youth Going Out of State

Beacon provides ongoing monitoring of members awaiting placement in the ED and the use of out-of-state hospitals. Beacon ICMs outreach to Emergency Departments daily and involve Peers and/or Care Coordinators as well as Beacon psychiatrists as indicated. In addition, Beacon continues participation in CCMC ED Stuck Rounds call daily, in order to continue to improve collaboration and make adjustments in strategies for support of ED stuck youth, EDs, and community providers. ED stuck youth are presented in Complex Case Rounds as needed for coordination of outreach and possible services to support discharge from, and future diversion from the ED. Beacon ICMs coordinate with facilities on concurrent alternate discharge planning for youth who demonstrate stabilization while awaiting inpatient placements. When indicated, Beacon Medical Affairs and Child ICMs outreach to inpatient facilities to obtain further information on facility specific circumstances hindering youth admissions. Child ICMs, with support from Beacon Medical Affairs, provide support to EDs in their outreach to inpatient facilities to support disposition of youth in their ED. It is Beacon's hope that the new inpatient bypass program, with its case-mix adjustment, will be an incentive to not decline admission of more complex youth who require longer admissions.

In April 2019, Beacon implemented the Intensive Response Team (IRT)-funded through the Autism Spectrum Disorder Advisory Council. This team began accepting referrals in June to support individuals who have barriers to successful discharge from the emergency department. This team specifically supports individuals up to 26 years old with an Autism Spectrum, Developmental Delay, or Intellectual Disability diagnosis. More can be read about this program in recommendation 13. The IRT and Intensive Care Coordination (ICC) teams (a DCF funded Community Program) increased participation in Complex Rounds at Beacon, leading to more efficient and effective strategizing and planning with our partner agencies. As a result of this collaboration, we are better coordinating across funding streams with the result being youth discharged from the ED more often connected to a broader array of services in their communities.

Hospitals, including ED facilities that do not typically treat youth with behavioral health issues, often have greater challenges assessing youth needs and services and struggle to understand the resources needed for youth who enter their EDs. Intensive care managers provide ongoing education and continued collaboration with these facilities, which has been beneficial to both the facility and the member, to support timely transition to the appropriate level of care.

Beacon Medical Affairs has continued to outreach to inpatient facilities to engage in further discussion regarding decisions not to admit a youth stuck in the ED to their facilities based on their presentation being "too acute" and to provide consultation for discharge to alternate levels of care as medically appropriate. Beacon medical directors convened a meeting in July, 2019 with Youth IPF medical directors to discuss barriers to admission from EDs. A follow-up meeting was held in November, 2019 with Youth IPF medical directors and ED medical directors to further discuss flow between EDs and youth inpatient units. During those meetings, the following were highlighted: 1) the role and importance of data to understand the current state; 2) the idea of a collective effort to start a Quality Improvement (QI) initiative to address throughput problems; 3) the role of having a common severity assessment tool in order to have consistency in assessments across providers; 4) the effect of the reduction in PRTF beds on the flow of patients, on the waiting times for PRTF beds, and duration of stays in inpatient psychiatric units; 5) the increase in acuity of clinical presentation of youth in need of mental health treatment; 6) the consequences of increase in acuity, including staff injury and on the environmental dynamics of inpatient units, EDs and PRTFs; 7) the shortage of skilled and qualified workforce; 8) the ineffectiveness of vague and non-descriptive statements such as "too acute" as the basis for declining referral of youth for inpatient psychiatric admission; and 9) the importance of having a process where responsibility is shared by all providers and where solutions are achieved through consensus.

Recommendation 2: Continue Pediatric Inpatient Provider Analysis and Reporting (PAR) Program

The Regional Network Managers (RNMs) continue to meet regularly with pediatric inpatient psychiatric (IPF) PAR hospitals to improve the quality of care for Medicaid youth. Topics discussed include: average length of stay (ALOS), 7-day and 30-day readmission rates, inpatient volume, discharge form completion (completed collectively at 95% or higher in 2019), connect-to-care post-hospital discharge, and four additional variables included in the latest case-mix adjustment/Bypass program: 1) length of stay (LOS) difference (the average difference between the hospital's predicted length of stay and its actual length of stay over a quarter); 2) LOS improvement/maintenance (the improvement or maintenance of the hospital's LOS difference over the preceding quarter); 3) behavioral health ED visits within 7 days post inpatient discharge; and 4) bed tracking completion.

The rising level of acuity among youth was a central theme noted during PAR meetings for CY 2019.

The rising level of acuity among youth was a central theme noted during PAR meetings for CY 2019. Natchaug Hospital reported that they are seeing a higher acuity present in a younger age cohort with a lack of appropriate-fit resources available at discharge. IOL and St. Francis have both expressed an increase in acuity and violence/aggression with an increased report of staff injuries. Trauma was also indicated as a re-occurring theme. Natchaug Hospital is working on a trauma-informed curriculum for their inpatient unit that they believe will reduce the use of restraints and seclusion. Managing the rise in acuity will be a focus of an upcoming pediatric workgroup in 2020.

