

UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

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



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UTILIZATION REPORT FOR YOUTH MEMBERS

Quarters 1 & 2 of 2019: January-June 2019

Reports

Used:



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

General Overview

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

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

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

Methodology

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

UTILIZATION MANAGEMENT FOR YOUTH MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2 of 2019: January-June 2019

Areas of Focus

Membership

Total Unique
DCF & Non-DCF, Benefit Groups
Demographics

Inpatient Hospital

Discharge Volume & Average Length of Stay
Admits/1,000 & Days/1,000
Delayed Volume, Days Delayed, & Percent of Days Delayed
Discharge Delay Reasons

Inpatient Hospital - Solnit Center

Discharge Volume & Average Length of Stay
Delayed Volume, Days Delayed, & Discharge Delay Reasons

Community & Solnit PRTF

Discharge Volume & Average Length of Stay
Admissions & Days/1,000
Awaiting Recommended Services Volume, Days, & Reasons

Autism Spectrum Disorder Services

Admissions & Admits/1,000
Provider Volume

Outpatient Enhanced Care Clinics (ECC)

Registration Volume
Access Standards

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The following additional utilization data points are also available:

RTC
Admissions &
ALOS

**PHP, IOP, &
EDT**
Admits/1,000

IICAPS
Admits/1,000

**Outpatient
(OTP)**
Admits/1,000

Membership

In the first quarter of 2019, the Connecticut Medicaid membership, including duals, reached 895,386 members, the highest volume reported to date. However, in Q2 '19 membership, including duals, declined 0.4% to 891,388 members, slightly less than the membership volume seen during the fourth quarter of 2018. Adults continued to account for the majority (63%) of the total Medicaid population including dually eligible members.

Total youth membership ages 0-17 remained extremely stable, ending the second quarter of 2019 with 331,545 members.

Total youth membership ages 0-17 remained extremely stable, ending the second quarter of 2019 with 331,545 members. Only two youth members were dually eligible in each quarter of 2019.

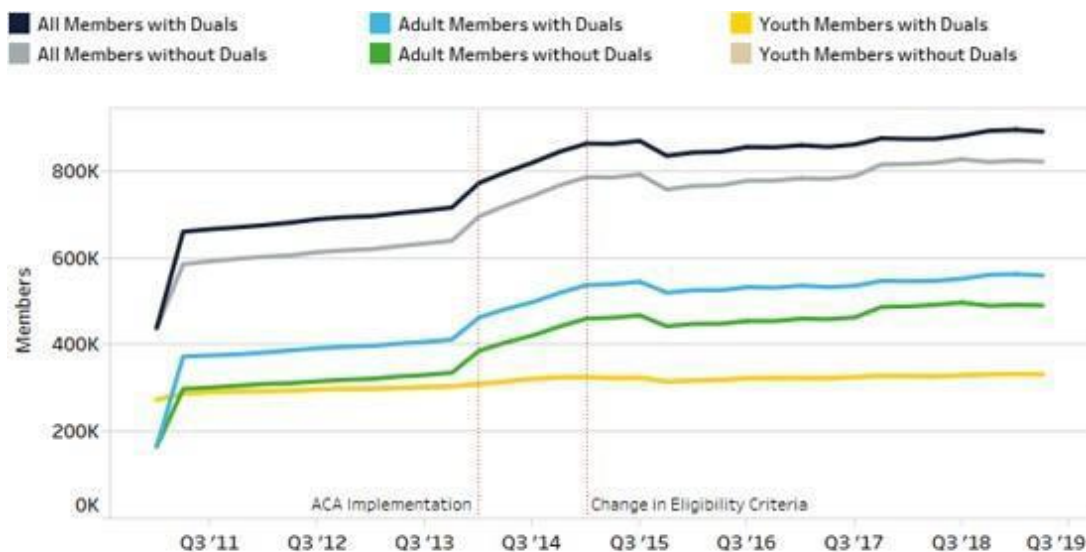


Figure 1: Quarterly Total Medicaid Membership

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

Benefit/DCF Membership

The majority of youth Medicaid members in Connecticut continued to be part of the HUSKY A Family Single benefit group (313,417 members in Q2 '19). The second largest benefit group for youth was HUSKY B (19,874 members in Q2 '19). The adult HUSKY A population declined in 2018, 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. In Q2 '19, the youth Medicaid membership

The adult HUSKY A population declined in 2018, 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.

remained stable by age group—mostly 3-12 year olds (56.5%), followed by 13-17 year olds (26.7%) and 0-2 year olds (16.8%). Gender demographics were also stable over the past four years, with slightly more male (51%) than female (49%) youth members.

As noted in the CY 2017 and 2018 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 group identified as Unknown continued to rise in 2019, up a further 13% from 2017. Today, more than one third of the youth Medicaid population (36%) is categorized as Unknown race/ethnicity. 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, indicative of health disparities. This is because 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. 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 of the predominantly "people of color" participating in the CFAC meeting opted not to answer questions related to race/ethnicity while nearly all of the predominantly white provider representatives were willing to self-identify on race/ethnicity. Beacon understands that our state partners share our concerns and are reviewing potential solutions, such as making the selection of a race or ethnic category mandatory.

After Unknown, the next largest racial/ethnic groups were Hispanic (23.5%), White (22.1%), and Black (13.2%). Other Races (2.7%) and Asian (2.4%) 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

"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.

Approximately 2.4% of the youth Medicaid population is DCF-involved at any point in a given year. So far in 2019, DCF-involved youth membership consisted of mainly 3-12 year olds (51.6%) with an even split between males and females.

As reported in previous semi-annual deliverables, anomalies in the eligibility file related to DCF status were identified in 2017 and fixed as of Jan. 1, 2018, so while comparisons cannot be made to 2017, DCF information can be reported for 2018 and the first two quarters of 2019. Continuing along the decreasing trend in previous quarters, 9,937 youth were identified as DCF-involved in Q2 '19. Approximately 2.4% of the youth Medicaid population is DCF-involved at any point in a given year. So far in 2019, DCF-involved youth membership consisted of mainly 3-12 year olds (51.6%) with an even split between males and females. Unknown race/ethnicity had the highest membership (37.0%), followed by White (25.0%), Hispanic (18.9%), and Black (15.4%) 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 breakdowns, with the exception of Voluntary Services, which had 153 members in Q2 '19, 63.4% of whom were 13-17 years old and 56.2% of whom were male. Due to SHB 5041, an act concerning the transfer of juvenile services from DCF to the Court Support Services Division

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

(CSSD) of the Judicial Branch effective July 1, 2018, data collection for these DCF groups was discontinued.

Inpatient Utilization (Excluding Solnit)

As of Q2 '19, 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.

