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Connecticut Behavioral Health Partnership (CT BHP) 2024 Annual Report

March , 2026

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Contents

Connecticut Behavioral Health Partnership (CT BHP)

- 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).
- Carelon Behavioral Health Connecticut (Carelon BH CT) continues to serve as the behavioral health Administrative Services Organization (ASO) for the CT BHP and managed behavioral healthcare for more than 1.1 million HUSKY Health members in 2024.
- Carelon BH CT'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 ensuring service delivery at the appropriate level of care.
- Carelon BH CT is responsible for enhancing communication and collaboration within the behavioral health delivery system, assessing network adequacy on an ongoing basis, improving the overall delivery system, and providing integrated services supporting health and recovery by working with the Departments to recruit and retain both traditional and nontraditional providers.

Carelon BH CT as Administrative Service Organization (ASO) for the CT BHP

- **History of the ASO:** Carelon BH CT has been the ASO since the inception of the CT BHP. Carelon BH CT was selected via a competitive RFP process in 2006 and 2010 for the child and then the adult ASO roles. In 2011, the programs were integrated to ensure seamless infrastructure for the Medicaid program, and the contract was most recently renewed in 2022.
- Carelon BH CT adopts a recovery model to develop and implement programs and services for HUSKY Health members. Guided by the SAMHSA Eight Dimensions of Wellness and other industry standards, our approach emphasizes being recovery-oriented, strengths-based, solution-focused, and having a system of care perspective with whole-person and health equity considerations. It also focuses on providing trauma-informed care and culturally competent, person- and family-centered services with community engagement.
- In 2024, Carelon BH CT was formally designated a Recovery Friendly Workplace by Connecticut Governor Lamont, and named one of the state's Top Workplaces for the ninth time.

CT BHP Annual Report Purpose and Context

Scope: This annual report is submitted by Carelon Behavioral Health Connecticut (Carelon BH CT) to the Connecticut Behavioral Health Partnership (CT BHP) to summarize the status, initiatives, and impacts of the HUSKY Health management of behavioral health services. This fulfills the requirements of Connecticut General Statutes Sec. 17a-22m and Sec. 17a-22n, which pertain to the annual evaluation and monitoring of the Behavioral Health Partnership's implementation. The analyses highlighting the challenges and opportunities will inform future strategic planning.

This report is divided into three thematic areas:

- **Chapter 1 Overview**: Description of the CT BHP performance standards and the programs and services Carelon BH CT provides.
- **Chapter 2 Current Status of HUSKY Health Behavioral Health Services**: Presentation of key data on the HUSKY Health membership, provider network, and behavioral health service utilization, offering valuable insights into the current state and performance of the HUSKY Health behavioral health system of care with a health equity lens.
- **Chapter 3 Programs and Initiatives**: Exemplar CT BHP initiatives showcasing efforts and impacts to improve access, quality, and outcomes, and eliminate disparities, including where the CT BHP excels and where improvements are needed.

Executive Summary: Membership and Provider Network

- **Decline in membership:** In 2024, youth HUSKY Health membership remained stable while adult membership declined by 4.7%, primarily due to the expiration of the COVID-19 Public Health Emergency and the unwinding of continuous coverage policies. This decline is expected to continue with ongoing changes in eligibility policies.
- **Unknown racial group posed challenges for demographic analysis:** Federal regulations limit the data elements that can be required in an application for HUSKY Health benefits; as such, race is not a required field when applying to HUSKY Health. In 2024, there was a significant portion (44.3%) of members with an unknown race among the HUSKY Health population. The unknown race has been the largest racial group since 2021. This substantial unknown group highlighted the need for improved data collection and hindered the full understanding of health disparities in behavioral health (BH) services.
- **Disproportionality in BH costs:** In 2024, White members contributed to 47.0% of the total BH claims costs and had the highest per-member-per-month (PMPM) cost while making up 31.8% of non-dual HUSKY Health members aged 3+. In contrast, 46.1% of members aged 3+ had an unknown race while accounting for 32.1% of the BH claims costs.
- **Considerable growth in CT BHP provider network:** The CT BHP provider network expanded by nearly 40% in the state from 2020 to 2024 across several service areas, including outpatient providers for medications used in substance use disorder (SUD) treatment.

Executive Summary: BH Services

- **PMPM costs rose by over 10% for both youth and adults in 2024:** 29.3% of HUSKY Health youth members aged 3+ and 30.3% of adult members accessed BH services, with PMPM costs for both groups rising by over 10%.
- **Inpatient psychiatric facility (IPF) discharges declined for both youth and adults in 2024:** There was a 2.8% reduction for youth and a 5.0% reduction for adult IPF discharges. However, the adult readmission rates rose and reached 7.1% within 7 days and 20.0% within 30 days post-discharge, despite the stable average length of stay.
- **Adult BH emergency department (ED) visits per 1,000 eligible member months increased:** There was a notable 18.2% increase compared to 2023, reaching approximately 14.8 visits per 1,000 eligible member months. However, the total number of BH ED visits among adult members remained relatively steady.
- **Delayed discharges in youth IPF and instances of youth being stuck in the ED remained significant challenges but showed encouraging progress:** Although the number of inpatient delayed discharges increased, the average duration of these delays improved considerably, decreasing from 34.4 days in 2022 to 20.9 days in 2024. Additionally, the average length of stay in the ED for youth awaiting placement in psychiatric residential treatment facilities (PRTFs) was reduced by 46.1%, dropping from 10.2 days in 2023 to 5.5 days in 2024. Continued effort to enhance service accessibility such as PRTF is recommended.

Executive Summary: Making Impacts

- **Data enhancement to promote health outcomes:** Recognizing the challenges in assessing health disparities, Carelon BH CT advanced its data capabilities by successfully matching 89% of HUSKY Health members with Area Deprivation Index (ADI) scores, allowing socioeconomic analyses in the future. There are also plans to investigate and enhance data on the unknown racial group.
- **Programs supporting members and providers:** Carelon BH CT continued to support members and providers through the utilization management (UM), care management (CM), and Provider Analysis and Reporting (PAR) programs, focusing on system throughput issues such as youth inpatient discharge delay and ED stuck.
- **Exemplar initiatives:**
  - **Aftercare Follow-Up (AFU):** Carelon BH CT launched the inpatient post discharge AFU program aimed at enhancing care connections to improve health outcomes and decrease the use of costly services like readmissions and emergency department visits.
  - **Value-Based Payment (VBP):** Carelon BH CT supported the Department of Social Services (DSS) in implementing the VBP model for pediatric inpatient psychiatric hospitals. The VBP payment model incentivizes providers to continuously improve efficiency and quality of care.
  - **Certified Community Behavioral Health Clinics (CCBHC):** Carelon BH CT collaborated with the state partners in implementing the planning grant on the CCBHC model for BH outpatient clinics, which has great potential to reduce readmission rates and emergency department visits.

Chapter

01

CT BHP Overview

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Continuous Quality Improvement to Drive Excellence in Performance

CT BHP Standards for the ASO

There are 21 Performance Standards covering call management, utilization management processes, and denials, complaints, and appeals processes. They are assessed quarterly and now reported semiannually.

- The **call management** standards are measured by average speed of answer (ASA), percentage of calls meeting ASA, call abandonment rate (CAR), and hold times.
- The **timeliness of utilization management** processes are measured by percentage of authorization request decisions meeting turnaround time (TAT).
- The **timeliness of denials, complaints, and appeals** processes are measured by percentage of notifications and/or resolutions meeting TAT.

ASO Performance Over Time

- From 2011 to 2024, Carelon BH CT met nearly 99% of all performance standards.

Summary of Performance Standards in 2024

- In 2024, Carelon BH CT met all performance standards except two metrics:
  - member appeal TAT (Q1)
  - crisis call ASA (Q4)
- Actions taken to improve member appeal TAT included re-training on workflows and an improved escalation protocol.
- Actions taken to improve call ASA included increased staffing capacity and overtime.

#	Area	Type	Metric	Standard	Met/Not Met			
					Q1 2024	Q2 2024	Q3 2024	Q4 2024
1	Call Management	Provider	ASA	30 seconds	Met	Met	Met	Met
2	Call Management	Member		30 seconds	Met	Met	Met	Met
3	Call Management	Crisis		15 seconds	Met	Met	Met	Not Met
4	Call Management	Provider Calls	Percentage Meeting ASA	90%	Met	Met	Met	Met
5	Call Management	Member Calls		90%	Met	Met	Met	Met
6	Call Management	Crisis Calls		90%	Met	Met	Met	Met
7	Call Management	All	CAR	5%	Met	Met	Met	Met
8	Call Management	Provider	Hold Times	5 minutes	Met	Met	Met	Met
9	Call Management	Member		3 minutes	Met	Met	Met	Met
10	Call Management	Crisis		1 minute	Met	Met	Met	Met
11	UM	Urgent - Initial	TAT	95%	Met	Met	Met	Met
12	UM	Urgent – Concurrent	TAT	95%	Met	Met	Met	Met
13	UM	Non-Urgent - Initial	TAT	95%	Met	Met	Met	Met
14	UM	Non-Urgent - Concurrent	TAT	95%	Met	Met	Met	Met
15	UM	Written Notification	TAT	98%	Met	Met	Met	Met
16	NOA* & Denials	Written Notification	Timeliness	98%	Met	Met	Met	Met
17	QM	Complaints	Timeliness	90%	Met	Met	Met	Met
18	Appeals	Provider Level 1	Timeliness	90%	Met	Met	Met	Met
19	Appeals	Provider Level 2	Timeliness	90%	Met	Met	N/A	N/A
20	Appeals	Member	Timeliness	90%	Not Met	Met	Met	Met
21	Appeals	Administrative	Timeliness	90%	Met	Met	Met	Met

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** NOA: notice of action*

Behavioral Health Care Management (CM) Programs

- The primary goals of the CM programs are to help individuals maintain community tenure, regain optimal health, improve life functioning capability, and promote recovery and resiliency. The CT BHP is committed to ensuring that HUSKY Health members receive the best behavioral health services possible.
- The CT BHP has established CM programs inclusive of intensive care managers (ICMs), peer support specialists, autism spectrum disorder (ASD) care coordination (CC)/peer support teams, and co-management teams that are designed to assist children and adults with complex medical and behavioral health conditions. The CM programs focus on individuals at higher risk for adverse clinical outcomes linked to mental health and substance use disorders, along with co-morbid medical conditions.
- Service delivery is conducted through direct interactions with members in the community and rehabilitation facilities, consultations with community providers on complex cases, and targeted meetings with treatment providers and state partners.
- CM staff also work closely with the medical ASO (Community Health Network), the dental ASO (BeneCare), and the non-emergency medical transportation (NEMT) broker (MTM, Inc.) to foster an integrated approach to meeting individual needs.

Behavioral Health Utilization Management (UM)

Carelon BH CT supports the CT BHP with a range of utilization management programs across various behavioral health levels of care (BH LOC):

- inpatient psychiatric facilities (IPFs)
- psychiatric residential treatment facilities (PRTFs)
- medically managed intensive inpatient withdrawal management (American Society of Addiction Medicine (ASAM) 4.0 WM)
- medically monitored intensive inpatient withdrawal management (ASAM 3.7 WM)
- medically monitored co-occurring enhanced inpatient treatment (ASAM 3.7 E)
- clinically managed high-intensity residential services (ASAM 3.5)
- clinically managed co-occurring enhanced high-intensity residential services (ASAM 3.5 E)
- clinically managed high-intensity residential services for pregnant and parenting women (ASAM 3.5 PPW)
- clinically managed population-specific high-intensity residential services (ASAM 3.3)
- clinically managed low-intensity residential services (ASAM 3.1)
- therapeutic group homes (TGHs)
- mental health group homes (Medicaid rehabilitation option or MRO)
- partial hospitalization (SUD-PHP and MH-PHP)
- intensive outpatient (SUD-IOP and MH-IOP)
- methadone maintenance treatment (MMT)
- outpatient (OTP) treatment
- extended day treatment (EDT)
- enhanced care clinics (ECCs)
- autism spectrum disorder (ASD) services
- home health (HH) services
- intensive in-home services (IICAPS, MDFT, MST, and FFT)
    - IICAPS (intensive in-home child and adolescent psychiatric services)
    - MDFT (multidimensional family therapy)
    - MST (multisystemic therapy)
    - FFT (functional family therapy)

Clinical and Peer Specialist Programs

On behalf of the CT BHP, the clinical and peer specialist teams at Carelon BH CT support a wide range of functions and programs within the behavioral health system.

Operational Responsibility	Description
Authorizations and Oversight of Utilization	Ensures efficient management of clinical authorization requests through a provider self-service portal, tailoring inpatient authorization processes based on facility performance and case mix. This responsibility includes oversight of outlier and bypass programs, with support from departments such as Medical Affairs, Quality, Regional Network Management (RNM), and Data Analytics. The focus is on integrating predictive analytics and care strategies to enhance overall service delivery.
Intensive Care Management	Provides comprehensive intensive care management (ICM) services for both adults and youth, including peer specialist support and coordination with non-emergency medical transportation (NEMT) brokers. Facilitates coordination with the dental ASO and medical ASO to support members requiring co-management of care.
Specialty Population Management	Oversees programs targeting specialized populations, including an autism spectrum disorder (ASD) program and services for youth requiring emergency department (ED) and inpatient care. Engages members in programs such as Connecticut Housing Engagement and Support Services (CHESS) for unhoused individuals and those experiencing housing insecurity.
Follow-up Care After Hospitalization	Supports members post-hospitalization by identifying individuals at high risk for not engaging in follow-up care. Allocates targeted interventions aimed at improving transitions of care and enhancing clinical outcomes.

Provider Analysis and Reporting (PAR) Programs

Goals of PAR Programs

- Serve as the main vehicle for assessing, supporting, and refining provider performance, led by the quality regional network management (RNM) team.
- Establish strong partnerships with providers to develop methodology of utilization and outcome data that is most helpful to providers, often bridging the gap for many providers lacking resources or data.
- Review data among providers, CT BHP clinical, medical affairs, and quality leadership, and state partners.
- Convene data reviews and other system enhancement meetings with representation from quality, clinical, and medical affairs.
- Plan and execute large scale workgroups and forums across several levels of care to review performance and strategize about quality improvements.

PAR Programs and Number of Providers in 2024

- Solnit Hospital (1)
- Pediatric Psychiatric Hospital (7)
- Adult Psychiatric Hospital (22)
- 3.7 Withdrawal Management (ASAM 3.7 WM) (7)
- Solnit and Community Psychiatric Residential Treatment Facility (PRTF) (5)
- Emergency Department (28)
- Methadone Maintenance (9)
- Youth and Adult Intensive Outpatient (77)
- Enhanced Care Clinic (24)

Quality Monitoring, Dashboards, and Advanced Analytics

Carelon BH CT conducts a variety of quality and service monitoring of the behavioral health system and performs advanced analytics to inform data-driven initiatives incorporating a health equity lens.

Operational Responsibility	Description
Quality Metrics and Utilization Indicators	Implements standardized quality measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) and those required by the Centers for Medicare and Medicaid Services (CMS). This responsibility also involves tracking key utilization indicators such as admissions, discharges, average length of stay (ALOS), and behavioral health service usage over time. Where applicable, measures are stratified by demographic factors to apply a health equity lens and identify and address potential health disparities.
Population Health Dashboards	Creates interactive dashboards that offer population-level analysis across various dimensions, including demographics, diagnoses, utilization trends, costs, and social drivers of health (SDoH). These dashboards provide actionable insights into cost trends and disparities within the population by examining key indicators.
Provider Performance Dashboards	Develops interactive dashboards to track provider-level performance indicators by level of care. These tools support the Provider Analysis and Reporting (PAR) program, driving performance improvement through data-driven insights and benchmarking.
Performance Standards and Targets	Tracks performance metrics against contract standards for internal operations, including call answering rates, appeals management, quality of care, and other contractual obligations. Establishes annual and biannual performance targets to ensure continuous improvement and accountability.
Advanced Analytics	Utilizes predictive modeling techniques to forecast behavioral health outcomes, such as expected inpatient lengths of stay and identifying individuals at higher risk of failing to follow up post-discharge from mental health treatment. These analytics help inform proactive intervention strategies to enhance behavioral health outcomes.