Recommendation 3: Monitor Impact of New Youth Inpatient Bypass Program

As mentioned in the mid-year submission of the semi-annual reports, during CY 2019 the prior Bypass Program, which evaluated providers' performance on three measures, was maintained for the first half of the year and then 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	--	1	--	1
	• Improvement	>= 1.0		>= 1.0	
	• Maintenance	>= 0		>= 0	
6	Bed Tracking	90%	1	90%	1

Table 1: IPF Bypass Measures, Standards, and Points

In the three quarters of data (Q1, Q2, Q3 2019) upon which the latest case-mix bypass statuses have been determined, two hospitals improved their tier over time (Hartford Hospital, St. Francis Hospital), two declined in their tier (Natchaug, Yale-New Haven), and three have stayed consistent across all three quarters (Prospect Manchester at tier 1, St. Vincent's at tier 1, and Four Winds at tier 3).

During inpatient provider PAR meetings, which occurred in the latter part of the year, Bypass information was reviewed and questions were answered to ensure that all the providers were knowledgeable, understood the metrics, and knew their corresponding performance. Performance for Q2 '19 was sent to providers in late October with an effective date of November 4, 2019 for any changes based on performance. In the three quarters of data (Q1, Q2, Q3 2019) upon which the latest case-mix bypass statuses have been determined, two hospitals improved their tier over time (Hartford Hospital, St. Francis Hospital), two declined in their tier (Natchaug, Yale-New Haven), and three have stayed consistent across all three quarters (Prospect Manchester at tier 1, St. Vincent's at tier 1, and Four Winds at tier 3).

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 program.

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

Inpatient Discharge Delay

Youth on an inpatient unit who are unable to discharge despite being clinically ready to discharge to the next appropriate level of care are considered "delayed." If youth on delay discharged in the reporting period, they were classified as a "discharge." Youth on delay during the reporting period, regardless of whether they discharged, are considered "delay cases." Beacon works closely with hospitals and community providers to ensure youth can access appropriate services as soon as they are clinically ready for them. Despite ongoing attention and collaboration with providers, there continues to be a number of system changes that have affected the discharge delay measure in recent years.

The volume of delayed discharges for members ages 0-18 on acute inpatient psychiatric units, excluding Solnit and the Hospital for Special Care, increased slightly from 119 in 2018 to 129 in 2019 while the Average Delayed Days decreased from 28.2 days to 21.6 days.

The volume of delayed discharges for members ages 0-18 on acute inpatient psychiatric units, excluding Solnit and the Hospital for Special Care, increased slightly from 119 in 2018 to 129 in 2019 [3] while the Average Delayed Days decreased from 28.2 days to 21.6 days. Delayed cases saw a similar pattern with an increase from 127 to 141 cases.

The overall percent of days delayed out of the total inpatient days for members (cases) ages 0-18 in any psychiatric facility (excluding Solnit and the Hospital for Special Care) decreased from 9.7% in 2018 to 7.4% in 2019. As previously noted, the annual percent of discharge delay days for 2018 was higher due to significant changes in system capacity.

The overall percent of days delayed out of the total inpatient days for members (cases) ages 0-18 in any psychiatric facility (excluding Solnit and the Hospital for Special Care) decreased from 9.7% in 2018 to 7.4% in 2019.

The majority of all delayed discharges in 2019 were adolescents ages 13-17 (66.7%), female (54.3%) and non-DCF involved (63.6%). Of the delayed adolescents (86 discharges), 51.2% (44 discharges) were waiting for Solnit Inpatient and 34.9% (30 discharges) were waiting for Solnit PRTF.

In 2019, more female adolescents (32) were awaiting Solnit Inpatient than males (12). Adolescents ages 13-17 waited for Solnit Inpatient on average for 27.8 days, which has decreased over time. Of the 41 delayed discharges for ages 0-12 in 2019, 27 (65.9%) were waiting for Community PRTF, eight (19.5%) were awaiting Solnit Inpatient, and the remaining six were awaiting RTC/GH (2), Solnit PRTF (2), and Other (2).

Beacon ICMs, AVP Clinical Operations, Medical Affairs, and the State Partners continue to participate in weekly Discharge Delay Rounds to discuss members who are on discharge delay. Rounds provide a venue for review of continued need for the level of care the member is awaiting as well as discussion to ensure ongoing treatment and concurrent planning by the current provider. Beacon ICMs, clinical supervisors, DCF Area Offices, State Agencies, and DCF Contract Managers meet weekly to discuss youth in PRTF who are DCF-involved. This meeting provides a venue for discussion regarding barriers that may be impacting discharge for youth from PRTF. Resolution of these barriers not only assist the youth in moving out of the PRTF when ready for the next level of care, but also allow for improvement in throughput and beds becoming available for youth on inpatient delay.