Discharge volume for in-state inpatient psychiatric hospitals, excluding Solnit, decreased slightly by 15.1% from 654 in Q4 '18 to 555 in Q2 '19. The average length of stay (ALOS) for all in-state inpatient psychiatric discharges, excluding Solnit, increased by 1.1 days in Q1 '19 before decreasing 0.7 days in Q2 '19 to 12.3 days. Although 13-17 year olds had more discharges (67.4%) than 3-12 year olds (32.6%), the ALOS for 3-12 year olds was higher (14.8 days) than for ages 13-17 (11.1 days). In Connecticut there are fewer PRTF beds for 3 to 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 two factors contributed to an increase in the ALOS for this younger population.

Females continue to have more discharges, however, this gap increased since the end of 2018. In Q2 '19, females comprised 59.1% of discharges (up from 53.1% in Q4 '18) while males were 40.9% (down from 46.9% in Q4 '18). Males continued to have longer ALOS (12.8 days), however, the ALOS among females increased in both quarters of 2019 to 12 days. This change in ALOS may be explained by the shift in gender among the 3-12 age group, as these youths had longer ALOS. Females comprised 51.9% of the inpatient discharges for 3-12 year-olds, an increase from 36.4% in Q4 '18. Also with the change in community PRTF capacity, female youth can only access one program (The Village for Children and Families) for this level of care where as male youth are able to access both programs (The Village and Children's Center of Hamden).

Most racial and ethnic groups saw a decrease in inpatient admissions with the exception of Hispanic youth, which rose from 2018 to 28.5%. Discharges from White youth decreased in both quarters of 2019 but this group continued to have the most discharges (165, 29.7%), just seven more discharges than Hispanic youth (158 discharges). While Unknown race/ethnicity increased in the youth Medicaid population (36%), IPF discharge volume among Unknown members decreased in the both Q1 and Q2 of 2019, representing 23.4% of discharges. Discharges by Black youth decreased nearly 28% from 93 discharges in Q4 '18 to 67 discharges in Q2 '19.

Discharges by Asian members were consistently low (seven in Q1 and eight in Q2) and their ALOS varied quarter to quarter, with the lowest ALOS in Q1 '19 (9.4 days) and the highest ALOS in Q2 '19 (16.3 days) compared to other groups. The ALOS for remaining race/ethnic groups ranged from 10.9 days (Hispanic) to 13.6 days (White) in Q2 '19.

Despite lower discharge volume, DCF-involved youth continued to have a disproportionate volume of inpatient stays, as they constitute roughly 2.4% of the youth population and had 18.2% of the youth inpatient discharges in Q2 '19. DCF-involved youth also consistently had longer ALOS compared to non-DCF-involved youth.

In-state inpatient discharges for non-DCF-involved youth decreased in both quarters of 2019 (499 in Q1, 454 in Q2), while discharges for DCF-involved youth were steady between 105 and 101 discharges in Q1 and Q2 '19, respectively.² Despite lower discharge volume, DCF-involved youth continued to have

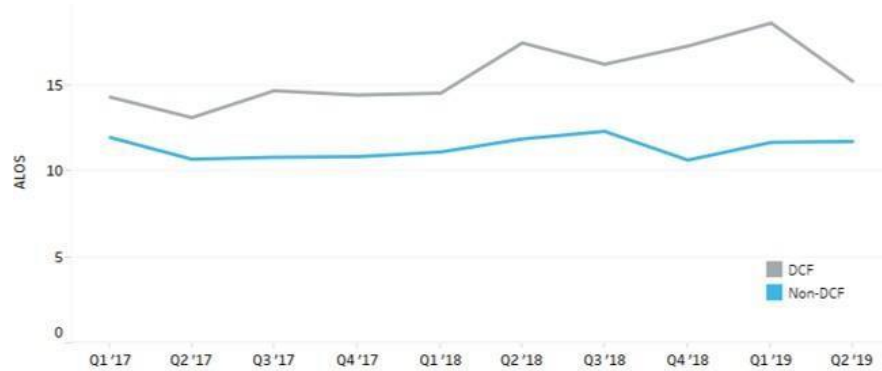


Figure 2: Youth Inpatient Psychiatric Average Length of Stay by DCF Involvement

a disproportionate volume of inpatient stays, as they constitute roughly 2.4% of the youth population and had 18.2% of the youth inpatient discharges in Q2 '19. DCF-involved youth also consistently had longer ALOS compared to non-DCF-involved youth. The ALOS for DCF-involved youth increased to a high of 18.4 days in Q1 '19 before decreasing to 16.2 days in Q2 '19; while the ALOS for non-DCF involved youth was 11.8 days and 11.5 days in the same period of time. The disproportionate use of inpatient services and longer lengths of stay for DCF-involved youth continued to be an ongoing trend and a well-documented concern.³

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 the first two quarters of 2019 combined, nearly 52% of discharges from in-network providers occurred at two in-state hospitals: Yale New Haven Hospital (362 discharges) and Natchaug Hospital (303 discharges).

In the first two quarters of 2019 combined, nearly 52% of discharges from in-network providers occurred at two in-state hospitals: Yale New Haven Hospital (362 discharges) and Natchaug Hospital (303 discharges). These providers, in addition to St. Francis Hospital, reported reduction in bed capacity during Q1 and Q2 due to unit acuity and staffing needs.

These providers, in addition to St. Francis Hospital, reported reduction in bed capacity during Q1 and Q2 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.

In-state PAR providers (not including Four Winds) had an ALOS of 12.3 days and 11.9 days in the first two quarters of 2019, respectively. Hartford Hospital notably had higher ALOS than other in-state PAR

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.

³ Connell et al (2019). "Caseworker assessment of child risk functioning and their relation to service use in the child welfare system." *Children and Youth Services Review* 99: 81-86. doi 10/1016/j.childyouth.2019.01.027

providers, approximately 4-9 days above average. In Q1 '19, Hartford's ALOS reached 21.6 days, with five delayed discharges (four awaiting state beds while one waited for PRTF). With these five youth removed, the ALOS for Hartford Hospital was 18.2 days, a reduction of nearly 3.5 days.

As mentioned in the prior deliverable, 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 Q1 and Q2 of 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. Beacon will continue to offer support in connecting to resources at both the member level (ICM) and provider level (RNM).

In order to increase support to the facilities with higher ALOS, Beacon resumed on-site rounds participation at Hartford Hospital, as well as began participation in CARES rounds at the same facility. Additionally, Beacon assigned a technical assistance clinician to focus on all cases with an ALOS greater than 10 days and offer increased support around discharge planning, coordination of care, and arrange 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.

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It is worth noting that Natchaug Hospital is participating in a pay-for-performance initiative and is evaluated on their ALOS in addition to readmissions and connections to care (C2C) post-IPF discharge. Based on their performance from Feb. 1, 2018 to Jan. 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). However, this provider is making progress and reduced their ALOS 3.7 days from 14.6 days in Q2' 18 to 10.9 days in Q2 '19.