Chapter

02

Current Status of HUSKY Health Behavioral Health Services

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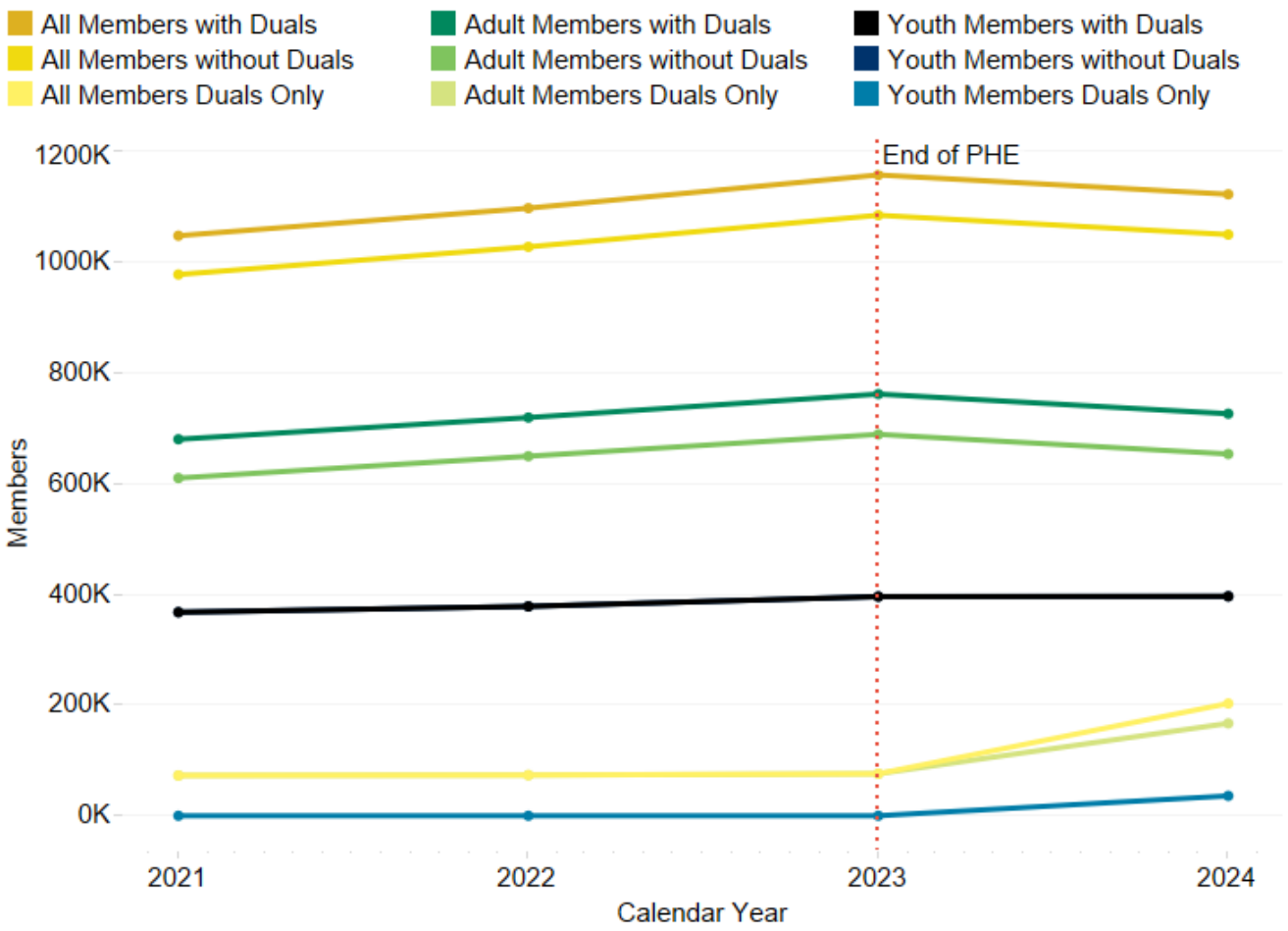
2.1. HUSKY Health Membership

CT HUSKY Health Membership Context

- Connecticut HUSKY Health had 1,122,632 members in 2024, including those who were dually eligible for Medicaid and Medicare/commercial. This was a slight decrease (-3.0%) compared to 2023, when there were 1,157,582 HUSKY Health members.
- The membership in 2024 was still 12.6% higher than in 2019 (*N* = 996,921) before the COVID-19 pandemic and declaration of the Public Health Emergency (PHE).
- These membership changes occurred in the following context:
  - The declaration of the PHE for the COVID-19 pandemic likely led to increased HUSKY Health membership starting in 2020.
  - The expiration of the PHE and the unwinding of the Medicaid continuous coverage requirement authorized under the Families First Coronavirus Response Act (FFCRA) that began on May 11, 2023, likely led to decreased membership in 2024. Continued decreases were expected in 2025, and total membership was below 980,000 as of the second quarter of 2025.

CT HUSKY Health Membership Overview

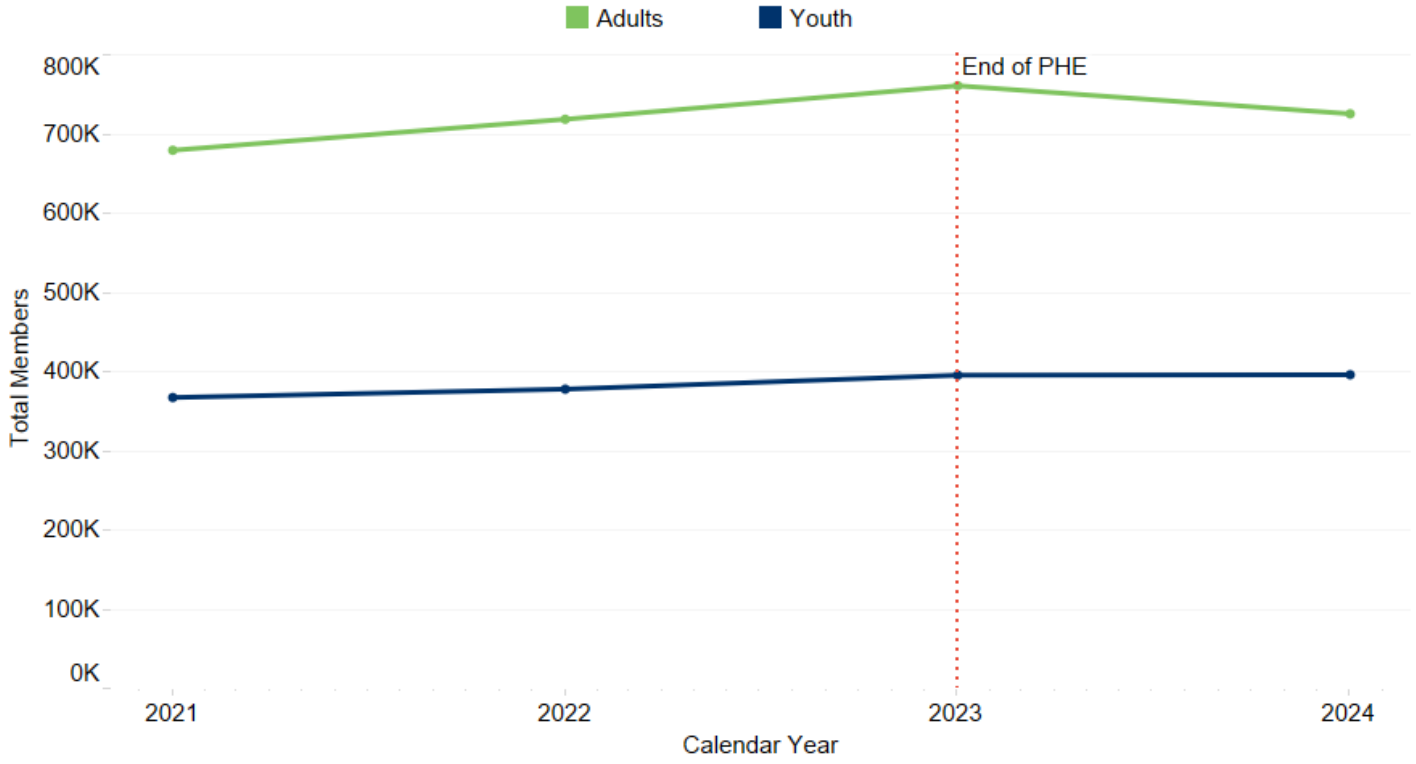


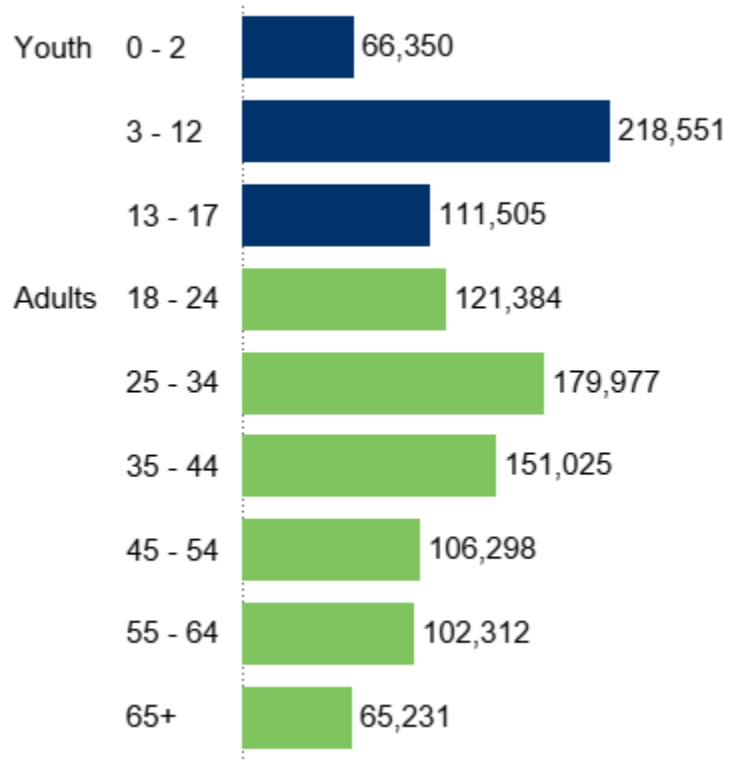
- In 2024, there were 726,227 adult HUSKY Health members aged 18+. This was a 4.7% decrease from 761,736 members in 2023.
- Total membership for youth aged 0-17 remained stable in 2024 (*n* = 396,405) compared to 2023 (*n* = 395,846).
- Adult and youth dual-only membership show an apparent increase in 2024. However, this is due to enhanced reporting to capture dual Medicaid/commercial members and is not necessarily reflective of a true increase in dual-only membership.

- *"Duals" refers to individuals with Medicaid who also have additional insurance coverage (e.g., Medicare, private insurance).*
- *Due to the small number of youth with dual membership, the "Youth Members with Duals" and "Youth Members without Duals" lines appear to overlap.*
- *A member is included if they were enrolled at any point in the calendar year.*

CT HUSKY Health Membership by Age

In 2024, children 3-12 years of age represented the largest age group (*n* = 218,551), accounting for 19.5% of HUSKY Health membership, followed by adults 25-34 years of age (*n* = 179,977, 16.0%).





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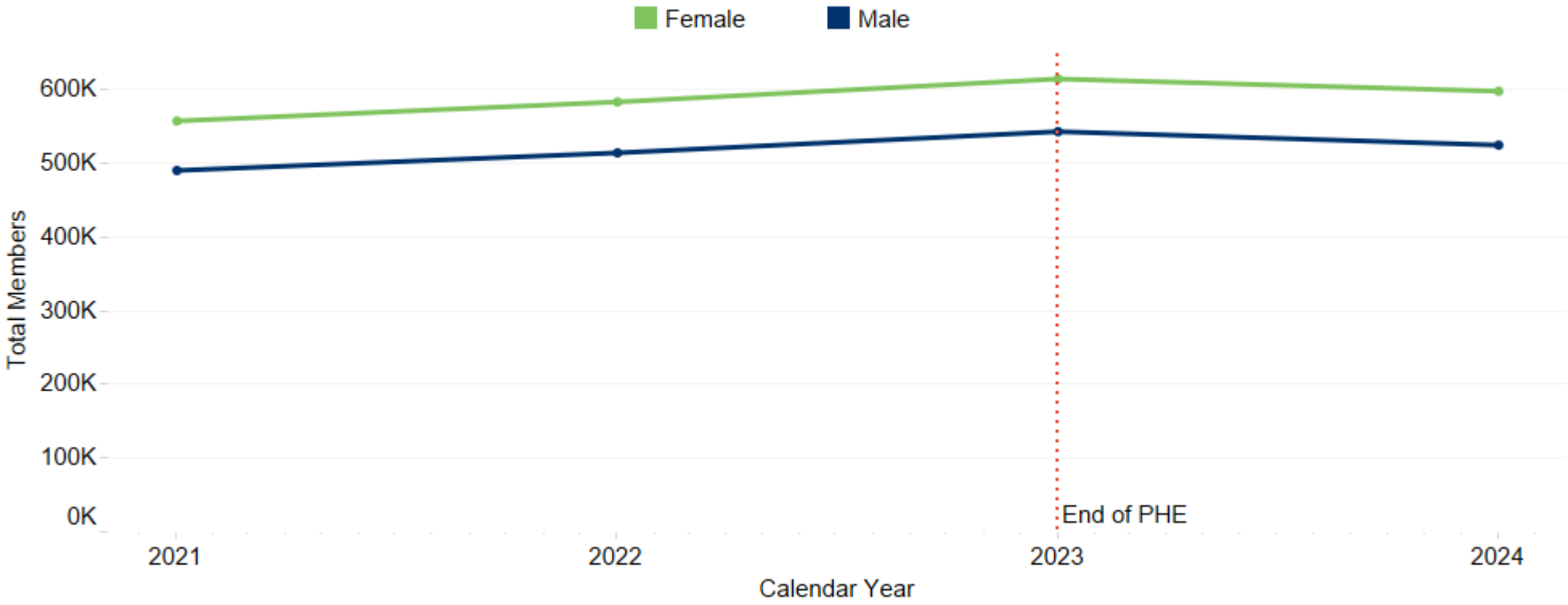
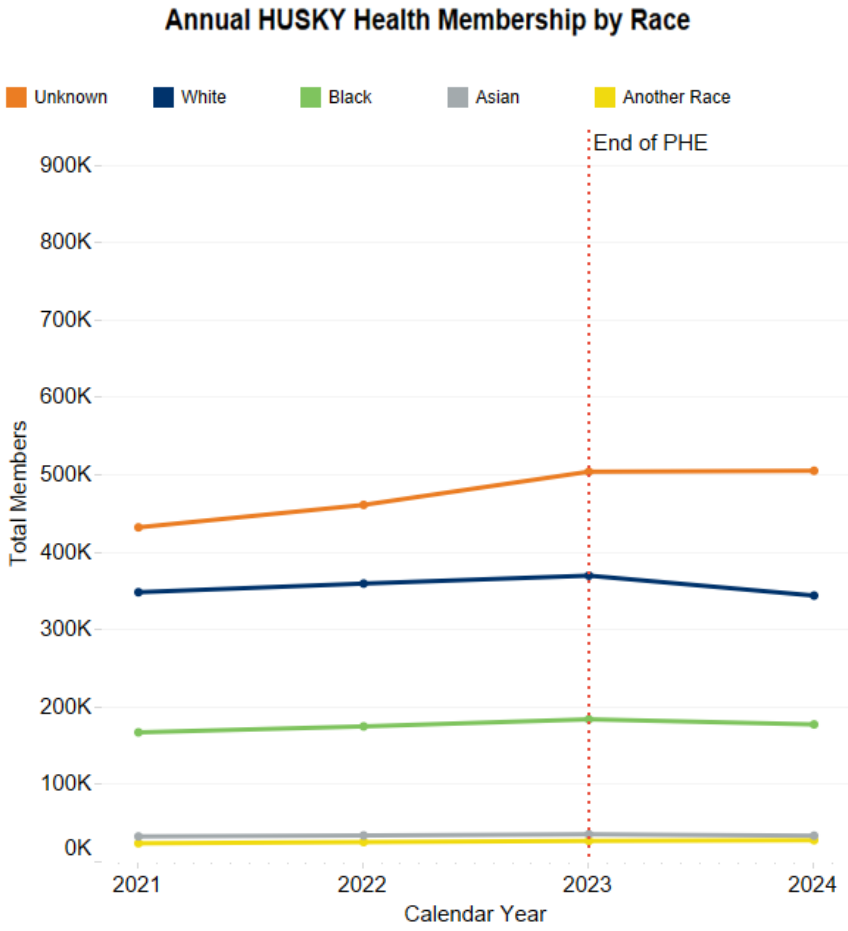
CT HUSKY Health Membership by Gender

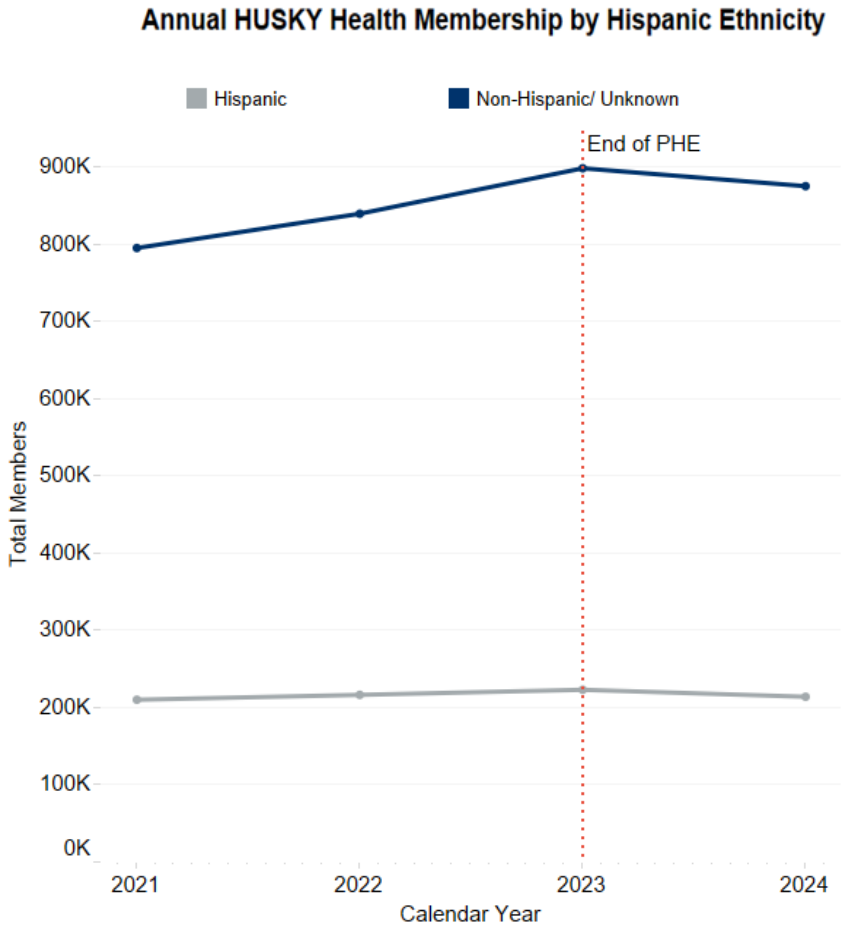
As in prior years, female members accounted for more than half of all HUSKY Health members (*n* = 597,890, 53.3%) in 2024, exceeding male members (*n* = 524,742, 46.7%).



CT HUSKY Health Membership by Race and Hispanic Ethnicity

- The proportion of HUSKY Health members for whom information on race is not available continued to increase.
- In 2024, the unknown race category accounted for 44.3% of the total HUSKY Health population and has remained the largest racial group since 2021.
- The lack of information on members' racial identity limits the accuracy of disparity analysis, making it challenging to fully assess inequities across racial and ethnic groups.