In addition, we currently host complex rounds to focus on members who are struggling with complex challenges that are not specifically in a PRTF or hospital setting and require a higher level of multi-disciplinary subject matter expertise and integrated approach to prevent the need for higher level of care. These meetings are attended by the assigned care managers, leadership of the child ICM and ASD programs, AVP of Clinical Services, Medical Affairs, State Partners and representatives of the Department of Developmental Services (DDS) and the Department of Social Services (DSS) as needed.

Beacon ICMs, clinical supervisors, DCF Area Offices, State Agencies, and DCF Contract Managers meet weekly to discuss youth in PRTF who are DCF-involved.

Recommendation 4: Increase PRTF capacity

Within Q4 of this year, the Children's Center of Hamden (CCOH) increased their bed capacity to include additional slots for both males and females. They began admitting new admissions on December 16, 2019. CCOH has also been very collaborative in reviewing and admitting youth who have otherwise been rejected from other PRTFs. As of this writing, CCOH is currently running at full capacity.

At this time, Beacon recommends the creation of an eight-bed PRTF program for females ages 10-14 with an evidence-based trauma treatment model that has a proven record of success with a 10-14-year-old population in a congregate care setting.

[3] Note: for the Discharge Delay section only, Beacon is reporting rates for 0-18 year olds instead of 0-17 year olds. Since Discharge Delay is a Performance Target, we wanted the methodology used in the semi-annual reports to match the methodology used in the Discharge Delay reports. Users can view rates and counts for 0-17 year olds only by unchecking the "18" box in the "Age Group" filter on Tableau.

Despite the additional bed capacity created at The Village and CCOH, we continue to struggle with wait times for members awaiting PRTF placements. Based on increased acuity and complex clinical needs of the younger youth, some PRTF providers have been more selective during the referral process to ensure both member and staff safety resulting in some beds being held unfilled despite active waitlists.

Beacon is also collaborating with the Center for Children with Special Needs BRISC program, which was reinstated in June 2019. In order to build capacity in supporting individuals with Autism Spectrum Disorder, this program will dedicate two beds to individuals with an Autism Spectrum Disorder at CCOH, provide training to milieu staff and individuals' family, and support the receiving in-home team assigned to this member. More information regarding this collaboration is included in recommendation 11.

Solnit Inpatient Utilization

Discharges from Solnit Inpatient were steady from 2016 to 2018, but then decreased in 2019 by 26.3% from 118 discharges to 87. The ALOS also decreased from 142.7 days in 2018 to 116 days in 2019, a decrease of nearly one month (27 days). A direct impact on discharges can be attributed to the 12-bed decrease for unit renovations at Solnit Inpatient. Another impact has been intermittent periods of lower census to compensate for members who required more attention based on acuity to ensure the safety of the milieu.

Consistent with prior years, Solnit continued to serve mostly youth between 13-17 years old. While discharge volume decreased for males and females from 2018 to 2019, this was greater for males at a 49% decrease (27 discharges) than females with a 7.7% decrease (60 discharges). Females stayed an average of 10.7 days longer than males in 2019 (119.3 days vs. 108.6 days). Discharges by most racial and ethnic groups declined, while discharges by White youth increased 47.8% in 2019 (34 discharges) making up 39.1% of total discharges. The ALOS decreased for every race/ethnicity from 2018 to 2019, ranging from 81.7 days for Other youth to 131.6 days for Black youth.

Despite being an estimated four percent of the total youth population, DCF-involved youth had more discharges (49, 56.3%) than non-DCF youth (38, 43.7%) from Solnit Inpatient in 2019.[4] The ALOS for both DCF-involved and non-DCF-involved youth were identical in 2018 at 142.7 days. In 2019, the ALOS decreased for both DCF-involved and non-DCF-involved youth with Non-DCF-involved youth staying just 2.5 days longer on average (117.4 days vs. 114.9 days).

Solnit Inpatient Discharge Delay

The number of delayed discharges and cases declined from 19 in 2018 to just one delayed discharge waiting for RTC/GH services for a total of 105 days. Beacon believes that this is not a true reduction, but rather a change in staffing that resulted in the underreporting of discharge delayed youth at Solnit. Beacon Staff reeducation is being provided to ensure the accuracy of discharge delay reporting in future deliverables.

Recommendation 5: Continue to hold PAR Meetings with Solnit Inpatient

Beacon Health Options will continue the Solnit Inpatient PAR program in CY 2020 in an effort to improve access to care and the quality of care for Medicaid youth. Areas of focus will continue to be average length of stay (ALOS), discharge delay, and readmissions post inpatient discharge. In addition, Beacon will explore the integration of additional measures into the Solnit Hospital PAR dashboard such as the 7- and 30-day inpatient connect-to-care rates.

To streamline and coordinate the quality management and performance improvement areas for Solnit Hospital, the Solnit Inpatient PAR program will move under the Beacon/Solnit QM program implemented during 2019. The Solnit QM team will work closely with the regional network managers to ensure that system barriers and gaps identified in the Solnit Hospital PAR meetings will continue to be monitored and addressed.