Four Winds Hospital is the fourth 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 valve when youth are unable to access inpatient beds in-state. Discharge volume increased for each of the past four quarters, ending Q2 '19 with 88 discharges. The ALOS at Four Winds remains approximately 3-5 days higher than the in-state PAR ALOS, which may be partly explained by Four Winds accepting Connecticut youth who were "stuck" in other levels of care awaiting inpatient.

Recommendation 1: Continue to Monitor ED Awaiting Placement Cases Going Out of State

Beacon continues to monitor the ED awaiting placement cases 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, as well as at the Mental Health Quarterly meeting at CCMC 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. When indicated, Beacon Medical Affairs outreaches to EDs and attending psychiatrists at inpatient facilities in an effort to facilitate disposition and to support the clinical teams. In 2018, Beacon initiated the Intensive Response Team (IRT) in an effort to support individuals who may 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 are discharged from the ED with a broader array of services in their communities. Others who are high utilizers of the ED are supported through a team approach to access appropriate levels of care in a more coordinated and timely manner. For example, Beacon worked with Solnit and Natchaug Hospital in Q1 '19 to prioritize admission for a youth awaiting Solnit Inpatient at Natchaug in order for Natchaug to admit a youth stuck in CCMC ED and not have that youth enter Solnit from the ED. This allowed for inpatient stabilization to begin in the community inpatient setting and avoid an un-necessary state IP admission due to system capacity.

Youth entering EDs at facilities that do not typically treat the youth behavioral health population often have greater challenges assessing overall needs and services, and struggle to understand the system resources for the youth who enter their ED. Education and continued collaboration with these facilities is beneficial to both the facility and the member to support timely transition to the appropriate level of care.

Beacon Medical Affairs has outreached to inpatient facilities to facilitate further discussion regarding the denial of ED stuck youth to their facilities based on their presentation being “too acute.” Beacon continues to monitor this reason for denial of admission as well as engaging in ongoing communication regarding the needs of the inpatient facilities and youth acuity impacting inpatient milieu.

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

The Regional Network Managers continue to meet with the statewide pediatric inpatient psychiatric PAR hospitals in an effort to improve the quality of care and access to care for Medicaid youth. Areas of focus include average length of stay (ALOS), discharge delay, and the introduction of the case-mix bypass methodology.

The statewide pediatric inpatient PAR discharge volume remained relatively stable from Q3 and Q4 '18 at 1,256 to Q1 and Q2 '19 at 1,279. Four Winds Hospital, the newest in-network/PAR provider, continues to increase the number of Connecticut Medicaid youth that they serve with a discharge volume rate increase of 53% from Q3 and Q4 '18 to Q1 and Q2 '19 (105 to 161 discharges, respectively).

In Q1 and Q2 '19, there were several factors that contributed to a reduction in system throughput as outlined below.

- **Reduction in inpatient bed capacity:** On several occasions, the PAR hospitals were not operating at full bed capacity due to numerous staffing shortages, high acuity youth, and milieu dynamics. For example, Yale New Haven Hospital's adolescent unit has a bed capacity of 23 and was capped at 18 beds due to being down one MD. At one point, St. Francis was operating with a

50% reduction in beds (six) due to staffing challenges. They are currently back up to eight beds and hope to continue to increase their capacity.

- High inpatient ALOS: The Institute of Living continues to have an ALOS significantly higher than the statewide average and well above their predicted ALOS target. Beacon Health Options continues to hold internal strategy meetings and external meetings with the Institute of Living in an effort to support the hospital as it assesses the root cause of a higher than anticipated ALOS.
- Reduction in access to beds post inpatient discharge: The closure of Boys & Girls Village PRTF continues to impact PRTF bed capacity for youth ages 12 and under. Despite the increase in PRTF bed capacity at The Village for Families and Children, there are still fewer available beds statewide. In addition, The Solnit inpatient hospital has been under construction, limiting access to their beds.

While the statewide ALOS remains relatively stable, this is the fourth consecutive quarter in which the 0-12-year-old cohort has a higher ALOS than the 13-17 year old cohort... The one common identified theme continues to be youth and trauma.

Despite the factors listed above, the total inpatient discharge delay volume and the average days waiting decreased from Q3 and Q4 '18 to Q1 and Q2 '19. The Regional Network Managers, in collaboration with Beacon's clinical team, continue to encourage early identification of disposition challenges and the use of concurrent discharge planning.

While the statewide ALOS remains relatively stable, this is the fourth consecutive quarter in which the 0-12-year-old cohort has a higher ALOS than the 13-17 year old cohort. In Q1 and Q2 '19, 19.1% of 0-12 year olds had a length of stay of 20+ days in comparison to only 10.9% of the 13-17 year-olds. When removing

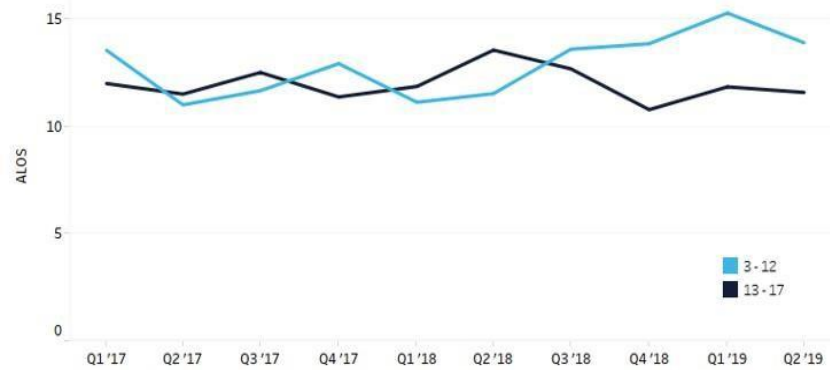


Figure 3: Youth Inpatient Psychiatric Average Length of Stay by Age Group

the youth in discharge delay status, this phenomenon also holds true, indicating a need based on acuity versus a barrier in disposition. The Institute of Living and St. Francis Hospital have described an overall higher acuity of youth with an increased report of recent staff injuries. Natchaug Hospital reported they are seeing a higher acuity present in a younger age cohort with a lack of appropriate-fit resources available for these youth at discharge. The one common identified theme continues to be youth and trauma. Natchaug Hospital, for example, is in the process of implementing a trauma-informed model of care for their unit that they believe will reduce the use of restraints and seclusion. As the case-mix bypass methodology is now in place, the Regional Network Managers will have the ability to explore this during the upcoming PAR cycle through a new lens. The goal is to identify trends in coefficients correlated with the higher lengths of stay in an effort to support the providers in developing a more targeted strategy to support the youth they serve. Beacon will continue to explore additional strategies to address increased length of stay for youth ages 0-12 years old.