**Non-Hispanic and unknown ethnicity are indistinguishable in the data and are grouped together.*

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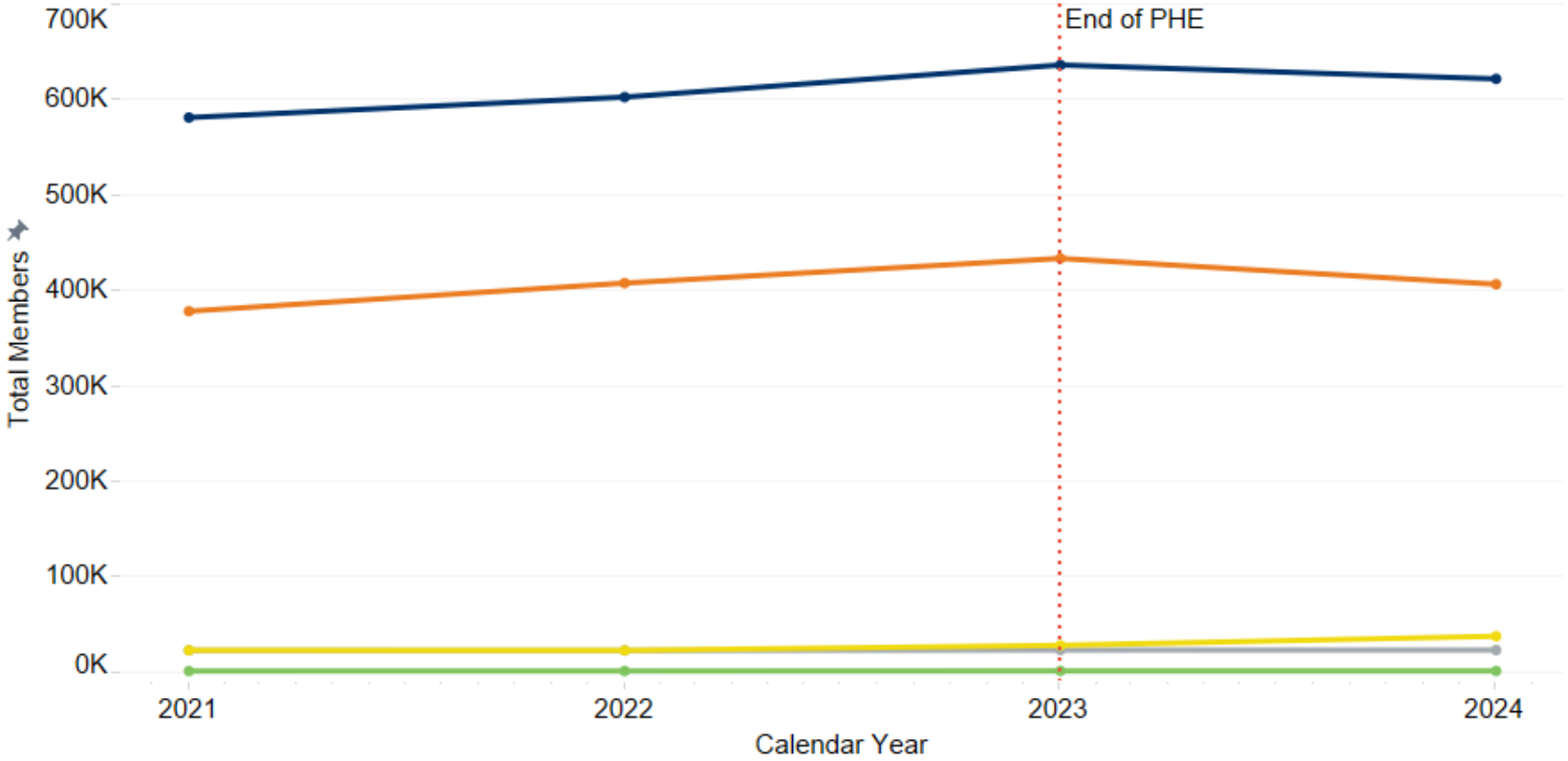
CT HUSKY Health Membership by Benefit Group

CY 2024 Membership Volume by Benefit Group	
HUSKY A (Family Single)	621,651
HUSKY B	37,246
HUSKY C (ABD/Other Single)	22,773
HUSKY C (LTC Single)	876
HUSKY D (MLIA)	406,318



- Most members continued to be covered by HUSKY A (*n* = 621,651) followed by HUSKY D (MLIA) (*n* = 406,318) in 2024. Membership for HUSKY A decreased by 2.3% and HUSKY D (MLIA) decreased by 6.2% from 2023 to 2024, while HUSKY B increased by 34.4% from 27,524 in 2023 to 37,246 in 2024. Both HUSKY C groups remained relatively stable.

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2.2. CT BHP Provider Network

CT BHP Behavioral Health Provider Types and Specialties

380+ Facilities, 1,600+ Practice Locations

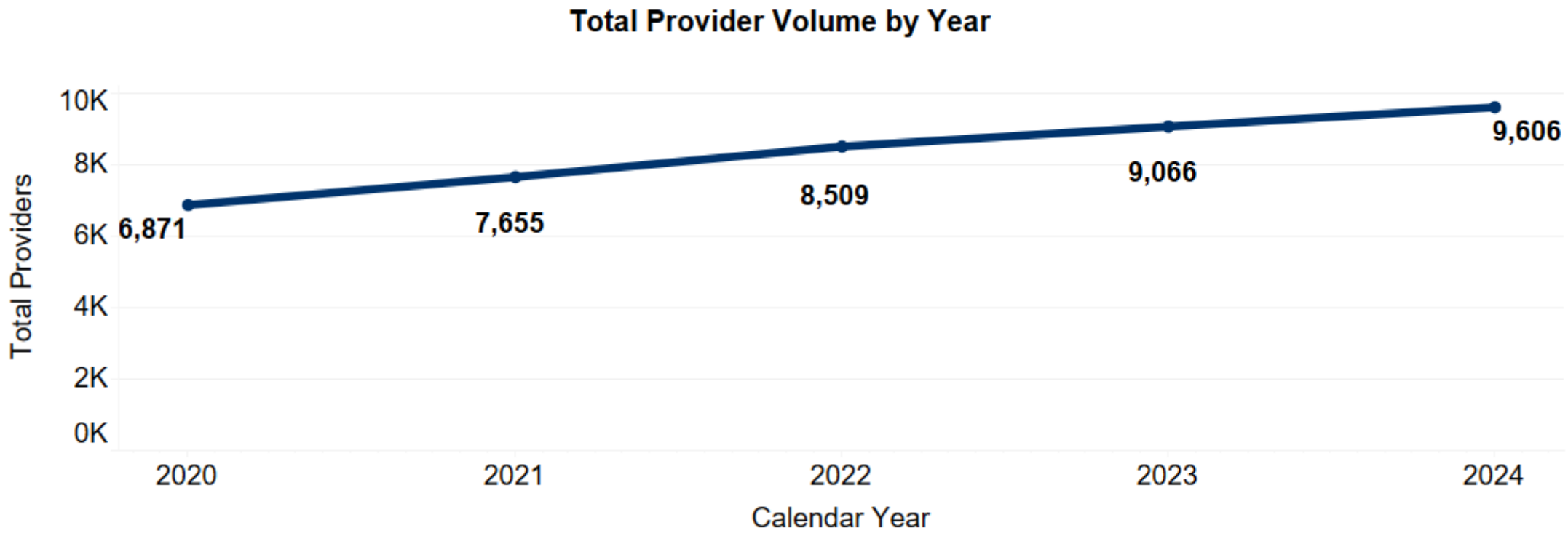
- hospitals (220)
- mental health/medical outpatient clinics (enhanced care clinics (ECCs), federally qualified health centers (FQHCs), rehabilitation centers, school-based service centers, and youth urgent crisis centers (UCCs)) (926)
- alcohol and drug treatment centers (including withdrawal management, intensive outpatient (IOP) programs, outpatient) (49)
- methadone maintenance clinics (32)
- home health agencies (195)
- adult group homes (30)
- DCF congregate care (136)
- psychiatric residential treatment facilities (PRTFs) (6)

9,200+ Individual Practitioners and Group Practices

- psychiatrists (260)
- psychologists (699)
- advanced practice registered nurses (APRN) (605)
- licensed clinical social workers (LCSW) (3,436)
- licensed marriage and family therapists (LMFT) (1,365)
- licensed professional counselors (LPC) (2,242)
- licensed alcohol and drug counselors (LADC) (431)
- board certified behavior analysts (BCBA) (205)

CT BHP Provider Network Growth

From 2020 to 2024, the number of credentialed providers enrolled in HUSKY Health open to accepting direct referrals has grown by nearly 40%. These include active individual, group, and facility providers enrolled in HUSKY Health in CT.



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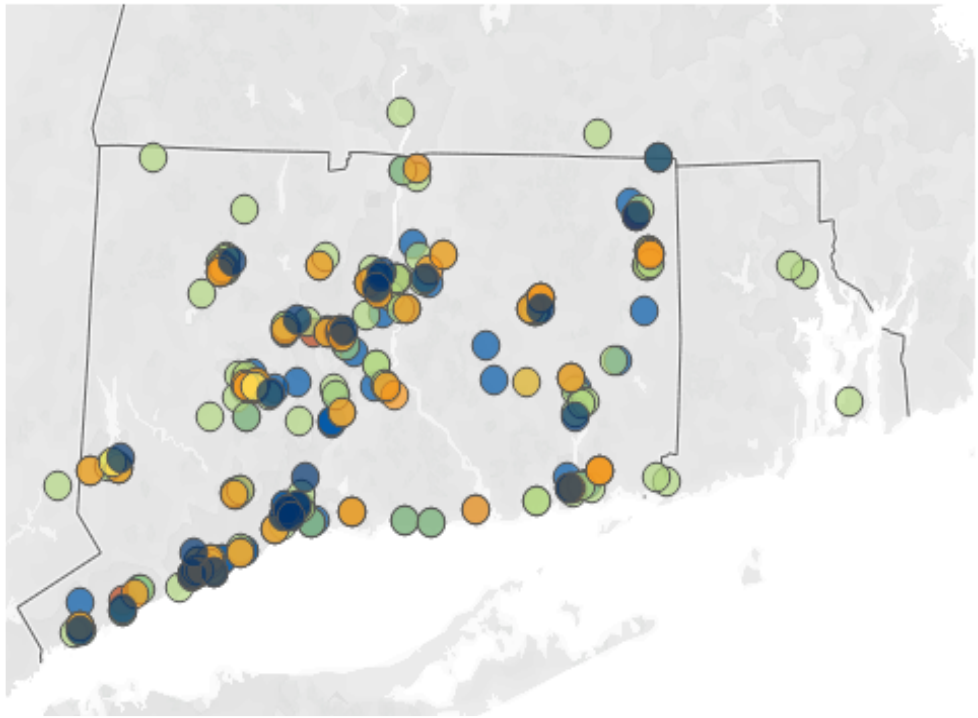
CT BHP Provider Network for Medications for Substance Use Disorder (SUD)

- In 2024, the outpatient provider network for medications used in SUD treatment expanded statewide with 27 new providers added to the interactive online provider locator map. The map received 1,857 page visits.
- Despite a stronger concentration of providers in urban areas, the average travel distances to IOP or outpatient providers in rural communities are significantly shorter than the 45-mile standard set by CMS.



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2.3. Behavioral Health Service Utilization

Behavioral Health (BH) Service Utilization Overview: Youth and Adult

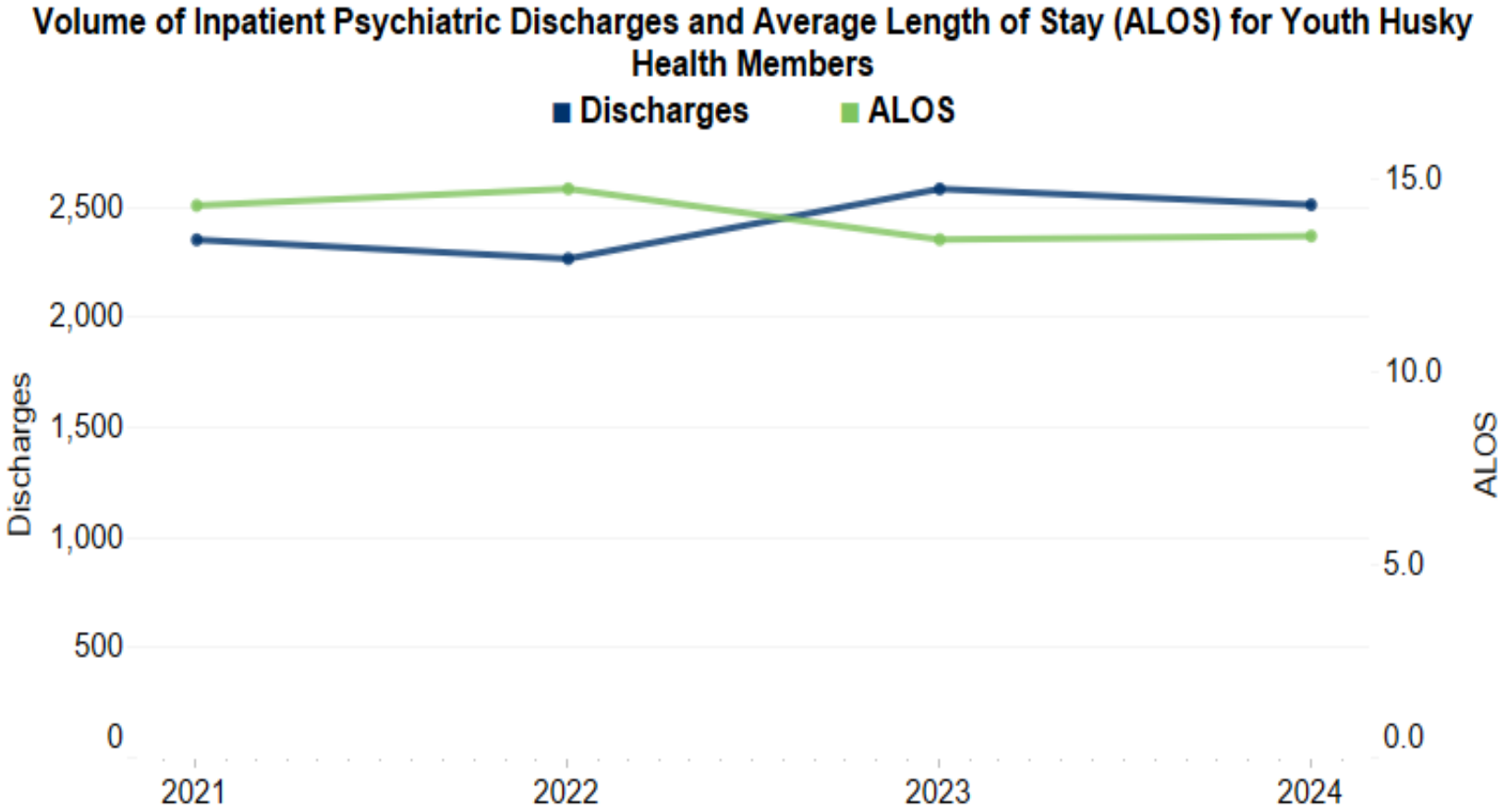
- Overall, 30.0% of HUSKY Health members aged 3+ (excluding members with dual eligibility) utilized a BH service at least once in 2024.
- Among HUSKY Health youth members, 29.3% utilized a BH service, compared to 30.3% among adults.

Behavioral Health Service Utilization* According to Age Group in 2024			
Demographic	**Percent**	**Members using BH Services**	**HUSKY Health Members**
Total Membership	**30.0%**	**257,472**	**859,376**
Age Group			
Youth (3-17)	29.3%	87,276	298,144
Adult	30.3%	170,196	561,232

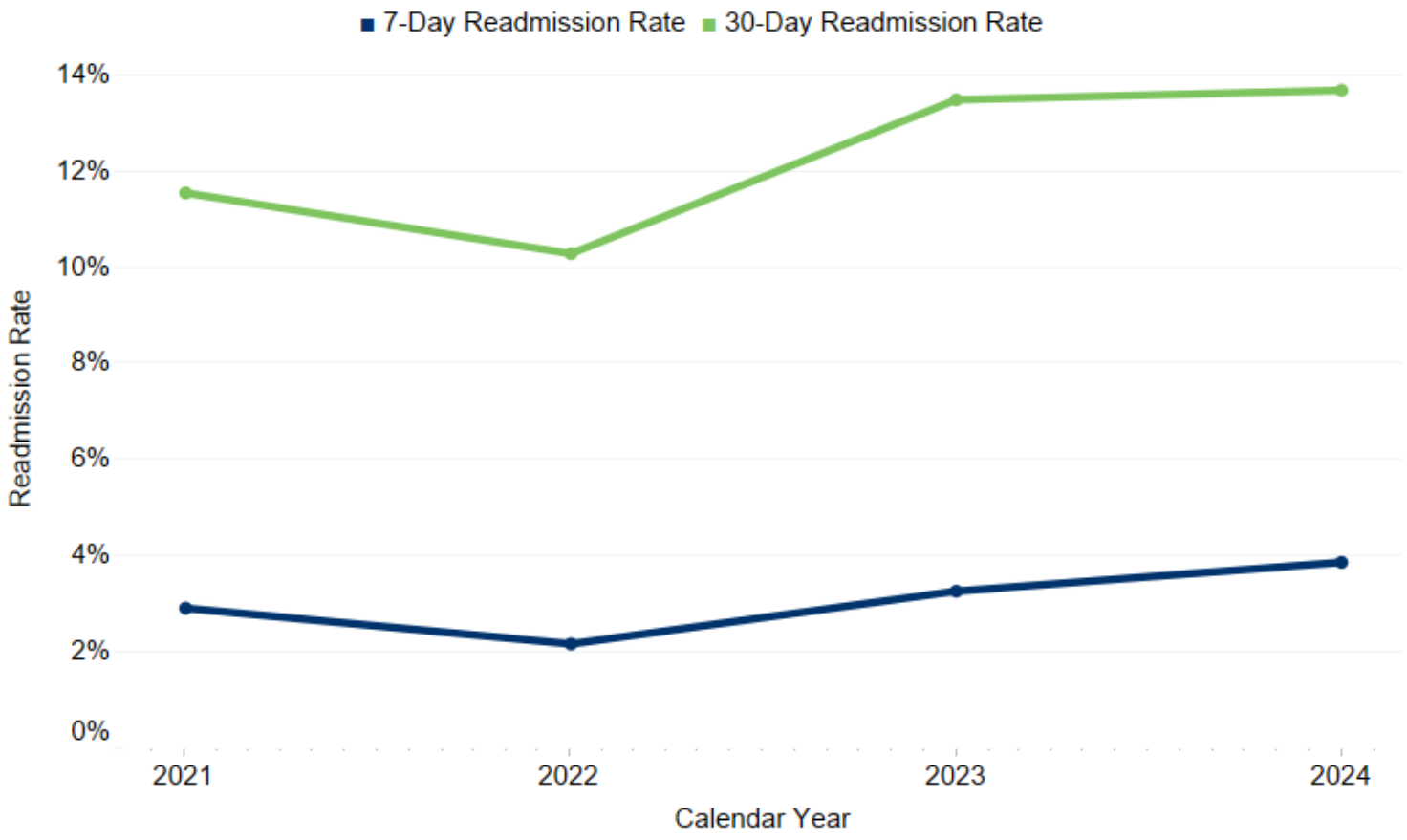
**Prevalence of BH service utilization was calculated by dividing the number of members within a specific cohort who had a claim for at least one BH service during the measurement year by the total number of members in that same cohort.*

Youth Inpatient Psychiatric Facility (IPF) Utilization (Acute)

- There were 2,513 claims-based discharges from youth psychiatric inpatient providers in 2024. This was a 2.8% decrease from 2,585 discharges in 2023 following the 14.0% increase from 2022 to 2023.
- The average length of stay (ALOS) remained stable at 13.5 days in 2024, compared to 13.4 days in 2023, following an 8.9% decrease from 14.8 days in 2022.