Through the support of the Solnit QM team, Solnit Hospital has now established a Quality Assurance Performance Improvement (QAPI) Committee that meets monthly. This committee will be responsible for review of the PAR data on a semi-annual basis and identification of areas of opportunity and next steps. Projects identified by the QAPI will then be assigned to the hospital's Steering Committee for follow up.

While Solnit Hospital's ALOS improved from CY 2018 to CY 2019, the readmissions to inpatient within 90 days post-discharge continue to be high in CY 2019 at 18.6% with 75% of readmissions being female. Solnit Hospital believes this is due to the high acuity of youth served and the internalizing behaviors of female members, such as self-injurious behavior and suicide ideation. Solnit Hospital is interested in exploring this area further in CY 2020 and the Solnit QM team will support these efforts. In addition, Solnit Hospital and Beacon are both interested in the addition of the 7- and 30-day connect-to-care rates and will explore any potential relationship between readmissions and connection to care.

[4] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs. In order to identify youth that are In-Home Child Welfare and Out-of-Home Committed, Beacon used a combination of the D and I/O identifiers as requested by State Partners. Please note that there are exceptions to the "Out-of-home Committed" status, however, the majority of youth with this status are out-of-home.

Psychiatric Residential Treatment Facility (PRTF) Utilization—Community and Solnit

Boys & Girls Village closed their psychiatric residential treatment facility (PRTF) near the end of 2018, resulting in two remaining community PRTF providers, CCOH and The Village for Families and Children. Solnit PRTF is a state-run PRTF facility for adolescents ages 13-17 and has two locations in Connecticut—one that treats males (Solnit North) and one for females (Solnit South). Due to member and milieu acuity and staffing needs, unit capacities on both Solnit campuses were temporarily reduced intermittently in 2019. Furthermore, there was continued reduction in census at Solnit South PRTF due to required building renovations, which were completed in the last quarter of 2019.

The number of PRTF discharges decreased 22.7% from 194 discharges in 2018 to 150 discharges in 2019. Meanwhile, the ALOS decreased 11 days (6.4%) from 171.4 days to 160.4 days in the same period of time. In 2019, 65 discharges (43.3%) came from Community PRTF providers, while 85 discharges (56.7%) came from Solnit PRTF. The ALOS for Community providers was longer (178.7 days) than for Solnit PRTF (146.3 days).

Community providers serve mostly children ages 12 and under, who accounted for 41.3 % of all PRTF discharges in 2019. On the other hand, Solnit PRTF serves mostly 13-17 year olds, who comprised 58.7% of PRTF discharges. As CCOH served only males until the middle of December 2019, when they increased their scope and bed capacity. While the Village for Families and Children and Solnit serve both male and female youth, it is not surprising that more males (62%) than females (38%) discharged from PRTFs in 2019. Males continued to stay longer than females on average, however, the ALOS for males decreased by 9.4% to 167.1 days compared with a slight 2% decrease to 149.4 days for females from 2018 to 2019.

Overall, White youth continued to be the largest racial and ethnic group with 36% of the PRTF discharges in 2019. White members are disproportionally overrepresented in PRTF utilization; as White youth comprise just 22% of the Medicaid youth population. Hispanic youth (23.3%), Unknown race/ethnicity (20.0%), and Black youth (18.0 %) groups made up most of the remaining discharges. ALOS decreased from 2018 to 2019 for all groups with the exception of Unknown, which increased 27.9% from 154.3 days to 197.4 days. The remaining ALOS was clustered between 143.3 days (Black) and 156.6 days (Hispanic).

The discharge volume of DCF-involved youth decreased 37.1% from 105 discharged in 2018 to 66 in 2019, however DCF-involved youth remain overrepresented as they are approximately four percent of the youth Medicaid population and 44% of PRTF discharges. Furthermore, DCF-involved youth also tend to have longer lengths of stay on average compared to non-DCF involved youth (180.8 days vs. 144.3 days).[5] We have observed that DCF involved youth are typically more complex given disruptions in the home environment requiring greater efforts to solidify permanency plans and supporting families with re-integration back into the community. While this disproportionate utilization is not surprising, the high level of need for PRTF services for DCF-involved youth remains evident.

Both community PRTF providers (CCOH and Village for Families & Children) increased admissions from 2017 to 2018, likely caused by the need to transfer youth from the Boys & Girls Village facility before it closed in October 2018. From 2018 to 2019, admissions continued to increase for CCOH (from 29 to 35), while admissions decreased slightly for the Village for Families and Children (from 37 to 32). This provider started to increase capacity, but had to put admissions on hold between October, 10 2019 and December, 18 2019 due to staff turnover and youth acuity.

Admissions at Solnit North PRTF (males) were stable at 53 admissions in each of the last three years. Over the same time, Solnit South (females) decreased and ended 2019 with 39 admissions.

White members are disproportionally overrepresented in PRTF utilization;
as White youth comprise just 22% of the Medicaid youth population.