The Regional Network Managers also continue to explore the use of standardized substance use screening tools with the pediatric inpatient PAR providers. While some providers completed the A-SBIRT

training, there is still large variation amongst the hospitals. As Beacon moves forward with the St. Francis Hospital pilot program incorporating the use of standardized screening tools for SUD, Beacon will look to transfer this practice to the inpatient pediatric hospitals.

Recommendation 3: Modify Youth Inpatient Bypass Program

While the Inpatient Bypass Program used the same three measures consistent with previous years for the first quarter of 2019, preparations were completed to implement the new bypass program (which incorporated case-mix) by mid-year.

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

The case-mix methodology and application to the bypass program, as well as the additional new bypass metrics, were presented to the hospitals in collaboration with Connecticut Hospital Association on April 16, 2019. The presentation was well attended, with representation from the majority of providers. The hospital providers were also informed that follow up meetings could be scheduled and the information would be reviewed again with additional parties as needed. In some cases, separate meetings were held, and in others, the information was reviewed during the inpatient PAR meetings, which began in July. Providers were given performance data for Q2 and Q3 '18 on the bypass metrics so that they could begin to see how they would perform on the bypass.

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

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

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

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

The data for new bypass measures for Q1 '19 performance ran on July 1, 2019. Providers were informed of their performance in late July with a go-live of the new tiered system and associated authorization process in early August. Hospitals' performance will be reevaluated every three months. With the changes in the authorization parameters, the length of stay will be monitored closely.

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." However, youth on delay during the reporting period, regardless of whether they discharged, are considered "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 from 24 to 28 in Q1 '19 before decreasing to 22 in Q2 '19.⁴ In addition, the Average Delayed Days was steady in the first two quarters of 2019 (23 days and 21.6



Figure 4: Youth Inpatient Psychiatric Quarterly Delayed Discharges

⁴ 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.

days, respectively). Delayed cases also saw a slight increase from 31 to 33 in Q1 '19 before decreasing to 29 in Q2 '19. At the end of Q2 '19, there were more delayed cases than discharges, thus seven cases remained on discharge delay at the start of Q3 '19. Five of those delayed cases were waiting for Solnit Inpatient, while the remaining two were waiting for Community PRTF and Solnit PRTF.

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 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 in the first quarter of 2019 to 4.8% before increasing to 6.3% in Q2 '19. This is an improvement from 2018, when three of the four quarters did not meet the target of 9.5% or fewer days delayed. As noted in the previous semi-annual deliverable, the annual percent of discharge delay days for 2018 was higher than previous years due to significant changes in system capacity.

In the first two quarters of 2019, the majority of all delayed discharges were adolescents ages 13-17 (68.6%), female (58.8%) and non-DCF involved (66.7%). Of the delayed adolescents (35 discharges), 57.1% (20 discharges) were waiting for Solnit Inpatient and 31.4% (11 discharges) were waiting for Solnit PRTF. In Q1 and Q2 '19 combined, more female adolescents (16) were awaiting Solnit Inpatient than males (four). Adolescents ages 13-17 waited for Solnit Inpatient on average for 26.5 days and 22.7 days in the first two quarters of 2019, respectively. Of the 16 delayed discharges for ages 0-12 in Q1 and Q2 2019 combined, 11 were waiting for Community PRTF, four were awaiting Solnit Inpatient, and one was awaiting residential treatment/group home services (RTC/GH). In Q1 and Q2 '19, youth ages 0-12 waited on average longer for a state bed (52.7 days, 26 days) than Community PRTF (9.6 days, 20.8 days).

Beacon Care Managers, AVP and Medical Affairs and 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 level of care the member is awaiting as well as discussion to ensure ongoing treatment and concurrent planning by the current provider. Beacon care managers, clinical supervisor, 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 next level of care, but also allow for improvement in throughput and beds becoming available for youth on inpatient delay.

Recommendation 4: *Increase PRTF capacity*

Community PRTF capacity was reduced from 48 beds to 32 following the closing of Boys & Girls Village PRTF in October 2018. DSS, in collaboration with DCF and Beacon, met with The Village PRTF leadership to discuss opportunities for expansion. The Village reported an ability to increase bed capacity and committed to adding an additional 12 beds over time. Currently The Village PRTF has added eight of the additional 12 beds.

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 track record of success with a 10-14-year-old population in a congregate care setting. The program should include a strong emphasis on family involvement throughout the episode of care.

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 Children's Center of Hamden (CCOH), provide training to milieu staff and the individuals' family, and support the receiving in-home team assigned to this member. More information regarding this collaboration is included in recommendation 11.

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 track record of success with a 10-14-year-old population in a congregate care setting.

Solnit Inpatient Utilization

Discharges from Solnit Inpatient further decreased in Q1 '19 to 19 and increased to 21 in Q2 '19, while the ALOS decreased in both quarters to 122.1 days. A direct impact on discharges can be attributed to the twelve-bed decrease for unit renovations at Solnit Inpatient.

Consistent with prior years, Solnit continued to serve youth between 13 and 17 years old. Males and females were less equally represented in discharges than in 2018, due to a decrease in discharges for males in Q1 '19 (four discharges) while discharges for females were steady (15 discharges, 7.1% increase). Discharges by most racial and ethnic groups declined, while discharges by White youth increased 71.4% in Q2 '19 (12 discharges) making up 57.1% of total discharges. Black and Hispanic each represented 14.3% of discharges and had longer lengths of stay (181.7 days and 179.3 days, respectively).

Despite being only about 2.4% of the total youth population, DCF-involved youth had more discharges (27, 67.5%) than non-DCF youth (13, 32.5%) from Solnit Inpatient in the first two quarters of 2019 combined.⁵ The ALOS for both DCF-involved and non-DCF-involved youth decreased in 2019, ending Q2 '19 with 133.3 days (Non-DCF) and 116.5 days (DCF-involved).

Solnit Inpatient Discharge Delay

The number of delayed discharges and cases declined from 2018, ending in Q2 '19 with zero delays. In Q1 '19, there was only one delayed discharge waiting for RTC/GH services for a total of 105 days. The youth was female, DCF-involved, and between the ages of 13 and 17.

Recommendation 5: *Continue to hold PAR Meetings with Solnit Inpatient*

Beacon Health Options will continue the Solnit Inpatient PAR program in an effort to improve access to care and the quality of care for Medicaid youth. Areas of focus will continue to be ALOS, discharge delay, and readmissions post inpatient discharge.