Readmissions for Youth Psychiatric Inpatient Admissions



- In 2024, 3.9% (*n* = 94) of claims-based IPF discharges had readmissions within seven days, an increase from 3.3% (*n* = 82) in 2023.
- The 30-day readmission rate remained stable at 13.7% (*n* = 333) in 2024 compared to 13.5% (*n* = 339) in 2023 following the 3.2% increase from 2022.
- Providers continued to report limited access to PRTFs, intensive home-based services, and other intermediate levels of care as a contributing factor driving readmissions.

Despite the rare occurrence of medical inpatient readmissions post-psychiatric inpatient discharges for youth, readmissions of all causes are included in the 7- and 30-day readmissions measures because of the significant role behavioral health often plays in medical readmissions.

Youth Psychiatric Inpatient Discharge Delay

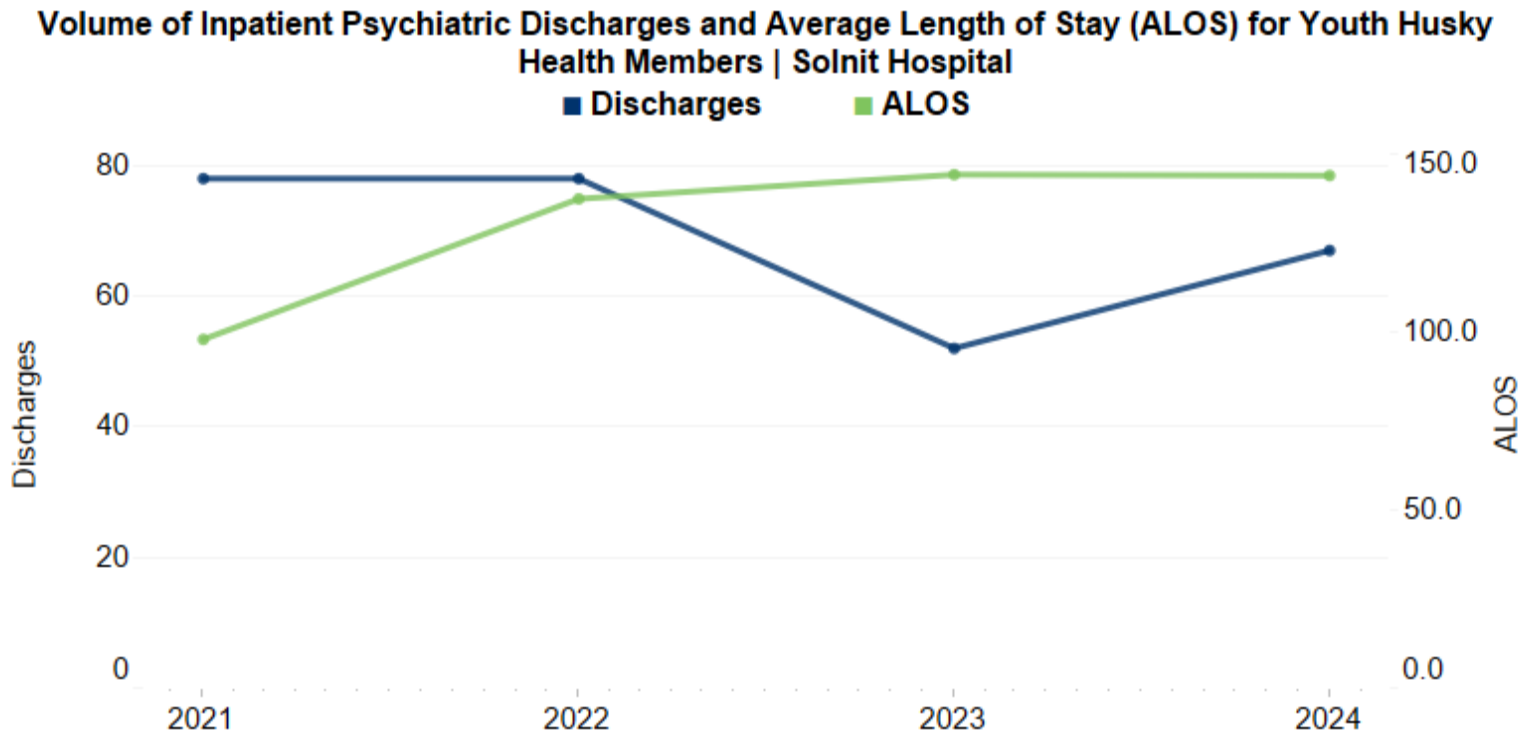
- Discharge delay occurs when a youth member is ready to leave a psychiatric hospital, but the needed services post discharge are not immediately available.
- There were 135 delayed discharges from youth IPFs in 2024, with members spending an average of 20.9 days on discharge delay. While discharge delay volume increased from 95 to 135 discharges between 2022 and 2024, average delay days decreased from 34.4 days to 20.9 days over this time. The total number of delay days decreased from 3,270 days in 2022 to 2,816 days in 2024.

- Of the **135 discharges on delay** in 2024, 38.5% (*n* = 52) were awaiting a community-based or state-operated psychiatric residential treatment facility (PRTF).
- Another 47 discharges on delay (34.8%) were awaiting an inpatient bed in a state-operated hospital.

	2021	2022	2023	2024
Awaiting State Hospital	50	27	42	45
Awaiting PRTF	8	19	14	31
Awaiting PRTF - Community	19	17	25	17
Awaiting PRTF - Solnit	24	12	10	4
Awaiting Community Services	1	9	5	4
Awaiting Other	3	3	3	10
Aw pl SUD Resi Rehab	0	1	3	1
Awaiting RTC/TGH	9	6	1	4
Awaiting State Hospital - Adult	0	0	0	2
Awaiting Therapeutic Foster Care	1	1	14	17
All Services	**115**	**95**	**117**	**135**

Youth Psychiatric Inpatient Utilization: State Hospital (Solnit)

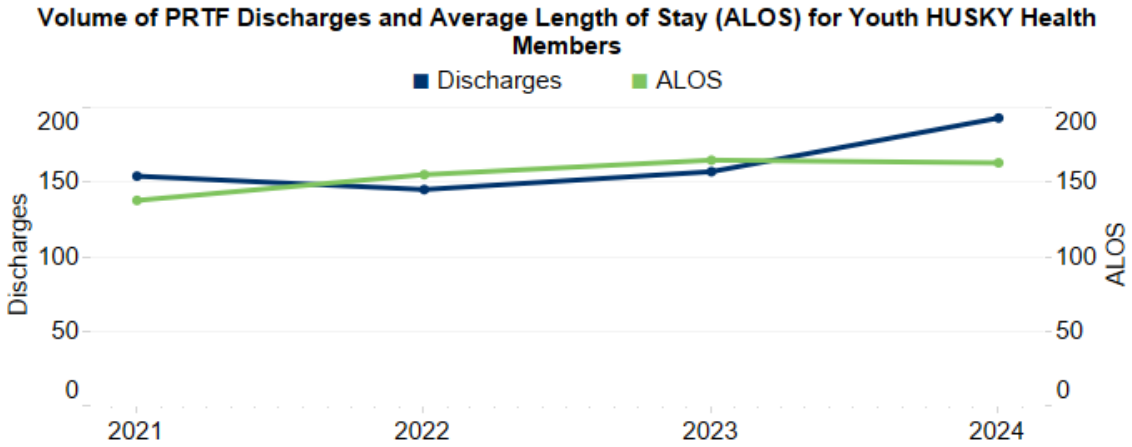
- Solnit inpatient continued to primarily serve adolescents aged 13-17, with all discharges coming from this age group in 2024.
- Discharge volume for Solnit inpatient increased 28.8% from 52 discharges in 2023 to 67 discharges in 2024, serving more HUSKY Health youth members.
- ALOS remained stable at approximately 144 days in 2023 and 2024.
- Of the 67 discharges in 2024, 34.3% (*n* = 23) were from Black youth, 32.8% (*n* = 22) were from youth with an unknown race, and 28.4% (*n* = 19) were from White youth.



Youth Psychiatric Residential Treatment Facility (PRTF) Utilization

There are three operating community PRTF providers: Children's Center of Hamden (CCOH), The Village for Families and Children, and Boys & Girls Village which reopened in April 2023. Solnit PRTF is a state-operated PRTF facility for adolescents aged 13-17 and has two locations in Connecticut — one for male youth (Solnit North) and one for female youth (Solnit South).

- In 2024, there were a total of 193 discharges from Solnit (84) and community-based (109) PRTFs.
- Discharge volume increased by 18.3% for Solnit PRTFs and 26.7% for community-based PRTFs from 2023 to 2024.
- ALOS for Solnit PRTFs decreased by 12.6% from 160.0 days in 2023 to 139.8 days in 2024, while the ALOS for community-based PRTFs increased by 7.2% from 168.6 days in 2023 to 180.8 days in 2024.



Youth PRTF Overstay

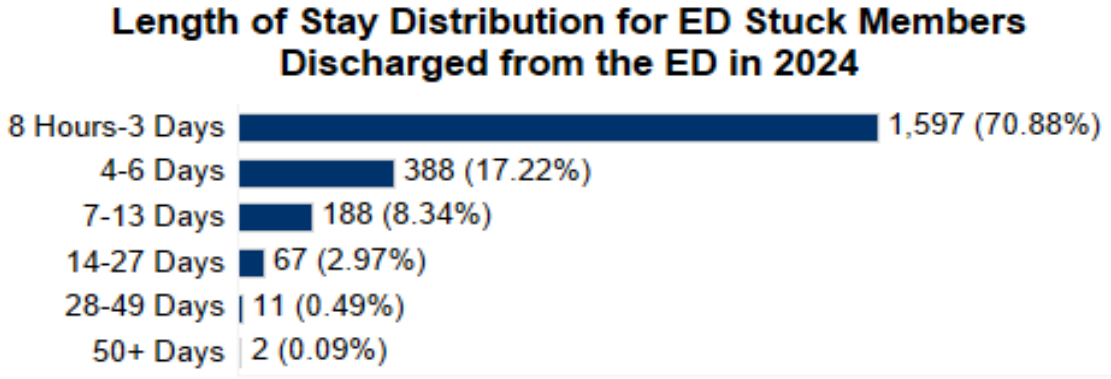
- PRTF overstay occurred when members could not be discharged due to awaiting recommended services for the next level of care.
- In 2024, there were 36 youth PRTF overstay instances and 2,556 delayed days, a 50.0% increase in instances from 24 overstay instances in 2023. The increase was mostly driven by community PRTF overstays.
- Members waited an average of 71.0 days for their next level of care, with the longest average wait of 137.1 days for foster care placement (*n* = 10).

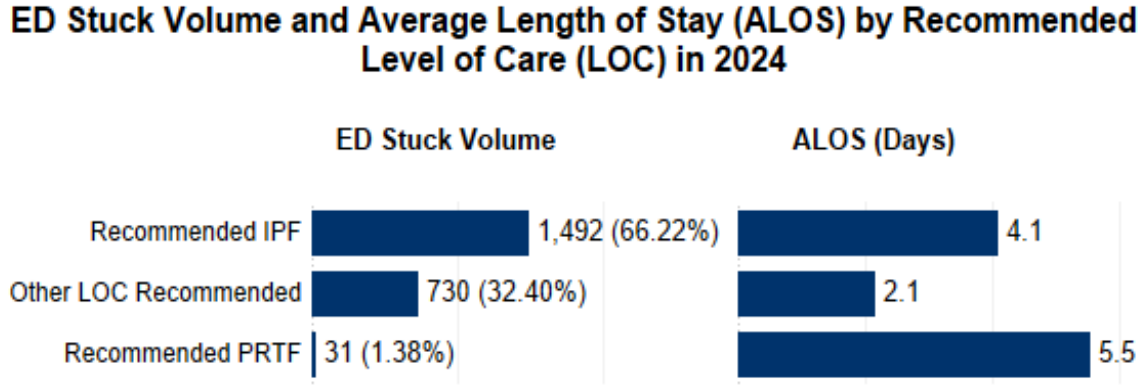
Psychiatric Residential Treatment Facility (PRTF)
Discharges Awaiting Recommended Services in 2024

	Delayed Discharges	Average Delay Days
Awaiting Foster Care	10	137.1
Awaiting Community Services	7	36.3
Awaiting TGH	6	81.2
Awaiting Educational Program	6	30.8
Awaiting RTC	4	54.3
Awaiting State Hospital – Child	2	17.5
Awaiting State Hospital	1	7.0
All Services	**36**	**71.0**

Youth Emergency Department (ED) Visits: ED Stuck

- "ED Stuck" refers to ED visits when youth stayed in the ED for over eight hours post medical clearance and psychiatric evaluation, awaiting disposition to recommended services.
- In 2024, among youth stuck in ED awaiting disposition, 70.9% were discharged within three days, while the rest waited four or more days before being discharged to the next level of care.
- Youth awaiting an inpatient admission (*n* = 1,492, 66.2%) were the largest group, staying an average of 4.1 days in the ED compared to 3.4 days in 2023.
- Youth awaiting PRTF (*n* = 31) had the longest ALOS at 5.5 days and accounted for 1.4% of ED stuck cases. The ALOS was reduced by 46.1% from 10.2 days in 2023.
- ED Stuck analyses highlight the need for youth services beyond the ED to improve the flow of members through the BH system.





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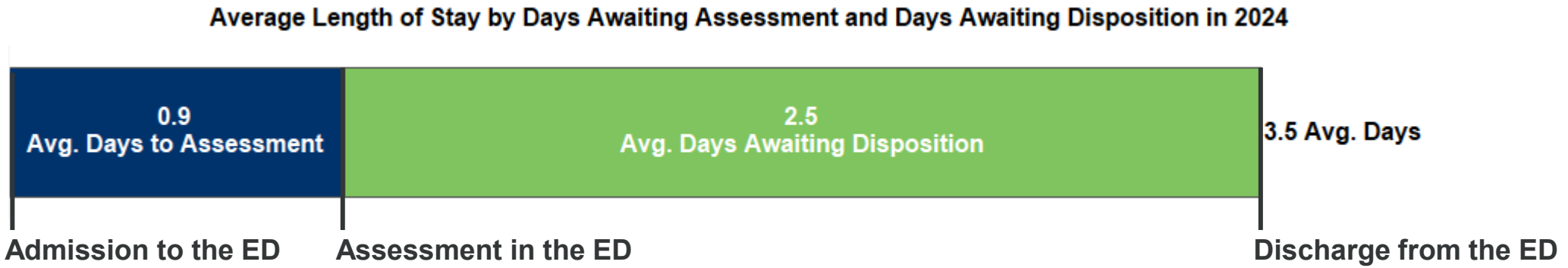
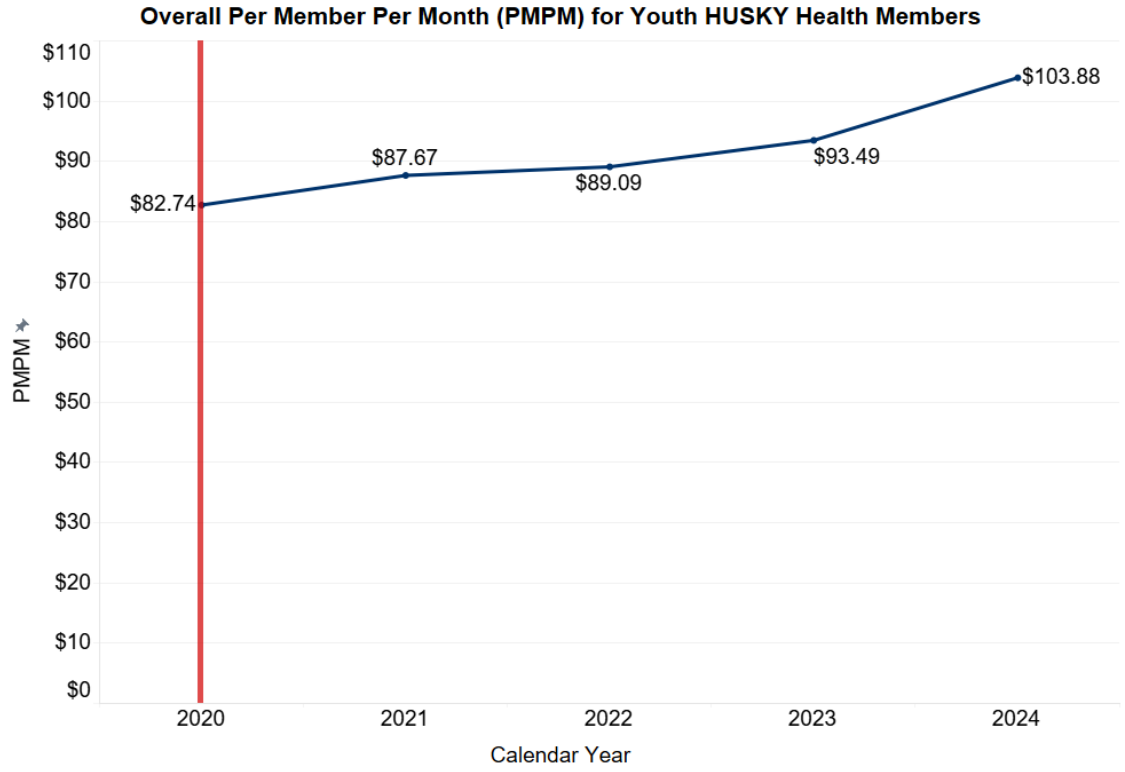
Understanding Youth ED "Stuck"



- The time awaiting psychiatric assessment versus awaiting disposition to the next level of care (LOC) were measured separately to better understand the cause of ED stuck.
- In 2024, there were 2,253 ED stuck episodes for youth (1,535 unique individuals). The average length of stay from ED admission to disposition was 3.5 days.
  - The average time to psychiatric assessment was 0.9 days, ranging from zero to five days.
  - The average time awaiting the next recommended level of care was 2.5 days, ranging from zero to 62 days.