Recommendation 6: Continue to Share Data with the PRTFs on a Semi-annual basis:

As mutually agreed upon with the State Partners, the Community PRTF PAR program was discontinued in 2018. The assigned Regional Network Manager continues to provide the semi-annual data to the community PRTFs and is available for follow up as needed. The most recent data was provided to the Community PRTFs in August 2019.

Additionally, the Community PRTF programs were identified for the 2019 annual retrospective level of care review. This review was completed in Q4 2019 by representatives from DCF and Beacon Health Options. The results will be shared with both Community PRTF programs in February 2020 with areas of opportunity reviewed and next steps identified. As agreed upon with the State Partners, Beacon will host a workgroup meeting with both Community PRTFs in an effort to share best practices and support mutually identified areas of need, such as risk events.

[5]"DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs. In order to identify youth that are In-Home Child Welfare and Out-of-Home Committed, Beacon used a combination of the D and I/O identifiers as requested by State Partners. Please note that there are exceptions to the "Out-of-home Committed" status, however, the majority of youth with this status are out-of-home.

Psychiatric Residential Treatment Facility (PRTF) Awaiting Recommended Services—Community and Solnit
In 2019, there were 29 delayed discharges from Community and Solnit PRTF (18 from Community PRTF and 11 from Solnit), which is an increase from 21 delayed discharges in 2018. The total number of cases also increased to 35, meaning there were six youth who continued waiting for recommended services at the start of 2020. The total awaiting recommended service days also increased from 1,715 days in 2018 to 2,526 days in 2019.

Of the 29 delayed discharges in 2019, most (31%) were awaiting foster care, followed by awaiting RTC/GH (20.7%). Five delayed discharges (17.2%) each waited for community services and "Other." It is worth noting that this information only captures the last reason for awaiting recommended services and a youth may have alternate planned treatment recommendations that the youth waited for prior to the final reason that was recorded at discharge. Some of these delays are reflective of increased acuity in DCF involved cases; where permanency plans were more difficult to establish. In 2019, 70% (20) of the delayed PRTF discharges were DCF-involved. Of those DCF-involved youth, nearly half (9) were awaiting foster care for an average of 139.2 days.

Global Recommendation: Improve Connections with Regional Networks of Care in order to Improve Outcomes for Children and Families.
Since 2016, Beacon Network of Care Managers have supported the development of Regional Networks of Care in each DCF Region as part of its Intensive Care Coordination contract with DCF.

In 2019, 70% (20) of the delayed PRTF discharges were DCF-involved. Of those DCF-involved youth, nearly half (9) were awaiting foster care for an average of 139.2 days.

The goal of each Network of Care is to increase collaboration among all child-serving systems to improve outcomes for children and families. In addition to providing information, resources, and opportunities for collaboration, the Regional Networks of Care serve as a resource to address system needs such as those outlined in population-specific recommendations (i.e., ASD, foster care), and can provide opportunities to include community-based, non-traditional programs along with families in systems-level discussions about current system challenges (i.e., system throughput, awaiting recommended services). Each Regional Network of Care includes representation from the local community, such as Community Collaboratives ("Systems of Care"), behavioral health providers, juvenile justice/LIST leads, schools, pediatric primary care physicians, and family champions. Each region's network of care is in a different development phase. There continues to be a need in all regions to continue the work of fully integrating and developing the networks of care. The Network of Care Managers continue to explore opportunities to collaborate with other community initiatives that support network of care development through the lifespan, with a focus on youth and families. This will continue to be a focus of the Network of Care Managers via CONNECT and the CONNECT 3 grant. One example is the effort to coordinate network improvement across various agencies (e.g., CSSD, DCF, and OEC) and projects (FEP network development, identification of resources available in each local service area, etc.).

Recommendation 9: Continue the Solnit PRTF PAR program.
Beacon Health Options will continue the Solnit PRTF PAR program in an effort to improve the quality of care and access to care for our Medicaid youth. Areas of focus will continue to be average length of stay (ALOS), awaiting recommended services, and transfers from PRTF to inpatient level of care. In addition, Beacon will explore the integration of additional measures into the Solnit PRTF PAR dashboard such as inpatient days and stays within six months prior to PRTF admission versus six months post PRTF discharge. This work will be integrated with a series of quality improvement programs being initiated in conjunction with the Solnit QAPI program.

To streamline and coordinate the quality management and performance improvement areas for Solnit PRTFs, the Solnit PRTF PAR program will move under the Beacon/Solnit QM program, similar to what has occurred with the Solnit inpatient program. The Solnit QM team will work closely with the regional network managers to ensure that system barriers and gaps identified in the Solnit PRTF PAR meetings will continue to be monitored and addressed. This integration of quality improvement efforts will be quite similar to what is occurring within the hospital including establishment of Quality Assurance Performance Improvement (QAPI) Committees responsible for review of PAR program data and other improvement projects.