Beacon Health Options held its first PAR meetings with Solnit Inpatient Hospital in Q3 and Q4 '18. This was a joint PAR meeting with Solnit Inpatient and Solnit PRTF due to the high rate of youth transferring between the two programs. As a next step, in Q1 and Q2 '19, Solnit reviewed the data details for this

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.

cohort in an effort to understand the underlying reason(s) for the transfers. This information will be reviewed in the upcoming PAR meeting and remain an area of focus moving forward.

Through the QM Program, Beacon Health Option's primary focus in Q2 '19 was on mitigating risk and ensuring the safety and well-being of youth currently in care at Solnit Inpatient Hospital and Solnit South PRTF.

While the Solnit Inpatient PAR program continues to be an area of importance, Beacon is also mindful of the current priorities for Solnit Inpatient Hospital. In Q2 '19, Beacon implemented a Quality Management (QM) Program at the three Solnit facilities. Through the QM Program, Beacon Health Option's primary focus in Q2 '19 was on mitigating risk and ensuring the safety and well-being of youth currently in care at Solnit Inpatient Hospital and Solnit South PRTF.

Concurrently, this team worked on the establishment of a multi-disciplinary steering committee in an effort to establish quality assurance, standardize procedures and workflows, and continue to minimize risk. The Regional Network Manager for Solnit Inpatient PAR program will be working closely with the Solnit QM team and Solnit Inpatient Hospital in order to align goals, priorities, and quality improvement activities. Additionally, the Solnit QM leadership will also attend upcoming PAR meetings to ensure that the use of the PAR data will inform current practices, identify existing barriers, and highlight areas of opportunity.

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

As noted in the last semiannual, the Boys & Girls Village closed their psychiatric residential treatment facility (PRTF) near the end of 2018, resulting in two remaining community PRTF providers, The Children's Center of Hamden 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, unit capacities on both Solnit campuses were temporarily reduced throughout 2018. Furthermore, we anticipated continued reduction in census at Solnit South PRTF due to required building renovations.

The number of PRTF discharges decreased in the last quarter of 2018, from 56 to 43, which was anticipated given the aforementioned changes. In Q1 '19, discharges decreased a further 30.2% to a low of 30 discharges, before increasing to 39 discharges in Q2 '19. Meanwhile, the ALOS decreased 21.4 days from Q4 '18 to Q1 '19, before

increasing 13.1 days to 151.2 days in Q2 '19. In the first two quarters of 2019 combined, 33 discharges (47.8%) came from Community PRTF providers, while 36 discharges (52.2%) came from Solnit PRTF. In Q2 '19, the ALOS for Community providers was longer (166.2 days) than for Solnit (137 days).

Overall, White youth continued to be the largest racial and ethnic group with 41% of the PRTF discharges in Q2 '19. White members are disproportionately overrepresented in PRTF utilization, as White youth comprise 22% of the Medicaid youth population.

Community providers serve mostly children ages 12 and under, who accounted for 42% of all PRTF discharges in Q1 and Q2 '19 combined. Solnit PRTF serves mostly 13-17 year olds, who comprised 58% of PRTF discharges. More males (66.7%) than females (33.3%) discharged from PRTFs, however, the ALOS in Q2 '19 was very similar for both males and females at 151.9 days and 149.9 days, respectively.

Overall, White youth continued to be the largest racial and ethnic group with 41% of the PRTF discharges in Q2 '19. White members are disproportionately overrepresented in PRTF utilization, as White youth comprise 22% of the Medicaid youth population. Hispanic (23.1%), Unknown race/ethnicity (20.5%), and Black (12.8%) groups made up most of the remaining discharges.

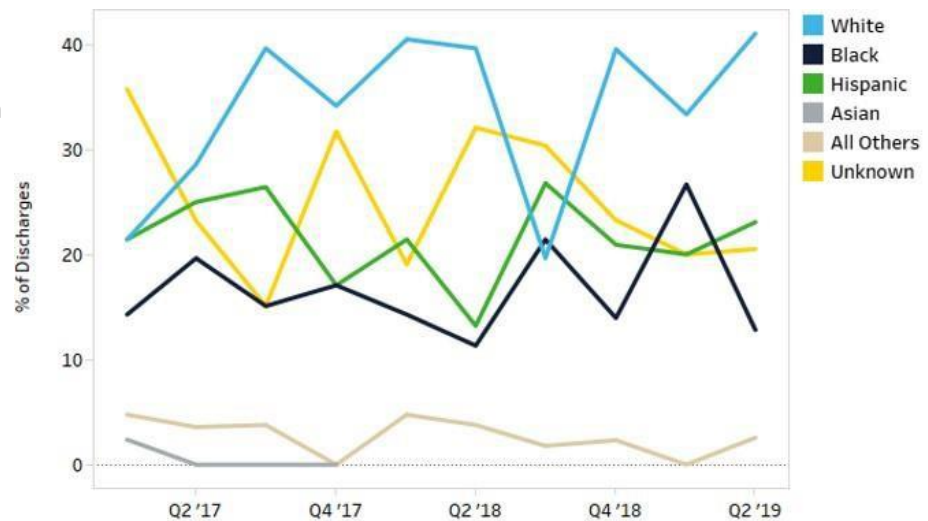


Figure 5: Percent of Community & Solnit PRTF Discharges by Race/Ethnicity

The discharge volume of DCF-involved youth decreased from 2018, down to 13 discharges (33.3%), however DCF-involved youth are overrepresented as they are approximately 2.4% of the youth Medicaid population and also tend to have longer lengths of stay on average compared to non-DCF involved youth (185.6 days vs. 134.0 days).⁶ While this disproportional overutilization is not surprising, the high level of need for PRTF services for DCF-involved youth remains evident.

Both community PRTF providers increased admissions in the second half of 2018, likely caused by the need to transfer youth from the Boys & Girls Village facility before they closed in October. However, in Q1 and Q2 '19, admissions at the remaining community PRTFs decreased to more historic levels observed prior to the closure of Boys & Girls Village.

Admissions at Solnit North PRTF (males) decreased 55% from 11 in Q4 '18 to five in Q1 '19. In the second quarter of 2019, admissions increased to a high of 19. Over the same time, Solnit South (females) increased to 11 admissions in Q1 '19 before decreasing in Q2 '19 to eight admissions.

Recommendation 6: *Continue to Share Data with the PRTFs on a Semi-annual basis:* As mutually agreed upon with the State Partners, the PRTF PAR Program was discontinued in 2018. It was agreed upon at that time that the RNM will send the Community PRTFs their data and data details on a semi-annual basis and will be available for follow up as needed. The most recent data was delivered electronically in August 2019.

Additionally, the annual retrospective level of care review for 2019 will be on the Community PRTF programs. On-site reviews will be completed in Q4 '19 and the results will be shared with the programs, including best practices and opportunities for improvement.

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.