Youth Behavioral Health (BH) Cost*

- The total expenditure for BH services by HUSKY Health youth aged 3 to 17 increased 11.8% from $345.02M in 2023 to $385.76M in 2024. Overall, the BH per-member-per-month (PMPM) expenditure increased by 11.1% from $93.49 in 2023 to $103.88 in 2024.
- Behavioral health outpatient services continued to have the highest PMPM among HUSKY Health youth members, with $31.26 PMPM and approximately 30% of the total youth BH expenditures.
- Autism services experienced the highest percentage increase in PMPM cost among all BH levels of care, rising by 27.0% from $13.51 in 2023 to $17.17 in 2024. While the number of eligible member months for autism services remained stable, the total cost rose by $13.9 million, reflecting a 27.9% increase.



The red line represents the start of the COVID-19 pandemic effects in Connecticut.

**CT Medicaid is a fee-for-service model providing diagnosis, utilization, and cost in the claim payment system. Utilization, cost, and diagnosis should not be interpreted to reflect the full needs of the HUSKY Health population and are influenced by factors such as access to care.*

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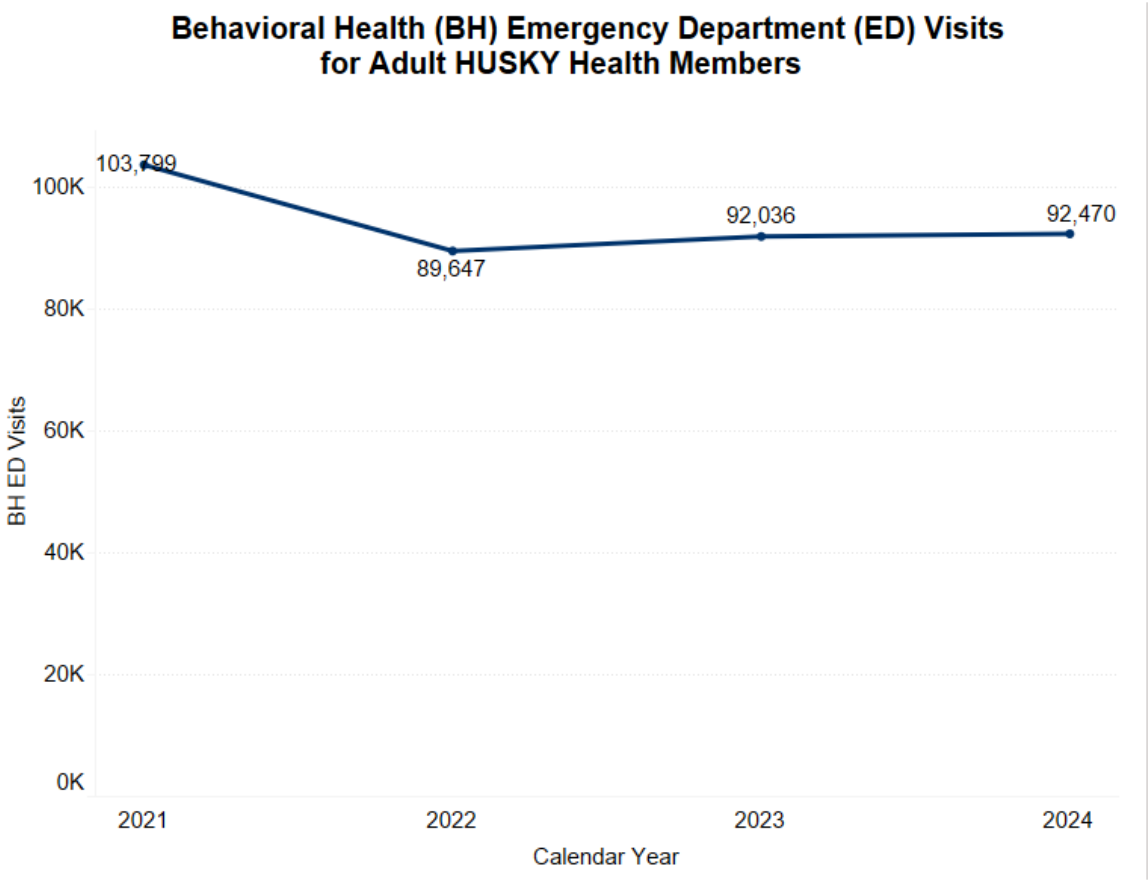
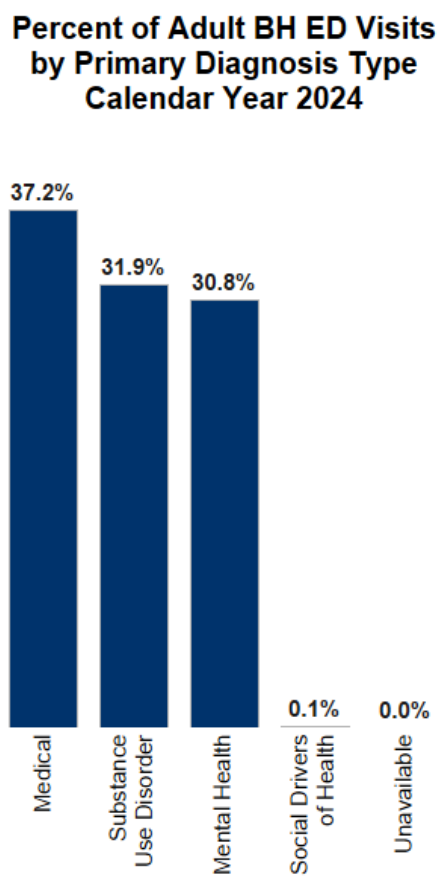
Adult BH Emergency Department (ED) Utilization



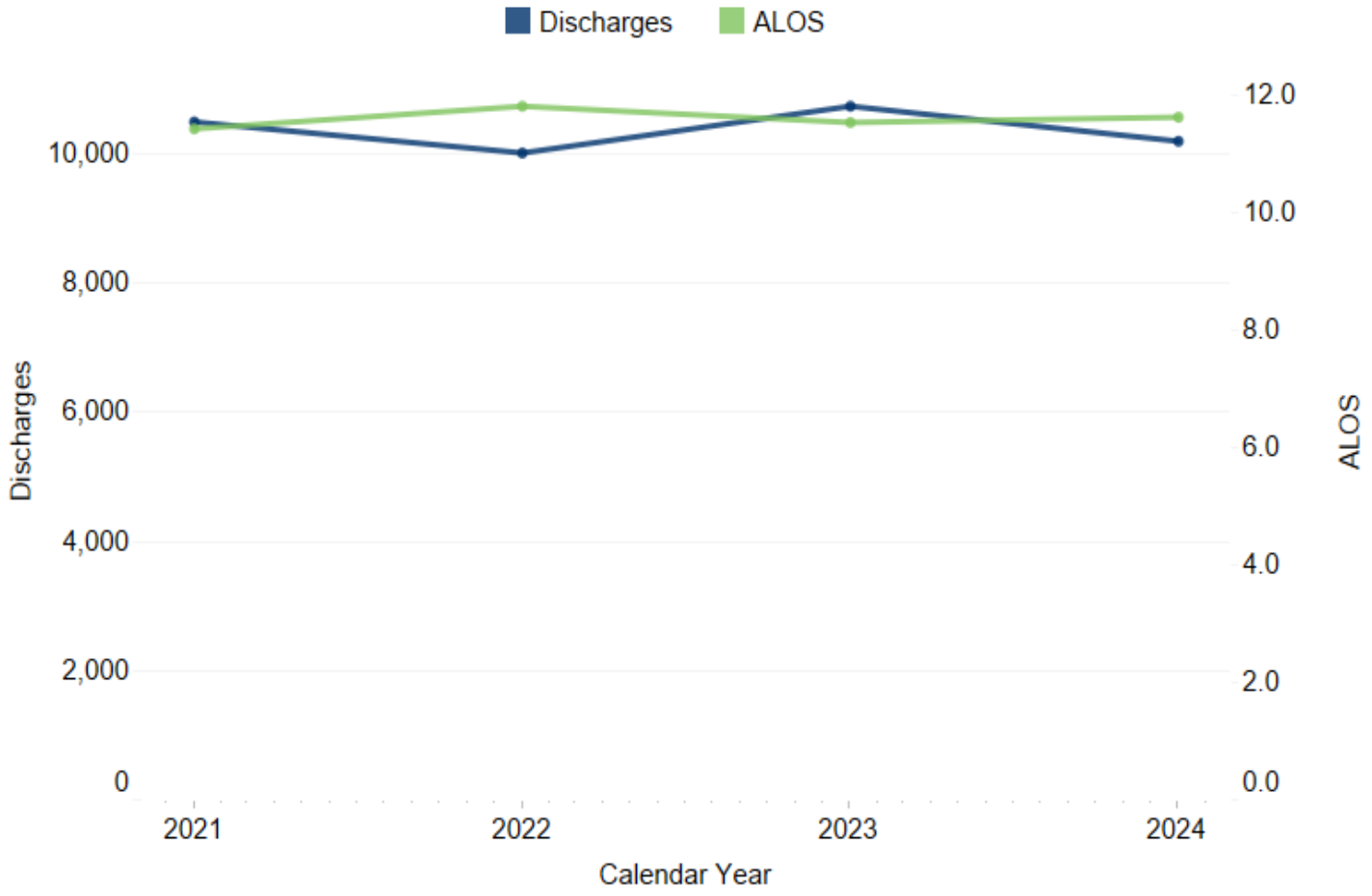


- In 2024, the number of BH ED visits among adult members remained relatively steady compared to 2023, with a total of 92,470 visits. However, this translated to about 14.8 visits per 1,000 eligible member months, marking an 18.2% increase from the previous year. This rise can only be partly attributed to a 5.1% reduction in membership.
- The majority of adult BH ED visits had a medical primary diagnosis (37.2%, *n* = 34,411) followed by SUD (31.9%, *n* = 29,477) and mental health (30.8%, *n* = 28,449).

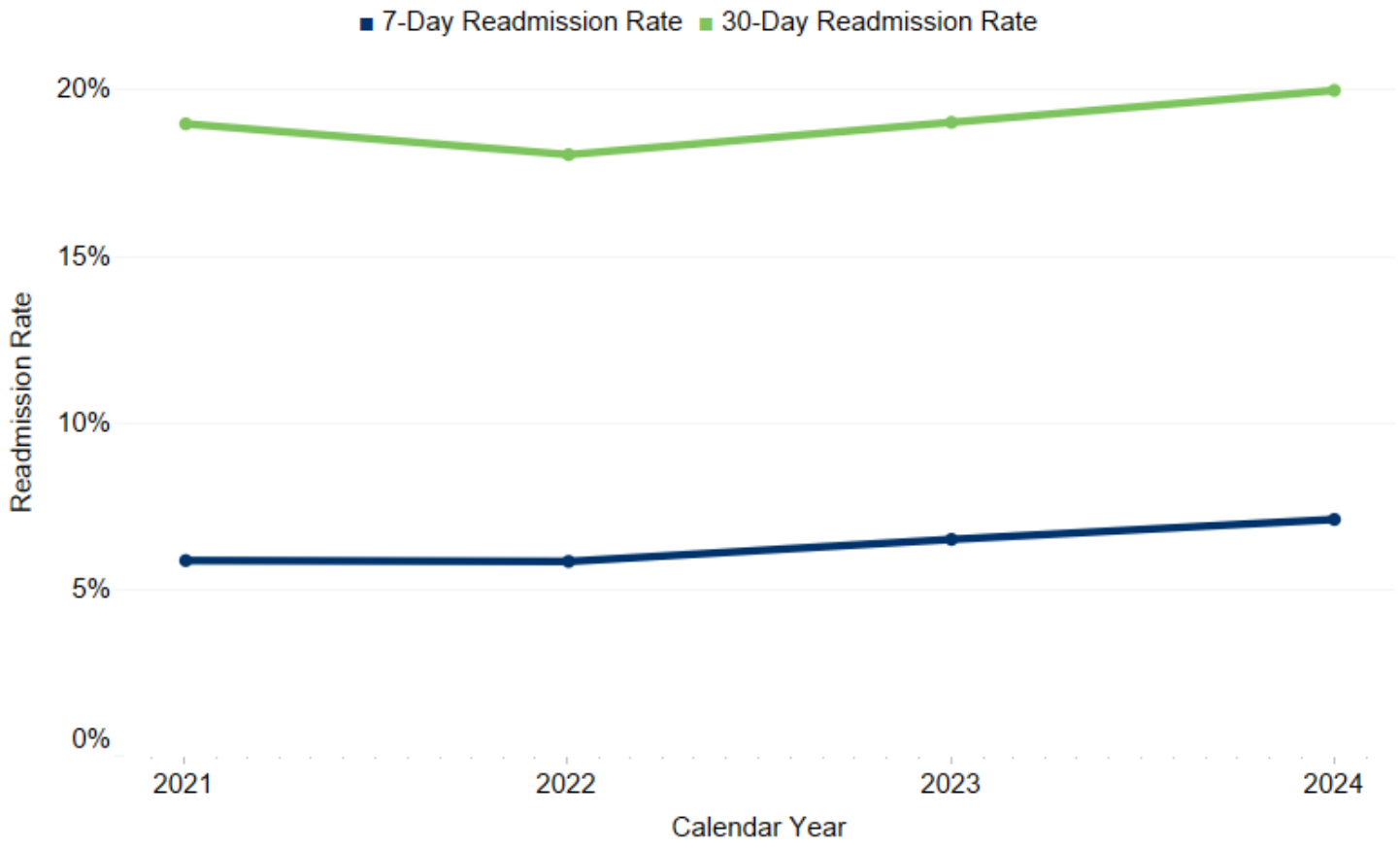
Behavioral health (BH) ED visits are defined as having a BH diagnosis on any of the first four positions on the claim.

Adult Inpatient Psychiatric Facility (IPF) Utilization (Acute)

- The volume of claims-based psychiatric inpatient discharges for adults has fluctuated over time, while the average length of stay (ALOS) remained relatively stable.
- Discharge volume decreased by 5.0% from 10,739 discharges in 2023 to 10,197 discharges in 2024.
- The ALOS remained consistent at 11.5 days in 2023 and 11.6 days in 2024.