While the Solnit PRTF statewide ALOS has remained relatively stable from CY 2018 to CY 2019, the transfers from PRTF to inpatient appear to be trending down from its peak in Q1 & Q2 2018 at 23.7% to 16.7% in Q1 & Q2 2019. Solnit South PRTF still has a significantly higher percentage of youth transferring to inpatient versus Solnit North PRTF as highlighted in Q1 & Q2 2019 at 40% versus 0% respectively. Like Solnit Hospital, the Solnit South PRTF believes that the higher percentage of inpatient transfers by females is in part due to internalizing behaviors such as self-injurious behavior and suicide ideation. Solnit South PRTF is interested in exploring this area further in CY 2020 and the Solnit QM team will support these efforts.

Residential Treatment Center (RTC) and Group Homes

In-state Residential Treatment Center (RTC) admissions decreased further in 2019 to a low of 66 admissions, a 45.5% decrease from the prior year. Out-of-state RTC admissions also decreased, down to just one admission in 2019. While both in-state and out-of-state RTC admissions and discharges continued to decline, the ALOS increased 57.3% from 250.4 days in 2018 to 394.0 days in 2019, based on 80 in and out-of-state RTC discharges.

In-state Residential Treatment Center (RTC) admissions decreased further in 2019 to a low of 66 admissions, a 45.5% decrease from the prior year.

Most RTC admissions (89.6%) were 13-17 year-old, male (65.7%), and DCF-involved (92.5%).[6] While admissions decreased among all race/ethnicity groups in 2019, the majority continue to be from youth with Unknown race/ethnicity (31.3%). The ALOS was nearly identical for both males and females in 2018, however, this changed in 2019 with ALOS increasing 82% for males (452.5 days) compared to a 15% increase for females (291 days). Admissions and discharges were consistently higher for DCF-involved youth versus non DCF-involved. Furthermore, the ALOS for DCF-involved youth reached a high of 412.2 days (based on 66 discharges). This longer length of stay appears to be due to the higher acuity of this population and challenges with finding an appropriate longer term family living arrangement.

Therapeutic Group Home (GH) admissions also decreased in 2019 to 60 admissions. After peaking in 2018 at 554.1 days, ALOS decreased to 507.3 days in 2019. Admissions were higher for males (55%) than females (45%), but females stayed longer on average (560 days vs. 472 days). Admissions and Discharges remain consistently higher for DCF-involved youth (88%) and this population stayed longer compared with non-DCF-involved youth (534 days vs. 297 days).

Autism Spectrum Disorder (ASD) Services

From 2018 to 2019, authorizations continued to increase for nearly every type of ASD service. In 2019, Treatment Plan and Program Book Development was the most authorized service (27.4%) followed by Diagnostic Evaluation (25.8%), and Behavioral Assessment (20.4%). Treatment Plan and Program Book Development can be authorized every 90 days as needed to make updates to goals, objectives, and teaching materials which accounts for the higher authorization of this service over Service Delivery.

Therapeutic Group Home (GH) admissions also decreased in 2019 to 60 admissions.

Overall, most of the youth accessing ASD services continued to be between the ages of 3-12, male, and non-DCF involved for all service classes. Youth with Unknown race/ethnicity had the highest utilization in all service authorizations. White youth was the second largest group for most groups with the exception of Diagnostic Evaluation, where Hispanic youth was the second largest group at 30.9% of ASD authorizations.

Consistent with prior annual reporting, the volume of unique agencies increased across all ASD service classes. Service Delivery had the highest volume of unique agencies in 2019 (59), closely followed by Treatment Plan and Program Book Development and Direct Observation and Direction, both with 58 unique agencies. There were 57 unique agencies delivering Behavioral Assessment services and 28 unique agencies offering Diagnostic Evaluation. In 2019, Family Strong was the largest provider (475), followed by Connecticut Children's Specialty Group, CCMC (334), A Piece of the Puzzle (318), and A Brand New Day (316).

The number of ASD providers continues to grow, increasing in individual service providers from 306 to 328 in Q1 and Q2 of 2019 and showed further growth to 358 in Q3 and 384 in Q4.

Recommendation 10: Continue to Build provider access, diversity, and quality

The number of ASD providers continues to grow, increasing in individual service providers from 306 to 328 in Q1 and Q2 of 2019 and showed further growth to 358 in Q3 and 384 in Q4. Beacon will continue to outreach to community providers and offer support to community-based clinicians through a second set of CHDI trainings and continue with quarterly EMPS trainings to increase their comfort level in supporting high functioning, verbal individuals impacted by ASD. This also helps to increase the capacity of traditional outpatient therapy which is typically how individuals access medication management in the community. In collaboration with DCF, DDS and DMHAS, Beacon continues to provide statewide trainings for mobile crisis teams, first responders, and outpatient clinic clinicians. There are discussions to more specifically target statewide EDTs and outpatient providers to develop their skill set in supporting individuals with an ASD. By continuing to grow the ASD Medicaid provider network, we look to continue to increase the connection to care rates and decrease the amount of time from referral to the Beacon ASD team for support and the first date of service with a provider.