Psychiatric Residential Treatment Facility (PRTF) Awaiting Recommended Services—Community and Solnit

As of Q2 '19, there were four delayed discharges from Community and Solnit PRTF (three from Community PRTF and one from Solnit), which is an increase from the end of 2018. The total number of cases also increased, to 11 in Q2 '19, so there were seven youth who continued waiting for recommended services at the start of Q3 '19. The total awaiting recommended service days increased in the first two quarters of 2019 to 365 and 776, respectively.



Figure 6: Community & Solnit PRTF Discharges Awaiting Recommended Services

Of the seven delayed discharges in both quarters of 2019 combined, most (42.9%) were awaiting “Other,” followed by awaiting RTC/GH (28.6%), and community services (28.6%). 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.

Recommendation 7: Enhance Collaboration Between PRTF and Therapeutic Foster Care Agencies

DCF and Beacon continue to provide education to the PRTF providers on appropriate next steps towards finding a foster care family, i.e., statewide recruitment, special recruitment, and for those agencies that also offer Therapeutic Foster Homes to work internally to identify viable families.⁷ In Q3 '18, PRTF rounds were reinstated and continue to be held weekly. Beacon, DCF, and both state PRTF clinical staff consistently attend rounds. The focus of discussions continues to be on identifying next steps and assigning tasks to provide direction and clarity for the team and access to therapeutic foster care (TFC) closer to the time the youth is ready for discharge. Since resumption of the PRTF rounds, we have seen many successful and timely discharges from this level of care and an overall reduction of youth awaiting recommended services. Beacon will continue to facilitate these rounds in collaboration with DCF as these rounds have shown to be beneficial to addressing system throughput issues.

Recommendation 8: Support DCF Efforts to Increase Recruitment and Capacity in Therapeutic Foster Care

Currently, some regional systems have efforts underway that focus on foster care engagement and recruitment. The Region Two South Central Network of Care (SCNC) continues to support the foster care workgroup and is currently exploring ways that the SCNC will support foster care recruitment. Ongoing efforts are also taking place in Region Five at the Adoption/Foster Care/Kinship Care Collaborative and through active participation in other community initiatives.

Since resumption of the PRTF rounds, we have seen many successful and timely discharges from this level of care and an overall reduction of youth awaiting recommended services.

⁷ “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.

Building on previous recommendations, Beacon will work to enhance collaborative relationships between various levels of care and TFC.

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 the DCF. The goal of each Network of Care is to increase collaboration among all child-serving systems in order to improve outcomes for children and families. In addition to providing information, resources, and opportunities for collaboration, the Regional Networks of Care can 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. The Network of Care Managers continue to explore opportunities to collaborate with other community initiatives that support network of care development through the lifespan. This resource should continue to be leveraged in service of all Connecticut youth, inclusive of HUSKY members.

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 ALOS, awaiting recommended services, and transfers from PRTF to inpatient level of care.

Beacon Health Options held its first joint PAR meeting with Solnit PRTF and Solnit Inpatient in late 2018 due to the high rate of youth transferring between the two programs. As a next step, in Q1 and Q2 '19, Solnit reviewed the data details for this cohort in an effort to understand the underlying reason(s) for the transfers. This information will be reviewed in the upcoming joint PAR meeting. Transfers will remain an area of focus as the Q1 and Q2 '19 data indicates that approximately 40% of youth at Solnit South PRTF were transferred to Solnit inpatient.

Solnit PRTF's average length of stay (ALOS) remained relatively stable from Q3 and Q4 '18 to Q1 and Q2 '19 (160.4 days to 137 days, respectively). Additionally, the volume of youth awaiting recommended services continues to be low since the initial decline in Q2 '18, with only two total youth awaiting services in Q1 and Q2 '19. There was also a reduction in the number of Solnit PRTF discharges from 51 discharges in Q3 and Q4 '18 to 36 discharges in Q1 and Q2 '19. One major contributing factor was cottages being offline due to construction.

While the Solnit PRTF PAR program continues to be an area of importance, Beacon Health Options is also mindful of the current priorities for Solnit PRTF. In Q1 and Q2 '19, Beacon implemented the new Solnit Quality Management (QM) Program. Initially, Beacon Health Options' primary focus was re-assessing areas of concern, particularly those related to mitigating risk and ensuring the safety and well-being of youth currently in care at Solnit PRTF. Concurrently, this team worked on the establishment of a multi-disciplinary steering committee in an effort to establish quality assurance, standardize procedures and workflows, and continue to minimize risk. The Regional Network Manager for Solnit PRTF PAR program will continue to work closely with the Solnit QM team and Solnit PRTF in order to ensure alignment with goals and priorities. Additionally, the Beacon Solnit QM leadership will also attend

upcoming PAR meetings to ensure that the use of the PAR data will inform current practices, identify existing barriers and highlight areas of opportunity.

Residential Treatment Center (RTC) and Group Homes

In-state Residential Treatment Center (RTC) saw an increase in Q1 '19 to 22 admissions before ending Q2 '19 with 16 admissions. The ALOS peaked in Q1 '19 to 391.1 days and decreased slightly in Q2 '19 to 357.9 days. Meanwhile, out-of-state RTC admissions continued to decrease and there were few, if any, in most of the last 10 quarters.

In Q1 and Q2 '19, most RTC admissions (89.7%) continued to be 13-17 year-olds, males (74.4%), and DCF-involved youth (87.2%).⁸ Unknown (43.8%) was the largest racial/ethnic group in Q2 '19, up from a low of four admissions in Q4 '18. However, in Q1 '19, most admissions were from White youth (39.1%). For the first time since Q3 '18, the ALOS in Q2 '19 was slightly higher for females than males (380.6 days vs. 344.9 days). Admissions and discharges were consistently higher for DCF-involved youth versus non DCF-involved. In addition, the ALOS for DCF-involved youth reached a high of 451.4 days based on 19 discharges.

Therapeutic Group Home (GH) admissions increased 29% in Q1 '19 and ended Q2 '19 with 17 admissions. The ALOS reached an all-time high of 666.0 days in Q4 '18 and decreased slightly in Q1 '19 to 645.8 days. From Q1 to Q2 '19, the ALOS decreased by nearly 207 days to 438.9 days. The ALOS was highest among males (483.9 days) and White youth (816.4 days).