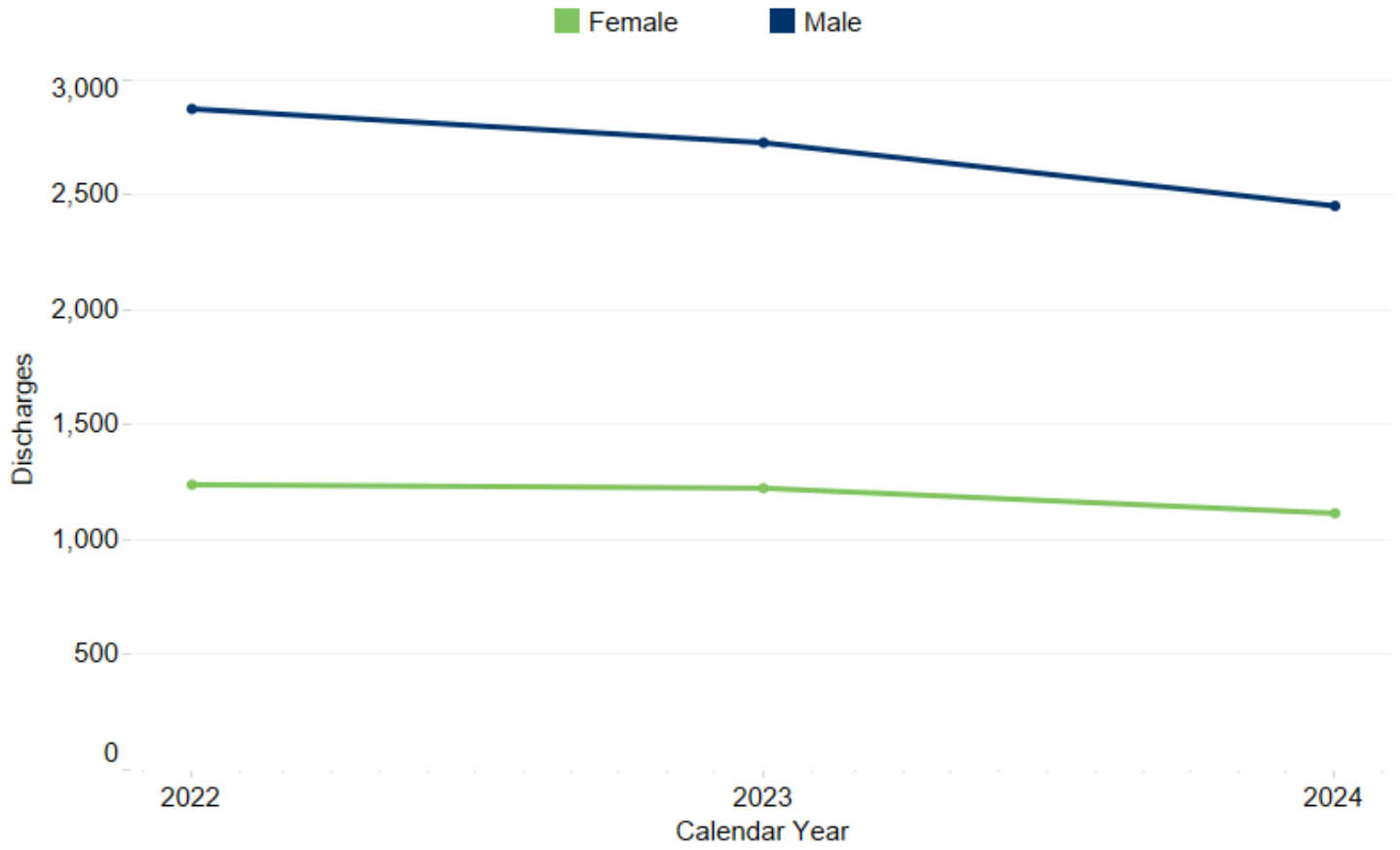


Readmissions for Adult Inpatient Psychiatric Admissions



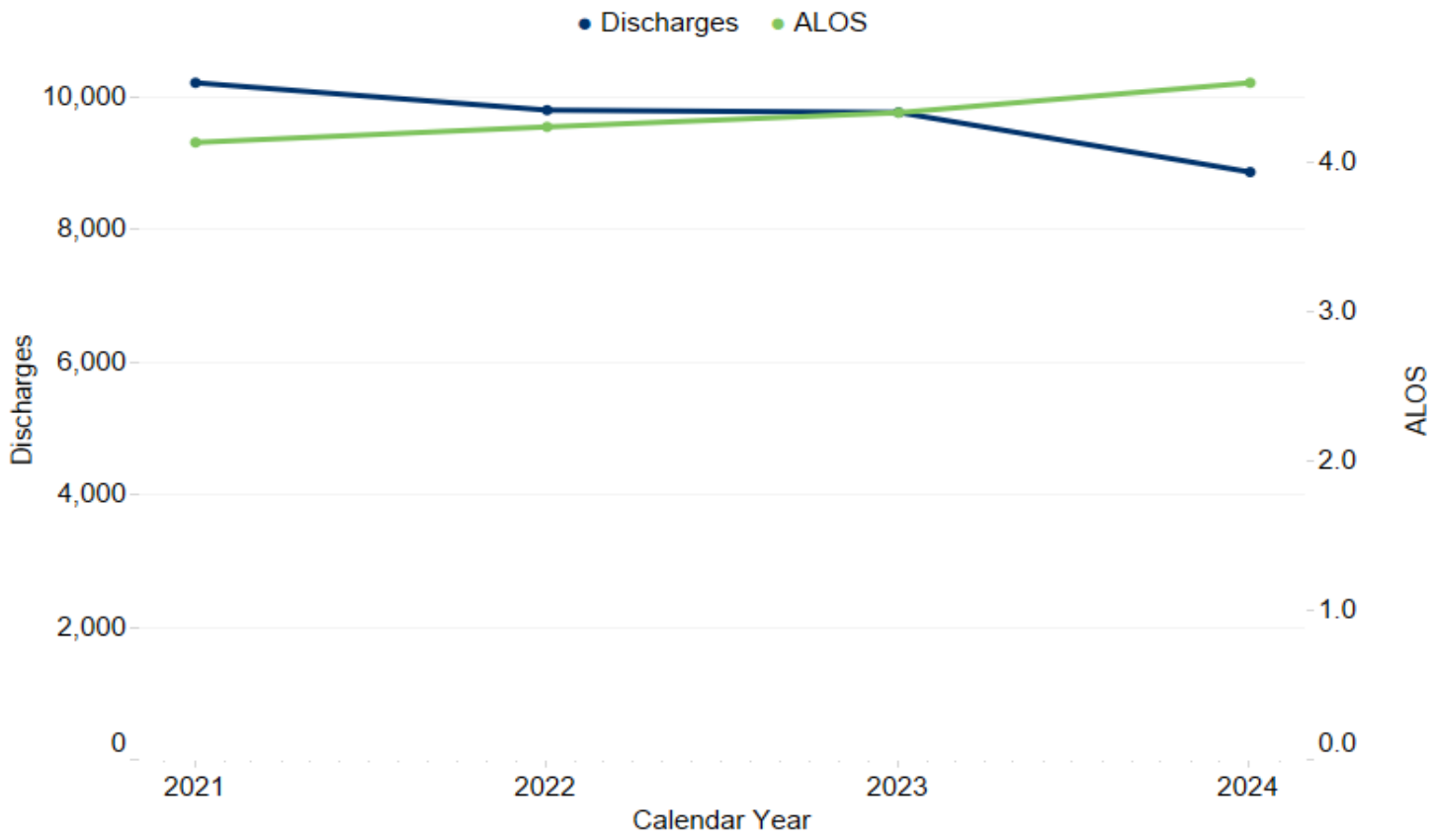
- The 7-day readmission rate for adult IPF discharges increased over time from 5.8% in 2022 to 7.1% in 2024.
- The 30-day readmission rate increased from 18.1% in 2022 to 20.0% in 2024.

Adult ASAM 4.0: Medically Managed Intensive Inpatient Withdrawal Management (WM) Utilization



- Authorization-based discharge volume from 4.0 WM providers was 3,568 in 2024 — down 9.7% from 3,952 discharges in 2023.
- ALOS remained stable at 5.8 days in 2024.
- Males accounted for 68.7% (*n* = 2,452) of 4.0 WM discharges in 2024 — an overrepresentation of 23.8 percentage points compared to their proportion of 44.9% in the total adult HUSKY Health population without dual membership.

Adult ASAM 3.7 WM: Alcohol and Drug Treatment Center (ADTC) Utilization



- There were 8,860 ASAM 3.7 WM discharges in 2024, a decrease of 9.2% from 9,759 discharges in 2023.
- The ALOS for discharges from ADTC providers remained stable at 4.5 days in 2024, compared to 4.3 days in 2023.

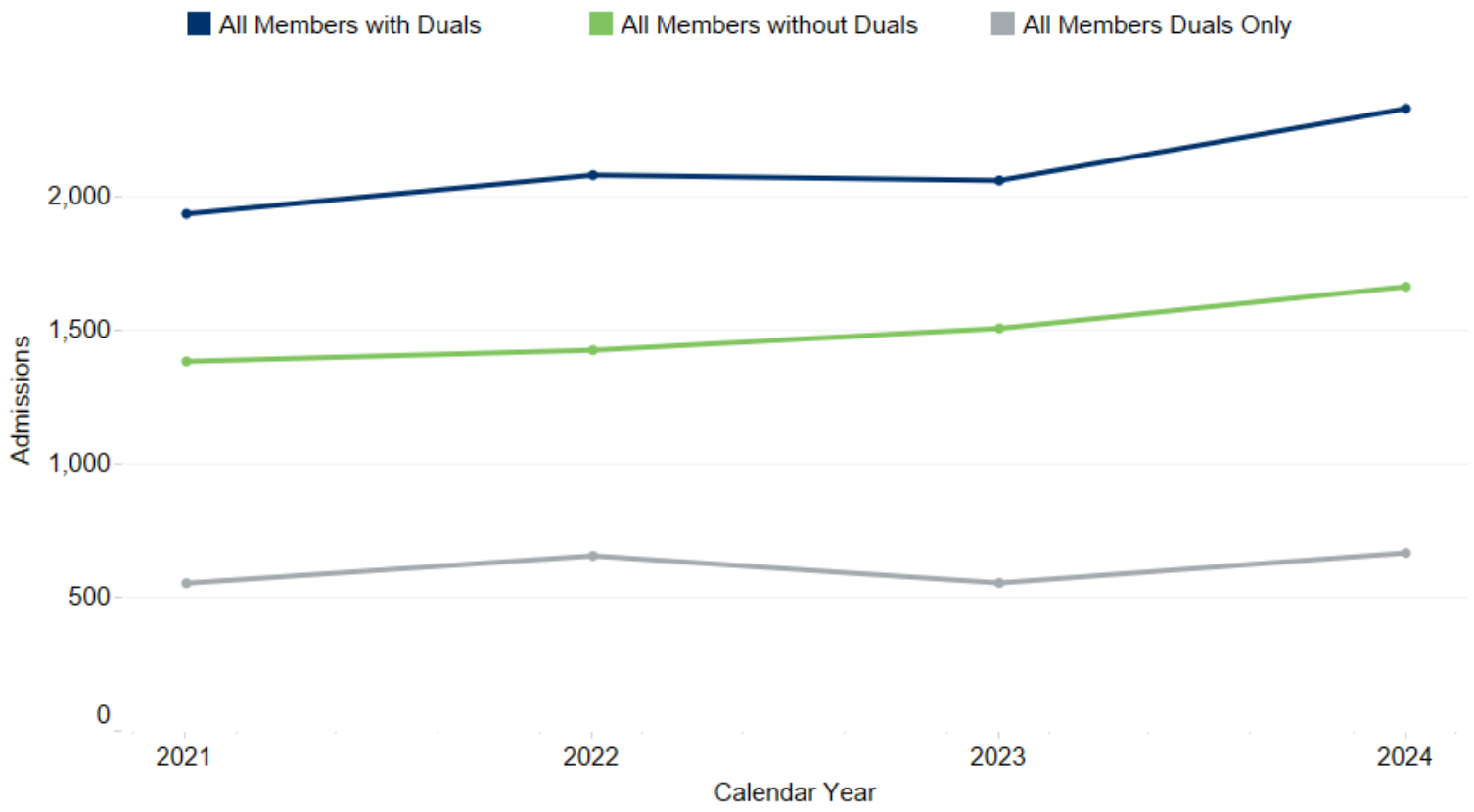
Adult ASAM 3.1 to 3.5 Residential Service Utilization

- Carelon BH CT began authorizing four different residential services (ASAM 3.1 to 3.5) on July 1, 2022, under the implementation of the 1115 SUD Demonstration Waiver.
- The ALOS for each level of these residential services decreased between 2023 and 2024.

Discharge Volume and Average Length of Stay (ALOS) by Residential Service

Residential Service	CY 2023 Discharges	CY 2024 Discharges	CY 2023 ALOS	CY 2024 ALOS
Clinically managed high-intensity residential services (ASAM 3.5)	2,551	2,312	61.4	56.5
Clinically managed high-intensity residential services for pregnant and parenting women (ASAM 3.5 PPW)	122	151	87.5	82.6
Clinically managed population-specific high-intensity residential services (ASAM 3.3)	88	84	108.0	80.4
Clinically managed low-intensity residential services (ASAM 3.1)	287	315	87.0	78.9

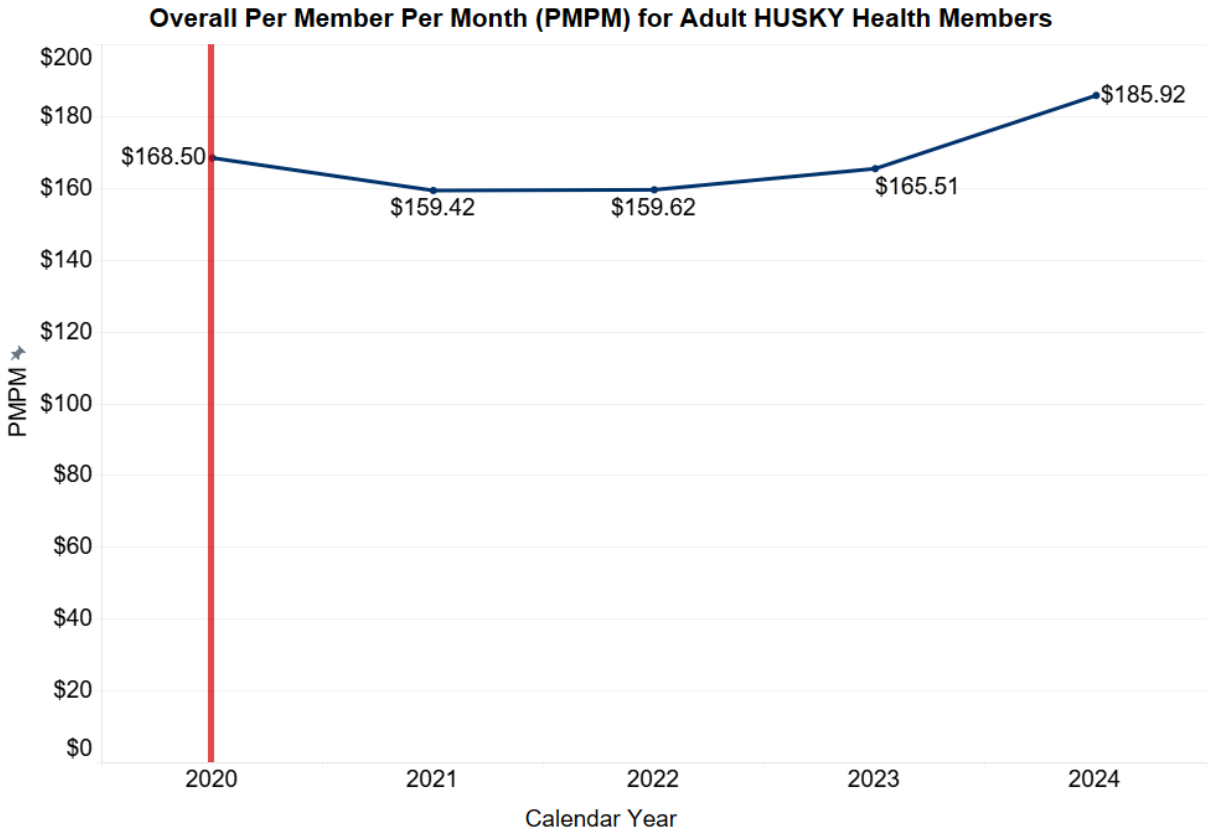
Adult Home Health (HH) Medication Administration



- In response to COVID-19, the CT BHP continued to provide authorization extensions for members with prior home health authorizations through June 1, 2021, when the standard authorization process resumed.
- Total authorization initiations for behavioral health medication administration increased for both dual and non-dual adult members from 2023 to 2024, with total initiations increasing 13.0% from 2,062 in 2023 to 2,331 in 2024.

Adult Behavioral Health (BH) Cost*

- The overall BH per-member-per-month (PMPM) expenditure for all eligible adult members increased by 12.3% from $165.51 in 2023 to $185.92 in 2024. This $20.41 PMPM increase was mainly driven by a $6.38 increase from skilled nursing facilities, $2.47 from ASAM 3.7 state, and a $2.75 increase from outpatient BH services.
- In 2024, the total paid amount for adult BH levels of care was approximately $1.38B.
- Outpatient services was the most highly utilized, with the PMPM expenditures at $34.00 and a total paid amount of $252.7M in 2024.



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Chapter

03

Programs and Initiatives

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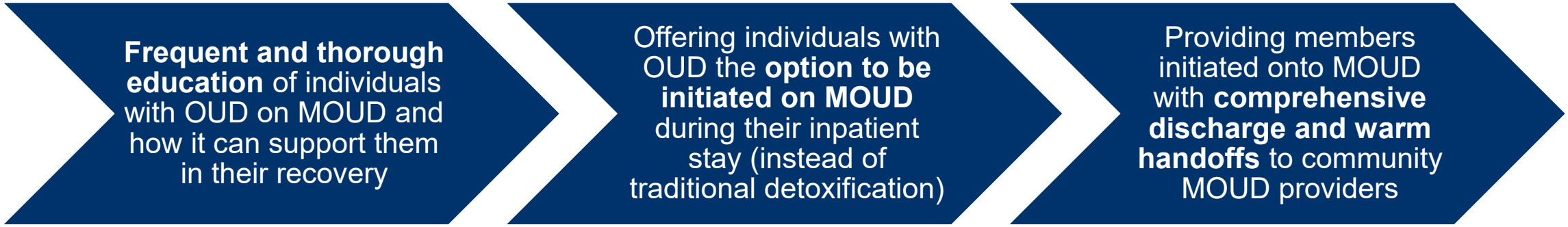
3.1. Exemplar Programs and Initiatives

Provider Analysis and Reporting (PAR) Programs for SUD

- The SUD PAR programs advocated for lifesaving, evidence-based treatments for substance use disorders (SUDs) through data-driven discussions and active provider engagement.
- The SUD PAR programs were greatly expanded to include all ASAM 3.7 through 3.1 levels of care with the implementation of the 1115 SUD Demonstration Waiver.
- Throughout 2024, regional network managers (RNMs) applied an integrated multi-systems approach during inpatient psychiatric PAR meetings to cultivate a cohesive statewide strategy for the expansion of the Changing Pathways model (see next slide for details) across inpatient, ambulatory, and community-based programs.
- Carelon BH CT collaborated with providers across all levels of care during PAR and workgroup meetings to identify opportunities for improvement related to the previously referenced quality measures and promote the delivery of MOUD/MAUD and stimulant use disorder treatment.
- RNMs convened the first statewide inpatient/residential levels of care workgroup in 2024, “SUD System Integration: Enhancing the Patient Journey Throughout the Continuum of Care."
- Carelon BH CT hosted two educational forums in 2024 entitled, “Substance Use, Society, and Social Impact: A Presentation and Fireside Chat with Dr. Gabor Mate” and “Healing Journeys Post-Incarceration: Integrating Clinical Insights and Lived Experience."