In addition, Beacon is dedicated to diversifying the provider network. While the number of qualified providers continues to grow, there are still not enough bilingual Autism Service providers to meet the service needs of the Hispanic population. Although there are sometimes behavior technicians who are bilingual, there is not the same diversity in qualified providers overseeing the service delivery.

[6] "DCF-involvement" includes any youth who is involved with the Department of Children and Families through any of its mandates. This includes youth committed to DCF through child welfare, and those dually committed. It also includes youth for whom the Department has no legal authority, but for whom DCF provides assistance through its Voluntary Services, Family with Service Needs and In-Home Child Welfare programs. In order to identify youth that are In-Home Child Welfare and Out-of-Home Committed, Beacon used a combination of the D and I/O identifiers as requested by State Partners. Please note that there are exceptions to the "Out-of-home Committed" status, however, the majority of youth with this status are out-of-home.

During Q2 '19, the network added two clinicians who speak both English and Spanish and two technicians who speak various Indian dialects. Along with continuing to grow the provider network, Beacon is committed to working with agencies to encourage the hiring of bilingual as well as ethnically and racially diverse clinicians and behavior technicians to improve access to services for the diverse Medicaid population.

Beacon hosted an open roundtable discussion with five providers across the state to discuss the barriers in hiring bilingual staff in Q3 '19. They identified that the education criteria to qualify as a behavior technician for State Plan Services is often a challenge when attempting to hire bilingual qualified staff. While Beacon Care Coordinators and Peer Specialists have access to a language line to meet the needs of a family in their engagement and support, this service is not available during the direct service delivery hours and typically creates a barrier to accessing services.

While the number of qualified providers continues to grow, there are still not enough bilingual Autism Service providers to meet the service needs of the Hispanic population.

To support the quality of services provided to Medicaid members, Beacon continues to be committed to collaborating with providers and clinicians in the community to support not only the growth of the provider network, but also the ability to impact highly complex individuals and increase the readiness to accept referrals of individuals with autism and behaviors that result in emergency department visits. This traditionally is accomplished through offering monthly ASD Provider Learning Collaboratives focused on state regulations, meeting documentation and chart review standards (including crisis assessment and planning), updating processes/procedures for accessing web-pended authorizations, and updating CPT codes and expectations. In Q3 '19 and Q4 '19, the ASD team collaborated with the BRISC team through The Center for Children with Special Needs to offer biweekly trainings and CEU opportunities targeted at supporting highly complex members and their families within the home setting. The first two modules of the four-part training series were completed in the last two quarters of 2019; Module 1: Behavior Assessment and Skill Acquisition Instruction for Complex Learners and Module 2: Providing In-Home Behavioral Services to Complex Learners and Their Families. Two more modules will be offered through June 2020: Module 3: Autism, Neurodevelopmental Disorders, and Associated Mental Health Difficulties: Foundations to Drive Meaningful Treatment Plans and Module 4: Multidisciplinary Teaming and Treatment Planning.

Beacon continues to see overall improvement in quality documentation during 2019 as reviews for providers enrolled in 2015 and 2016 continues.

In conjunction with the documentation review as part of utilization management and authorization of services to ensure quality services are being delivered, chart reviews continue to be conducted. Providers are made aware that, should the review team identify areas of concern related to the quality of treatment provided or circumstances which may violate license or regulatory requirements, the team will be responsible to report such concerns to the appropriate agencies. Providers assessed in Q3 and Q4 '19 averaged a weighted score of 97.2% (with a range from 93.9% to 99.7%). No Quality Improvement Plans (QIPs) were requested by providers during Q3 and Q4. Also in Q3 '19 and Q4 '19 two providers had second reviews who had been reviewed previously and required QIPs.

One provider who was originally assessed in September 2018, was reassessed in March 2019 and showed vast improvement from 62% in 2018 to 95% in 2019. Another provider, who had been placed on a Corrective Action Plan was also assessed for a third time: May 2018 at 62%, September 2018 at 70%, and September 2019 at 98.2%. With changes in their clinical structure and additional supervision and support by a BCBA, they showed dramatic improvements. Beacon continues to see overall improvement in quality documentation during 2019 as reviews for providers enrolled in 2015 and 2016 continues. This is in part due to a change in "onboarding" and outreach to newly enrolled providers to walk them through documentation standards, chart review expectations, and the authorization request process.

Recommendation 11: Collect data regarding authorization to first claim

The number of ASD members receiving direct services continued to grow by approximately 670 youth in 2019, resulting in a total of 2,325 unique members connected to a provider for direct ABA service delivery. An additional seven members were connected to Group Treatment services (ASG).[7]

The number of ASD members receiving direct services continued to grow by approximately 670 youth in 2019, resulting in a total of 2,325 unique members connected to a provider for direct ABA service delivery.

The increase in direct service delivery is explained by an overall growth in the provider network for providers who perform direct services. Due to FOCUS Center for Autism no longer providing ASG, the number of individuals able to access this service decreased. In 2019, Beacon began to collect data to show the length of time members are waiting to start services once connected to a provider by measuring the date of first authorization to the date of first claim for services. By collecting this information, we are able to begin shaping the performance of network providers regarding timely service delivery.