Autism Spectrum Disorder (ASD) Services

Authorizations increased for nearly every type of ASD service with the exception of service delivery and direct observation and direction. In Q2 '19, Treatment Plan and Program Book Development continued to be the most authorized service (26.8%) followed by Diagnostic Evaluation (25.6%), and Behavioral Assessment (22.2%). Treatment Plan and Program Book Development can be authorized every 90 days

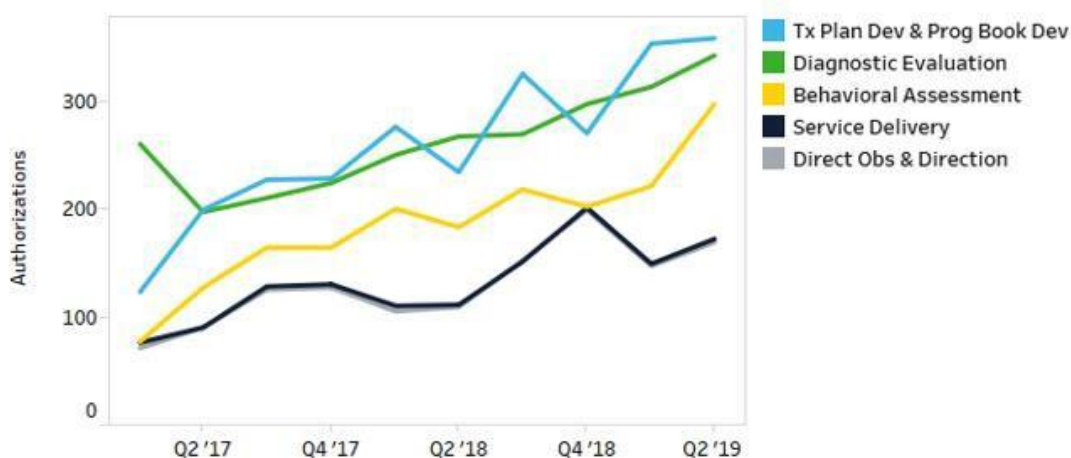


Figure 7: ASD Authorization Volume by Service Class

⁸ "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.

as needed to make updates to goals, objectives, and teaching materials which accounts for the higher authorization of this service over Service Delivery.

Overall, most of the youth accessing ASD services continue to be ages 3-12, male, and non-DCF involved for all service classes. Youth with Unknown race/ethnicity had the highest utilization in all service authorizations, while Hispanic was the second largest group for Treatment Plan and Program Book Development (94), followed by Diagnostic Evaluation (97), and Behavioral Assessment (81). Service Delivery authorizations for Hispanic youth remain low (34).

While the number of ASD agencies historically increased in every service class, 2019 saw a decrease in unique agencies as some agencies modified their enrollment status or chose not to re-enroll as a Medicaid ASD Provider. As of June 2019, one agency, Comkey, chose to no longer accept Medicaid members for any ASD services due to the documentation requirements and reimbursement rates. Two other agencies, Focus Center for Autism and HARC, changed their enrollment status to only providing Autism Diagnostic Evaluations citing both low reimbursement rates for group intervention (Focus) and the inability to maintain behavior technicians who meet the state plan requirements (HARC). While there was a reduction in unique agencies in 2019, it is important to note that the number of individual providers within the agencies who are able to provide or oversee direct service delivery increased by 22 providers. In Q1 and Q2 '19 combined, Family Strong was the largest provider (229), followed by A Piece of the Puzzle (179), Connecticut Children's Specialty Group, CCMC (175), and A Brand New Day (157).

Recommendation 10: 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. Beacon will continue to outreach to community providers and offer support to community-based clinicians through CHDI and 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, the Director of Autism Services continues to provide statewide trainings for mobile crisis teams, first responders, and outpatient clinic clinicians. 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 their 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. During Q1 and 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 and ethnically and racially diverse clinicians and behavior technicians in order to improve access to services for the diverse Medicaid population. While Beacon Care Coordinators and Peer Specialists have access to 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 quite a barrier to accessing services.

To support the quality of services provided to Medicaid members, Beacon is committed to collaborating with providers and clinicians in the community to continue supporting 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), updated processes/procedures for accessing web-pended authorizations, and updates to CPT codes and expectations. In Q3 '19 and Q4 '19, the ASD team will be collaborating 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.

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 concerns 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 Q1 and Q2 '19 averaged a weighted score of 78.9% (with a range of Comkey at 55.2% to Bloom at 99.7%). Quality Improvement Plans were submitted by providers whose chart review indicated a "member safety item," meaning if this information was not present in documentation and there was not an indication of this information being assessed, a member's safety or the safety of others around them may be at risk and is not being addressed, or is not being addressed appropriately.

In addition to these plans for future support and training of Medicaid providers, the Beacon Director of ASD participated in bimonthly meetings with DDS Behavior Support Program (BSP) leadership to ensure smooth transition of services for individuals who will no longer be eligible for State Plan services at 21 years of age and will be serviced by DDS. The goal of these meetings is to support individuals through this transition through Peer Support and early collaboration with the receiving DDS case manager and service providers.

Recommendation 11: Collect data regarding authorization to first claim

The number of ASD members receiving direct services continued to grow, increasing from 149 total new authorizations in Q1 '19 and 172 total new authorizations in Q2 '19, making up a total of 2,220 unique members connected to a provider for direct ABA service delivery. An additional 23 members were connected to Group Treatment services (ASG).⁹ This increase is explained by an overall growth in the provider network for providers who perform direct services. Beacon has begun 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 will be able to target the shaping of providers in the network. We recognize that the longest wait times are from when a member is connected to an ASD Clinical Care Manager (CCM) to the time a provider submits the first claim indicating the start of services. While we have been working to make modifications to this process, prior to April 2019, our process has been for the peer specialist or care coordinator to assist in gathering necessary documentation and Release of Information prior to transferring a member to a CCM. Once this transfer occurs, the CCM begins outreaching to providers to determine if they are accepting new referrals and wait times, if applicable.

The ASD team built in efficiencies over Q1 and Q2 of 2019, empowering and assisting families with reaching out to providers directly, as we have seen this decrease wait times. We have also modified how

⁹Note: 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.

peer specialists or care coordinators support families by implementing a tiered approach to support. Tier 1 includes resources by phone, while Tier 2 includes face-to-face support to outreach to resources and referral options, building natural supports for the family. A Tier 3 approach 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 bench marks 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. We are also looking to demonstrate a decrease in emergency department visits once services have started; this data will specifically be collected for the IRT program.

Recommendation 12: Enhance supports to individuals in the Emergency Departments and Inpatient Settings

Implementation of the Intensive Response Team (IRT – under a program specific contract with DSS) began in April 2019 with our first referrals coming in June 2019. The overarching vision of the IRT program is to enhance the system of care for members and families impacted by autism spectrum disorder, intellectual disability, and/or developmental disorders. These individuals are typically the highest utilizers of all levels of care throughout the state and require the support of care coordinators with specialized training and knowledge. The specific goals of this team are to (1) to decrease the frequency of emergency department visits and ED awaiting recommended services; (2) to decrease inpatient psychiatric hospitalizations and length of stays in acute hospitals; and (3) increase "successful" referral and connection to appropriate levels of care for this vulnerable population.

Members of the IRT work with children and young adults with the highest frequency of emergency department visits and inpatient admissions.