Changing Pathways Model

- The most successful outcomes for individuals with opioid use disorder (OUD) result from the use of medications for opioid use disorder (MOUD), but the practice is underutilized.
- Traditional withdrawal management, formerly known as detoxification, on its own is associated with high rates of relapse, and the risk of accidental overdose and death is high due to decreased tolerance.
- The Changing Pathways model uses a multidisciplinary approach across all staff including nursing, physicians, clinicians, and recovery peer specialists to incorporate MOUD initiation into withdrawal management care.
- The three essential components of the Changing Pathways model are:



- The Changing Pathways pilot, launched in 2018, expanded in 2020 for a total of three pilot withdrawal management facilities and one inpatient psychiatric facility with the addition of an emergency department in 2023.

Changing Pathways Outcomes

- In 2024, there were seven in-state, community-based medically monitored intensive inpatient withdrawal management (ASAM 3.7 WM) alcohol and drug treatment center (ADTC) providers, and all have adopted the Changing Pathways model.
- Members who were initiated and adhered to medications for opioid use disorder (MOUD) following discharge experienced the following positive outcomes measured in the 90 days prior to and 90 days post the initiation of MOUD. Reductions in the post period were observed in 2024 with similar or improved rates in 2023.*

reduction in the percent of members with an overdose

The percent of members with overdose was 0.8% in the 90 days after treatment initiation compared to 8.2% in the 90 days prior.

reduction in the average number of BH ED visits per member

reduction in the average number of inpatient days per member

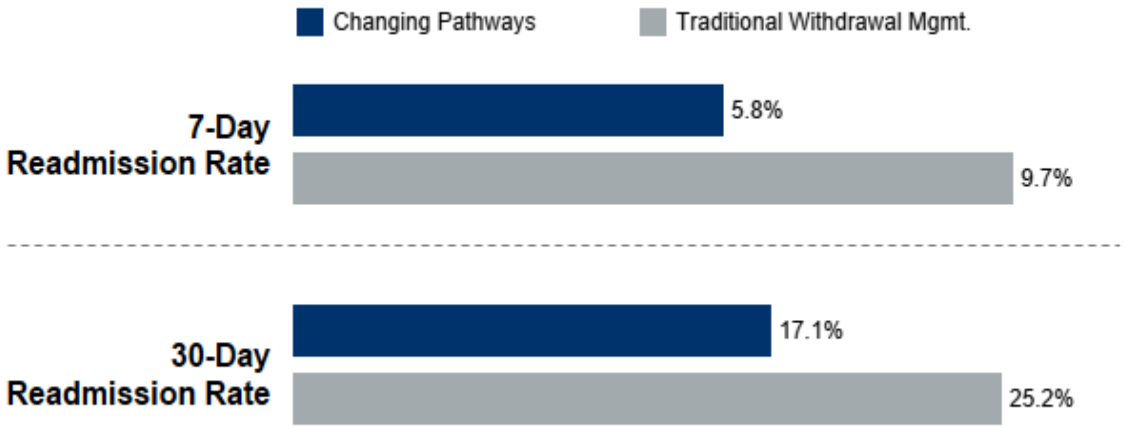
reduction in the average number of withdrawal management episodes per member

*The 2023 results were presented as part of a poster at the Rx and Illicit Drug Summit 2025. The poster can be found at: https://s18637.pcdn.co/wp-content/uploads/sites/76/08091_CarelonHealth_P1S_01-002.pdf.

Changing Pathways Outcomes

Members who initiated MOUD during a medically monitored intensive inpatient withdrawal management (ASAM 3.7 WM) episode demonstrated:

- **Lower readmissions** to an inpatient facility 7- and 30-days post discharge than members in traditional withdrawal management in CY 2024.



- **Higher MOUD adherence** and were more likely to be adherent to MOUD post discharge (34.3%) compared to members who did not start MOUD during a 3.7 WM episode of care (24.3%). Members who initiated MOUD during an inpatient psychiatric facility (IPF) stay (56.7%) were more likely to achieve at least 80% MOUD adherence than members who were not initiated (42.5%).

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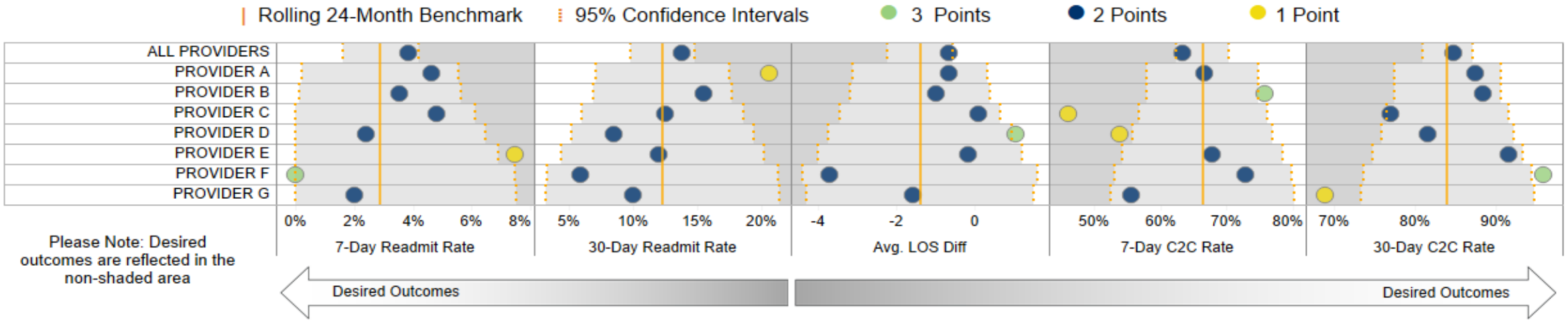
Pediatric Psychiatric Inpatient Value-Based Payment (VBP)

- The Department of Social Services (DSS) is planning to implement a new VBP program for pediatric inpatient psychiatric units in 2027 to continue to recognize and reward hospitals that demonstrate consistent use of best practices and better health outcomes for HUSKY Health members.
- Carelon BH CT developed a methodology based on a tiered system reflecting provider performance on five key quality measures.
- Provider performance would be measured against the statewide average, with points allocated for each metric, leading to an annual tier assignment based on the total points earned (illustrated below).
- In the VBP model, performance from a prior period will determine payment in a future period.

VBP Informational Report by Measure and Provider (Blinded)



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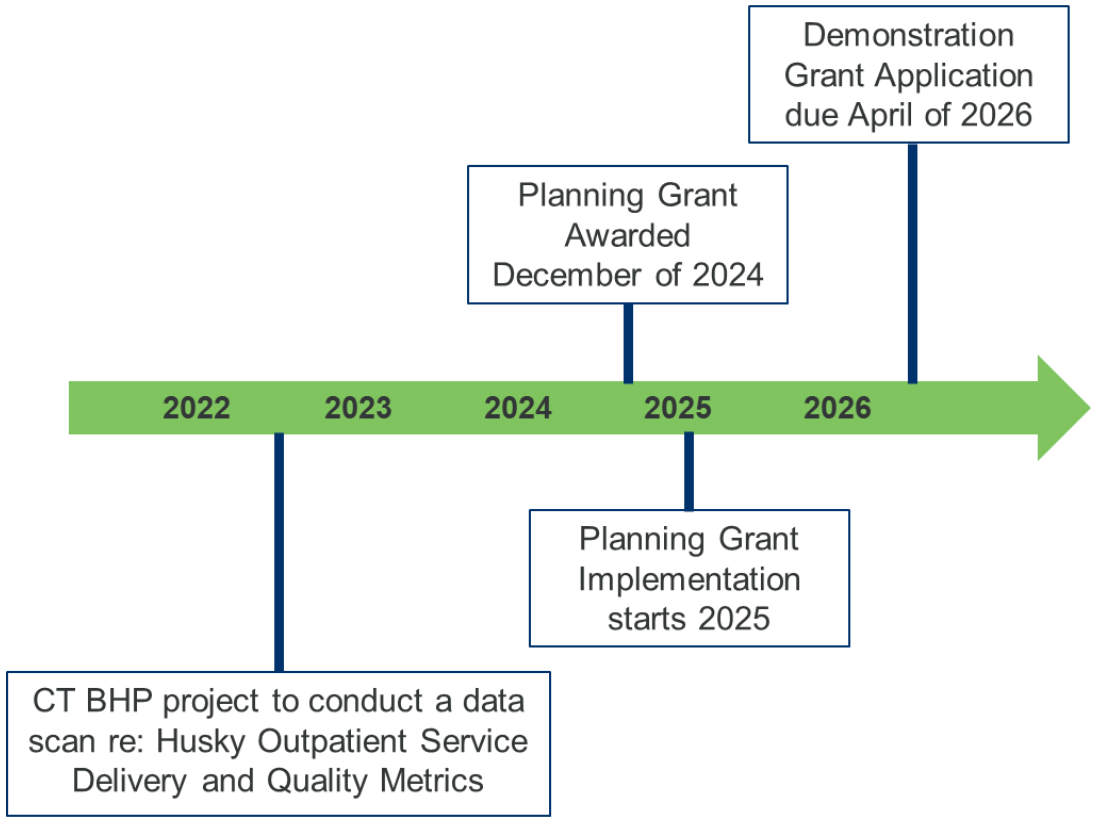
Certified Community Behavioral Health Clinics (CCBHC)

Program Overview

- The CT BHP conducted an extensive review of the BH system of care and the utilization of services by HUSKY Health members in 2023, providing the foundation for the CCBHC planning grant application submitted in 2024.
- The Substance Abuse and Mental Health Service Administration (SAMHSA) CCBHC program is designed to improve access, quality, and outcomes of mental health (MH) and substance use disorder (SUD) services in an outpatient clinic setting.
- Connecticut applied to the CCBHC planning grant in December 2024.

CCBHC Timeline



Certified Community Behavioral Health Clinics (CCBHC)

Impact and Reach

- In December 2024, DSS was awarded the CCBHC planning grant to implement the CCBHC model with three behavioral health outpatient clinics selected through a request for proposal (RFP) process.
- CCBHCs are required to offer comprehensive services for MH and SUD to anyone, regardless of their financial situation, location, or age. They ensure timely access to a range of services, including prevention, crisis intervention, screening, care coordination, and evidence-based practices.
- CCBHCs must meet organizational and practice standards and adhere to quality improvement processes to ensure effective and equitable care.
- Implementation of the planning grant in 2025 will be a collaborative effort between the state and several partners. It will also include the participation of persons with lived experience and community stakeholders. In addition to working with Carelon BH CT on daily management and data, the state will work with Mercer on financial analysis, the Child Health and Development Institute focused on workforce and practice sustainability, and the National Council on CCBHC provider certification.

Adult Home Health (HH) Bypass Program

- The Home Health (HH) Bypass program incentivizes HH providers to improve care quality by extending authorization time periods if meeting specified quality metric benchmarks.
- The HH Bypass program promotes member recovery and independence, aiming to decrease frequency of visiting nurse services for medication administration and maintain quality of care by tracking emergency department (ED) utilization.
- 2024 concluded with 75.0% (*n* = 21) of the 28 eligible providers receiving the administrative benefits provided by the HH Bypass Program, compared to 42.3% (*n* = 11) of the 26 eligible providers in 2023.

Home Health Bypass Requirements and Authorization Process

Bypass Status	Twice Daily (BID) Rate	Emergency Department (ED) Visit Rate	QD (Once Daily) Rate	Authorization Process
Home Health Bypass Plus	Less than or equal to 15%	Less than or equal to 32%	Monitor Only	Initial - Four months Concurrent - Four months
Home Health Bypass	Less than or equal to 20%	Monitor Only	Monitor Only	Initial - Four months Concurrent - Three months

Home Health Bypass Q1-Q4 2024 Results Based on Q3 2024-Q2 2025 Claims Data

Reporting Quarter	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Claims Data Quarter	**Q3 2024**	**Q4 2024**	**Q1 2025**	**Q2 2025**
BID (Twice Daily) Rate	18.05%	18.99%	18.76%	19.99%
ED (Emergency Department) Rate	25.63%	27.60%	27.50%	24.89%
QD (Once Daily) Rate	42.25%	42.00%	41.87%	41.89%

CT Substance Use Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Section 1003

Program Overview

- Enhance the quality of care for HUSKY Health members with an SUD diagnosis and their families across all stages of life.
- Identify disproportionalities among HUSKY Health members and subpopulations with an SUD diagnosis.
- Recommend improvements to CT's infrastructure that will strengthen the delivery of SUD services.

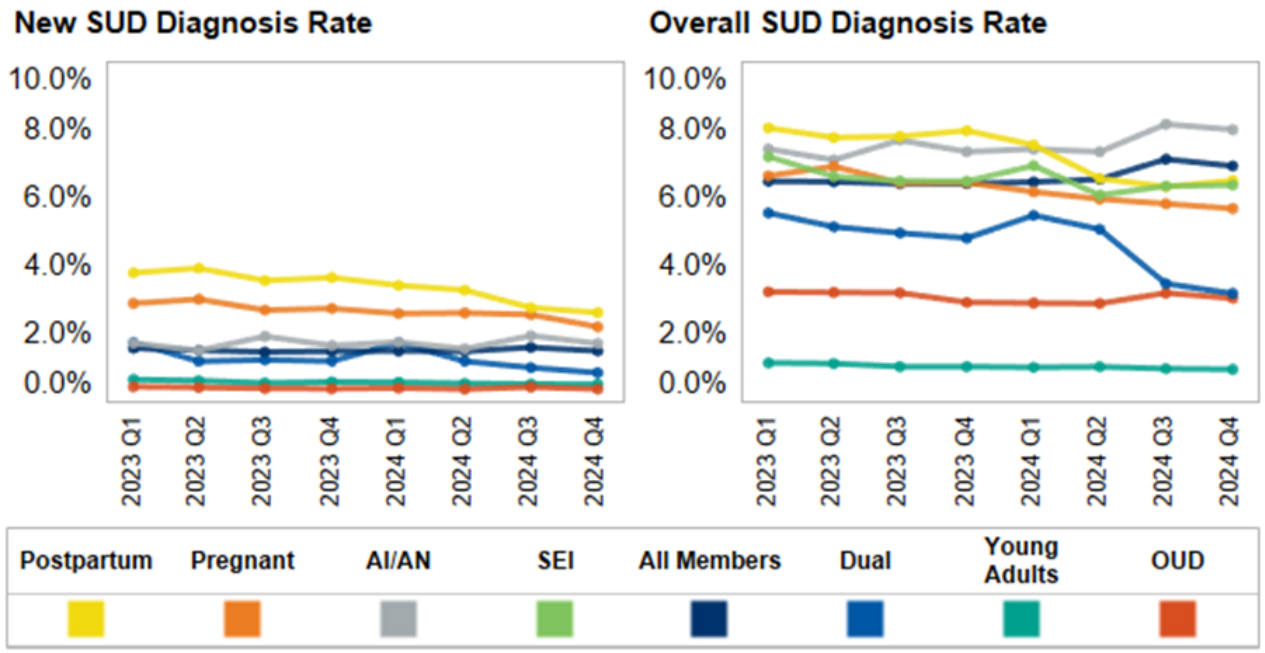
Impact and Reach

- Developed comprehensive reporting and metrics to track SUD prevalence, service utilization, and provider/system quality.
- Collected statewide qualitative data from diverse partners.
- Conducted annual subpopulation analyses and reporting to identify health disparities.
- Built partnerships with the faith community as a critical access point to increase awareness of substance use, reduce stigma, and reduce racial and ethnic disparities.

Future Activities

- Continue to produce and enhance reporting, including interactive dashboards to identify areas of opportunity and disparities and make recommendations for population health interventions.
- Acquire overdose fatality data and develop reporting dashboards to inform and make recommendations to policy boards.
- Explore options for facilitating a Trauma-Informed Faith Community/Congregations training.
- Create and disseminate a comprehensive trauma-informed faith leaders toolkit, incorporating a health equity lens that is inclusive of SUD information, harm reduction principles, MOUD/MAUD education, and language matters materials.
- Explore opportunities for creating impactful SUD data briefs that include health disparity findings.

SUPPORT Grant: SUD Rate Subpopulation Analyses



SEI: substance-exposed infants

- From Q1 2023 to Q4 2024, there was a notable decline in the new SUD diagnosis rate across most populations. The postpartum and pregnant groups experienced the largest decreases, a particularly encouraging trend as it reflects a potential shift in maternal and infant health outcomes.
- There was a shift in the subpopulations with the highest SUD diagnosis rates. The rates for the traditionally high postpartum and pregnant populations decreased to come in line or fall below that of the general HUSKY Health population. Still, the American Indian/Alaskan Native (AI/AN) population remained higher than the overall HUSKY Health SUD rate.
- The decreases in the rates for the dual-eligible members were driven by an artificial increase in this population due to enhanced reporting to capture dual Medicaid/commercial members and is not reflective of a true increase in membership.

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3.2. Impacts on Quality Measures: HEDIS® Measurement Year (MY) 2023

Standardized Quality Measures: HEDIS®

- The Healthcare Effectiveness Data and Information Set (HEDIS®), developed by the National Committee for Quality Assurance (NCQA), includes over 90 standardized performance measures across six domains: effectiveness of care, access/availability of care, experience of care, utilization, and risk-adjusted utilization.
- Carelon BH CT has programmed 13 HEDIS® measures to track performance over time, utilizing dashboards to compare to the regional New England rates and the nationwide rates. On the demographic dashboard for each measure, the end user can filter the Connecticut rates by gender, race, Hispanic identity, age group, and primary spoken language.
- Carelon BH CT underwent an annual HEDIS® audit and used HEDIS® measures to identify health disparities to inform performance improvement initiatives.
- A pharmacy analysis* using HEDIS® measures and advanced analytics was conducted by Carelon BH CT in 2024. The analysis provided insights on factors that impacted medication adherence and disproportionalities among racial groups.