[7] Note: this data comes from the ASD Monthly Review dashboard. The data feeding this dashboard is updated monthly, and data updates may impact prior months' numbers as well, so any numbers reported from the ASD Monthly dashboard in this deliverable may differ slightly from the numbers currently shown on the ASD Monthly dashboard.

After recognizing that the longest wait times occur when a member is connected to a Beacon ASD Clinical Care Manager (CCM) to the time a provider submits the first claim indicating the start of services, the ASD team has begun to address the issue. Process improvements were implemented over Q1 and Q2 of 2019, empowering and assisting families with reaching out to providers directly, as we have seen this result in decreased wait times. We have also modified how peer specialists or care coordinators support families by implementing a tiered approach to support. Tier 1 includes resources by phone. Tier 2 includes face-to-face support, outreach to resources, identification of referral options, and building natural supports for the family. Tier 3 implements a Wraparound care coordination model to assist our members and families with the highest needs and complexities. Through this process, the ASD Care Coordinator and Peer Specialist team identify natural supports and assist in developing a family vision and benchmarks to build a plan of care. Our goal is to decrease wait times and increase connection to appropriate services and show this through ongoing data collection. Beginning with the next semi-annual submission, Beacon will begin reporting out on this data.

Lower Levels of Care

Outpatient services for youth continued to be the highest authorized service (10.8 admits/1,000), representing the vast majority (86.5%) of all admissions to lower levels of care in 2019. While the number of authorizations increased for each of the last four years, the increase from 2018 to 2019 was minimal at 0.6% (41,674 to 41,937).

Recommendation 12: 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. The assessment and planning process for outpatient services should be inclusive of the reassessment of the ECC program as noted below.

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.

Intensive In-Home Child Adolescent Psychiatric Services (IICAPS) was the second most utilized service in 2019 with 1,982 authorizations. Most services declined slightly or were steady with the exception of Intensive Outpatient (IOP), which increased 6.3% from 1,668 to 1,773 authorizations, making it the third largest lower level of care in 2019.

In the last semiannual submission, it was noted that Multi-Dimensional Family Therapy (MDFT) referrals were "on hold" throughout the month of November 2018 due to a new contract start date of December 1, 2018. While overall authorizations decreased slightly from 2018 to 2019, authorizations for this level of care in fact increased every quarter in 2019 and returned to more historic levels seen prior to Q4 '18.

Also noted in prior semiannual submissions, Multi-Systemic Therapy (MST) services split off into a separate contract through CSSD. As anticipated, authorizations for MST services declined, as we may not have access to CSSD utilization information. In 2019, MST was the least authorized lower level of care at 0.5% of authorizations.

Recommendation 13: 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 site. More importantly, meetings were utilized to strengthen existing partnerships across the network to support a successful launch of the anticipated IOP PAR program. RNMs used 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 to other similar programs.

To further this collaborative partnership, 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 improved 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 were introduced:

- 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)

Through Beacon's retrospective record reviews, IOP clinical study, data analytics, and UM experience, it appears that there is notable variation in practice across the network. As such, RNMs will use the CY 2020 PAR cycle to share the aforementioned metrics, explore opportunity for improved practice across the network, and report findings at a future IOP workgroup meeting.

The youth non-ECC registration volume continued to climb in 2019, reaching 29,844 (77.2% of total youth registrations), while youth ECC volume decreased a further 4% to 8,792 registrations (22.8%).

Enhanced Care Clinics (ECCs)

In 2019, the total registration volume for adult and youth members reached a high of 167,688 registrations in 2019. Youth represented 23% at 38,636 registrations. The youth non-ECC registration volume continued to climb in 2019, reaching 29,844 (77.2% of total youth registrations), while youth ECC volume decreased a further 4% to 8,792 registrations (22.8%).

ECC access standards were met for routine (98.4%), urgent (96.7%), and emergent evaluations (97.3%) in 2019.

In 2019, 67.2% of youth evaluations were required to meet ECC access standards, while 32.8% were not required. The number of evaluations required to meet access standards at ECC clinics has declined since 2017, now at 7,332. Meanwhile, the number of evaluations required to meet access standards for non-ECC freestanding clinics (FSC) increased in that time (now 5,296). ECC access standards were met for routine (98.4%), urgent (96.7%), and emergent evaluations (97.3%) in 2019. Furthermore, ECC clinics continued to have higher rates of meeting the 95% access standards than non-ECC clinics.

Recommendation 14: Re-Assess ECC initiative

Over 2018 and early 2019, many meetings were held to discuss an ECC redesign that addressed the operationalization of ECC program metrics, incorporation of value-based payment methodologies, and opportunities to broaden the initiative. Beacon developed a preliminary draft proposal to redesign the way outpatient services 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.

Enhanced Care Clinics (ECC) Appendix Summary: January-December 2019

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

Enhanced Care Clinics (ECC) Appendix Summary: January-December 2019

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.