Community collaboration is a key component to the success of connecting members to appropriate services in the home in a timely manner. Intensive Response Team care coordinators combine the expertise of an ASD informed Care Coordinator/Peer Specialist while utilizing the Wraparound principles of care and family focused methods of building a family plan of care, empowering the family to take the lead in their goals and treatment. Members of the IRT work with children and young adults with the highest frequency of emergency department visits and inpatient admissions. They are available to meet individuals in crisis at Connecticut Children's Medical Center (CCMC), Yale Children's Hospital or Yale New Haven Hospital emergency departments, Mobile Crisis team locations, and higher level of care facilities. By implementing a Wraparound care coordination model, IRT staff will be able to partner with families in planning to address their child and family needs. The goal is to assist in triage, collaborative management of the member's care, and develop a person-centered discharge plan. This will help the member transition back to their community successfully and minimize the possibility of readmission to the emergency department and/or inpatient psychiatric hospitalization.

Referral criteria includes any individual who has been diagnosed with an Autism Spectrum Disorder, Intellectual Disability, or Developmental Disability, is at risk of overstay in the ED, or delayed discharge from an inpatient setting, and/or has utilized multiple services that are unable to meet their needs. The IRT is available to anyone who meets this criteria under the age of 26 years old and is offered to Medicaid members, those covered by commercial insurance, or the uninsured. As of July 31, 2019, the IRT received 24 referrals from CCMC emergency department and Center for Care Coordination. Of these 24 referrals, 13 were appropriate referrals and were interested in engaging with the team; one was closed due to being transferred to a group home and one was closed due to lack of response from the family. Of these 24 referrals from CCMC, two individuals had commercial insurance without Medicaid as

a back-up. Also, as of July 31, 2019, the IRT received 12 referrals from various Yale teams including Yale Pediatric Emergency Room, Yale New Haven Emergency Room, their inpatient psychiatric units, and one from the pediatric medical unit. Of these 12 referrals, eight were opened with the IRT. One has successfully discharged from IRT supports, two closed due to lack of interest from the family, and one closed due to the individual being placed in a group home. Of these referrals, two included individuals who had commercial insurance. The individuals who the IRT determined to not be appropriate referrals were referred to the Beacon Health Options ASD team or to a family peer for support.

Lower Levels of Care

Outpatient services for youth continued to be the highest authorized service (10.7 admits/1,000), representing the vast majority (85.6%) of all admissions to lower levels of care. Quarterly admissions for youth tended to follow a seasonal pattern, likely related to school and summer vacation. Admissions dipped in the summer months of Q3 '18 (8,970 admissions) and peaked in Q1 '19 with 11,556 admissions before declining to 10,396 admissions in Q2 '19.

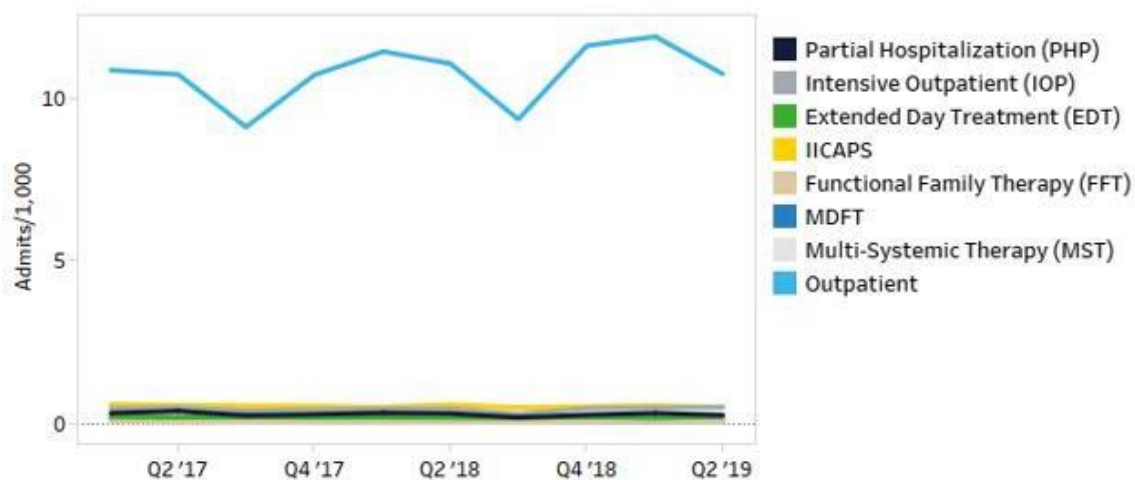


Figure 8: Admits per 1,000 by Lower Levels of Care

Intensive In-Home Child Adolescent Psychiatric Services (IICAPS) was the second most utilized service in Q1 '19, with 543 admissions. However, Intensive Outpatient (IOP) admissions increased in Q2 '19 and was the second largest lower level of care with 504 admissions, three admissions more than IICAPS (501 admissions in Q2 '19).

In the last semiannual submission, it was noted that Multi-Dimensional Family Therapy (MDFT) referrals were “on hold” throughout the month of November due to a new contract start date of Dec. 1, 2018. As expected, the capacity and utilization of MDFT services increased in both quarters of 2019 (89 and 94, a 22% increase).

Also noted in the last semiannual submission, Multi-Systemic Therapy (MST) services split off into a separate contract through CSSD. Reduced utilization of MST services was anticipated, as we may not have access to CSSD utilization information. However, admissions for this service class increased in both quarters of 2019.

Outpatient services for youth continued to be the highest authorized service (10.7 admits/1,000), representing the vast majority (85.6%) of all admissions to lower levels of care.

Recommendation 13: Develop an Intensive Outpatient Provider Analysis and Reporting (PAR) Program

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

Enhanced Care Clinics (ECCs)

In Q2 '19, the non-ECC registration volume represented 76.3% of total youth outpatient registrations and reached a high of 8,638 registrations in the first quarter of 2019. While youth ECC volume tends to peak in the first quarter and dip in the third quarter, overall, volume was steady, ending Q2 '19 with 2,180 registrations.

In the first two quarters of 2019, the 95% access standard was met for all three classes in ECCs. In Q2 '19, routine standards were met 98.7% of the time, urgent were met 95.0% of the time, and emergent were met 100% of the time. Across all outpatient evaluations, ECCs had higher rates of meeting the 95% access standard than non-ECC clinics.

Recommendation 14: Assess ECC initiative

Many meetings were held over the past year with key stakeholders to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, the incorporation of value-based payment methodologies, and opportunities to broaden the initiative. These discussions remain ongoing. During the September Operations Subcommittee, an open invitation for feedback on ECC redesign was given to providers. While the subsequent Operations Subcommittee meetings have not generated any additional feedback, the CT BHP ECC team remains open to provider input.