**The results were presented as part of a poster at the 2025 NATCON conference. The poster can be found at: https://natcon2025.ipostersessions.com/Default.aspx?s=BD-13-03-41-A5-7B-42-D7-B8-2F-60-09-22-8F-A2-33*

2023 Annual HEDIS® Rates Summary (1 of 2)

How is Connecticut HUSKY Health performing year-over-year?

Measure Abbr & Measure Name	Measure Subset	Measure Age Group	2021	2022	2023	CT Annual Change 2021	CT Annual Change 2022	CT Annual Change 2023	Comparison to National/New England Rates 2021	Comparison to National/New England Rates 2022	Comparison to National/New England Rates 2023
ADD: Follow-up for Children Prescribed ADHD Medication (MY2023 is ADD-E data)	Initiation	6-12	41.6%	46.3%	45.4%	↓	↑	↓	◑	●	●
	Continuation	6-12	49.4%	54.8%	49.9%	↓	↑	↓	●	●	◑
AMM: Antidepressant Medication Management	Effective Acute Phase Treatment	Total (18+)	64.8%	64.0%	64.9%	↑	↓	↑	●	◑	◑
	Effective Continuation Phase Treatment	Total (18+)	47.5%	46.3%	47.5%	↑	↓	↑	◑	◑	◑
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics (MY2023 is APM-E data)	Blood Glucose Testing	Total		49.7%	49.6%	*	*	◆		●	●
	Cholesterol Testing	Total		34.5%	35.7%	*	*	↑		●	●
	Blood Glucose and Cholesterol Testing	Total		32.7%	33.6%	*	*	↑		●	●
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Total Rate	Total	79.2%	78.4%	75.2%	↓	↓	↓	●	●	●
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	7-Day	Total	17.3%	36.0%	31.4%	◆	↑	↓	◑	◑	◑
	30-Day	Total	30.1%	50.6%	44.1%	◆	↑	↓	◑	◑	◑
FUH: Follow-Up After Hospitalization for Mental Illness	7-Day	Total (6+)	47.9%	45.8%	44.2%	◆	↓	↓	◑	●	◑
	30-Day	Total (6+)	67.9%	66.8%	65.0%	↑	↓	↓	◑	●	◑
FUM: Follow-Up After Emergency Department Visit for Mental Illness	7-Day	Total (6+)	50.1%	47.0%	47.8%	*	↓	↑	◑	◑	◑
	30-Day	Total (6+)	64.2%	61.5%	62.3%	*	↓	↑	◑	◑	◑
HDO: Use of Opioids at High Dosage	Total Rate	Total (18+)	7.3%	7.2%	7.2%	↑	◆	◆	●	●	●

Key for Connecticut Trend Comparisons

- ↑ Improved Rate from Previous Year*
- ↓ Declined Rate from Previous Year*
- ◆ No Change from Previous Year (less than 0.5% change)
- * Previous Year Not Available For Comparison

Key for National & New England Average Rate Comparisons

- ● CT was more favorable than (or equal to) both comparison rates
- ◑ CT was more favorable than (or equal to) only one of the comparison rates
- ● CT was less favorable than both comparison rates
- ◆ Either the regional or national comparison rates was unavailable
- ○ Comparison rates unavailable

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Please note: For the HDO measure, a decreased rate is considered an improvement.

2023 Annual HEDIS® Rates Summary (2 of 2)

How is Connecticut HUSKY Health performing year-over-year?

Measure Abbr & Measure Name	Measure Subset	Measure Age Group	2021	2022	2023	CT Annual Change 2021	CT Annual Change 2022	CT Annual Change 2023	Comparison to National/New England Rates 2021	Comparison to National/New England Rates 2022	Comparison to National/New England Rates 2023
IET: Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	Initiation	Adolescents (13-17)	45.9%	39.7%	39.6%	↓	↓	◆	●	◑	◑
		Adults (18-64)		44.3%	45.9%	*	*	↑		●	◑
		Adults (65+)		39.2%	41.9%	*	*	↑		◆	◑
		Adults (18+)	41.0%			↓	*	*	●		
		Total	41.1%	44.1%	45.6%	↓	↑	↑		●	◑
	Engagement	Adolescents (13-17)	26.7%	21.5%	22.5%	↑	↓	↑	●	●	●
		Adults (18-64)		24.9%	25.4%	*	*	↑		●	●
		Adults (65+)		9.7%	9.7%	*	*	◆		◆	●
		Adults (18+)	20.2%			↓	*	*	●		
		Total	20.4%	24.6%	25.1%	↓	↑	↑		●	●
POD: Pharmacotherapy for Opioid Use Disorder	Total Rate	Total	37.4%	35.0%	33.6%	◆	↓	↓	●	●	●
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Total Rate	Total (18-64)	64.7%	65.1%	66.2%	↓	◆	↑	◑	◑	◑
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Total Rate	Total		74.6%	75.9%	*	*	↑		●	●
UOP: Use of Opioids from Multiple Providers	4+ Pharmacies	Total (18+)	1.8%	2.2%	3.8%	◆	◆	↓	●	◑	◑
	4+ Prescribers	Total (18+)	23.9%	22.5%	25.7%	↓	↑	↓	●	●	◑
	4+ Prescribers & Pharmacies	Total (18+)	1.2%	1.3%	2.2%	◆	◆	↓	●	◑	◑

Key for Connecticut Trend Comparisons

- ↑ Improved Rate from Previous Year*
- ↓ Declined Rate from Previous Year*
- ◆ No Change from Previous Year (less than 0.5% change)
- * Previous Year Not Available For Comparison

Key for National & New England Average Rate Comparisons

- ● CT was more favorable than (or equal to) both comparison rates
- ◑ CT was more favorable than (or equal to) only one of the comparison rates
- ● CT was less favorable than both comparison rates
- ◆ Either the regional or national comparison rates was unavailable
- ○ Comparison rates unavailable

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Please note: For the UOP measure, a decreased rate is considered an improvement.

2023 Annual HEDIS® Rates Summary

- Carelon BH CT monitored 13 BH-related HEDIS® measures and their 29 subsets against national and regional (New England) benchmark rates in measurement year (MY) 2023.
- Rates for most measures and subsets being monitored were more favorable than one of the two benchmark rates.
- Rates for ADD initiation, APP, IET engagement subsets, and POD were better than both the national and regional benchmarks, despite the rates for ADD initiation, APP, and POD declining from the previous year.
  - ADD initiation: 45.4% compared to 45.0% for national and 43.6% for New England
  - APP: 75.2% compared to 57.9% for national and 67.4% for New England
  - IET engagement (13-17): 22.5% compared to 12.2% for national and 11.8% for New England
  - IET engagement (18-64): 25.4% compared to 15.3% for national and 19.9% for New England
  - POD: 33.6% compared to 25.0% for national and 29.0% for New England

2023 Annual HEDIS® Rates Summary (continued)

- Rates for five out of the 29 measure subsets, including all three APM subsets, HDO, and SSD, fell short of both the national and regional benchmarks. APM Blood Glucose Testing: 49.6% compared to 56.6% for national and 54.7% for New England
  - APM Cholesterol Testing: 35.7% compared to 39.1% for national and 39.1% for New England
  - APM Blood Glucose and Cholesterol Testing: 33.6% compared to 37.6% for national and 37.4% for New England
  - HDO: 49.6% compared to % for national and % for New England
  - SSD: 49.6% compared to % for national and % for New England
- However, there was an improvement in the rates for two of the three APM subsets and maintenance for the third compared to the previous year. Carelon BH CT has initiated efforts to enhance these measures.
  - APM Cholesterol Testing: increase from 34.5% in 2022 to 35.7% in 2023
  - APM Blood Glucose and Cholesterol Testing: increase from 32.7% in 2022 to 33.6% in 2023
  - APM Blood Glucose Testing: maintenance at 49.7% in 2022 and 49.6% in 2023

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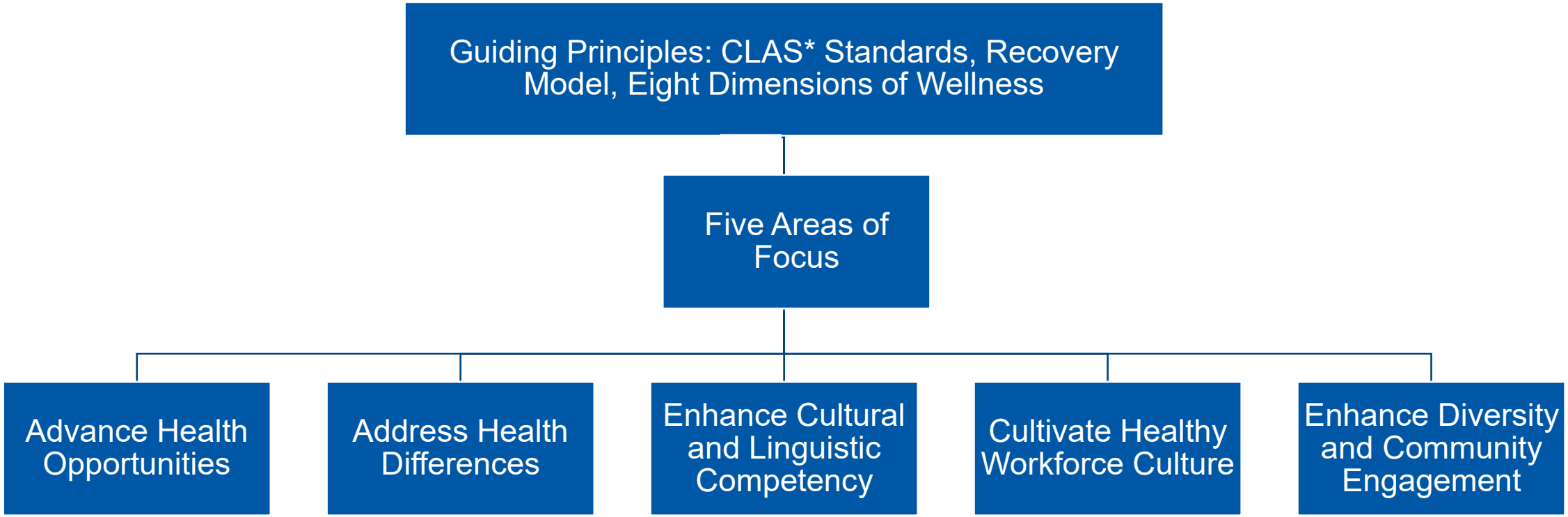
3.3. Impacts on Health Equity

Carelon BH CT Health Outcomes Strategy



**Culturally and Linguistically Appropriate Services (CLAS)*

Promoting Health Equity: Highlights from 2024

- **Advance health opportunities and address health differences:**
  - completed the Follow-up After Hospitalization (FUH) predictive model to identify members at the highest risk of not following up with aftercare plans post inpatient discharge
  - launched the FUH program to reach out to and assist HUSKY Health members in connection to care after discharge from hospital admissions
  - conducted a pharmacy analysis with a health equity lens and provided insights on factors that impacted medication adherence and disproportionalities among racial groups
  - completed an analysis on the utilization of medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD) by race, highlighting disparities in utilization between Black and White HUSKY Health members
- **Enhance cultural and linguistic competency:**
  - standardized health equity and demographic terminology including Bias-Free and Person-First Language, Demographics, and Health Equity Terminology
  - created and distributed an internal Health Equity Data Guide which defines key health equity-related terminology and provides examples using data and offered trainings to staff
- **Cultivate healthy workforce culture and enhance diversity and community engagement:**
  - expanded the role of an existing assistant vice president (AVP) to include development of the ASO's health equity strategy and monitoring of related activities

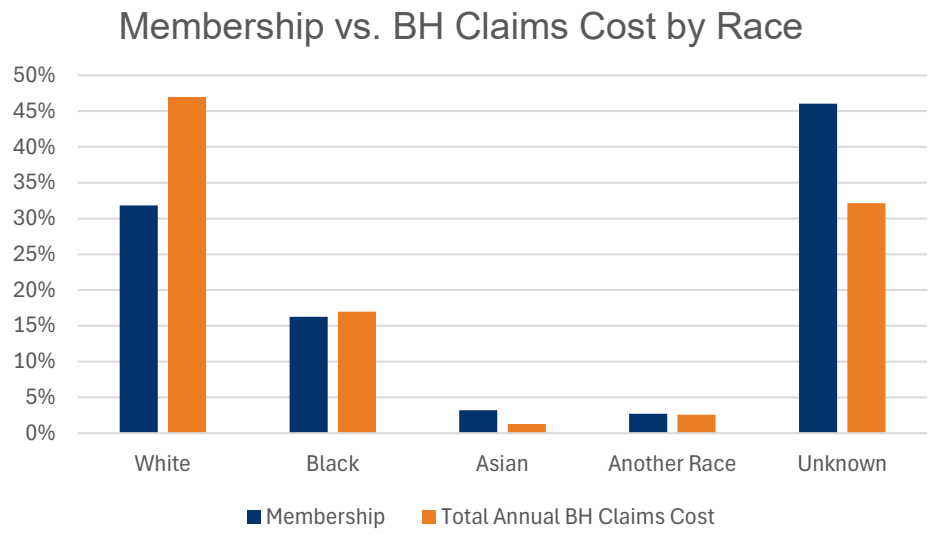
Promoting Health Equity: Area Deprivation Index (ADI)

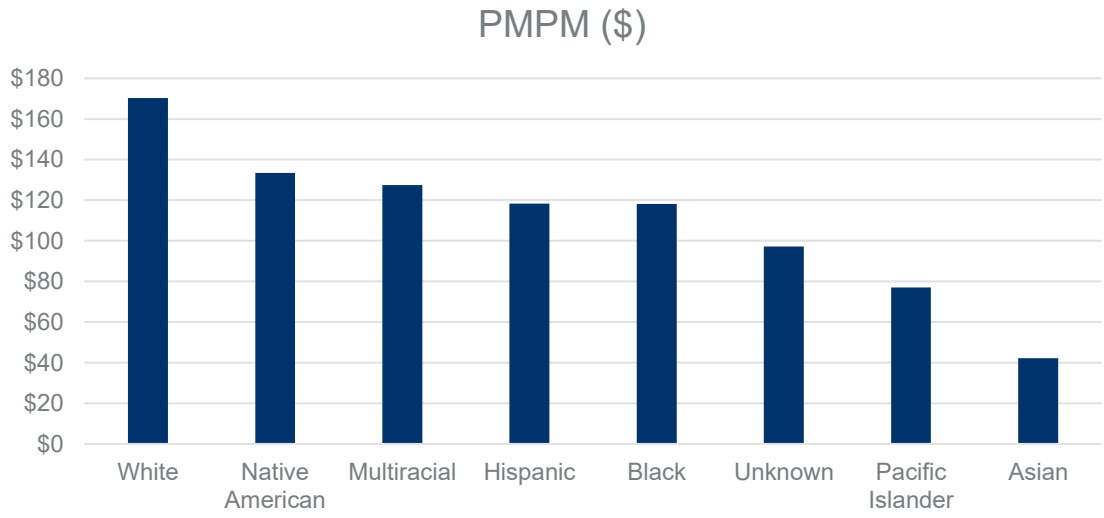
- **ADI Scoring System:**
  - The ADI is a scientifically validated tool created by the Neighborhood Atlas at the University of Wisconsin Center for Health Disparities Research.* It ranks U.S. neighborhoods by relative socioeconomic disadvantage from 1 to 10 at the level of census block groups, with 1 indicating the least disadvantaged neighborhoods and 10 the most, based on information like income, education, employment, and housing quality.
- **Data Collection and Attribution:**
  - Using advanced address validation software, Carelon BH CT compiled detailed 9-digit ZIP codes to accurately assign ADI scores to HUSKY Health members, resulting in a significant 89% of members matched with ADI scores in the 2024 Population Profile.
- **Integration in Health Assessments:**
  - ADI can be used as a composite social driver of health (SDoH) to provide a comprehensive view of the socioeconomic challenges impacting HUSKY Health members.
  - Carelon BH CT continues to make strides towards increasing the percentage of members attributed to ADI scores and incorporating ADI throughout its datasets, dashboards, and analyses, enhancing the reliability of health disparity assessments.

* *https://www.neighborhoodatlas.medicine.wisc.edu/*

Identifying Health Disparities: Data Analysis

- Carelon BH CT continued to use claims data from HUSKY Health members to identify health disparities, aid in developing interventions and policies, and monitor progress.
- In 2024, White members made up 31.8% of HUSKY Health members aged 3+ and contributed to 47.0% of the total BH claims costs. In contrast, 46.1% of members had an unknown race while accounting for 32.1% of the BH claims costs.
- The 2024 BH PMPM cost* exhibited variations by race and ethnicity as well. White members had the highest PMPM cost among all groups, whereas Asian members had the lowest PMPM expenditures.





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**CT Medicaid is a fee-for-service model providing diagnosis, utilization, and cost in the claim payment system. Utilization, cost, and diagnosis should not be interpreted to reflect the full needs of the HUSKY Health population and are influenced by factors such as access to care.*

Identifying Health Disparities: Data Analysis

- Within each racial group, the BH service utilization was highest among White members (36.7%) and lowest (15.9%) among Asian members. 28.0% of Black members and 35.1% of members with a race other than White, Black, or Asian utilized a BH service.
- Among all HUSKY Health members who utilized BH services, 38.9% were White, compared to 31.8% in the overall membership. Conversely, 46.1% of members had an unknown race but composed 41.0% of those who utilized BH services.

Prevalence of Behavioral Health Service Utilization* by Race in 2024			
Demographic	**Percent**	**Members Utilizing BH Services**	**HUSKY Health Members**
Total Membership	**30.0%**	**257,472**	**859,376**
Race			
White	36.7%	100,253	273,299
Black	28.0%	39,058	139,671
Asian	15.9%	4,362	27,348
Another race other than White, Black, or Asian	35.1%	8,175	23,278
Unknown	26.7%	105,624	395,780

**Prevalence of BH service utilization was calculated by dividing the number of members within a specific cohort who had a claim for a BH service during the measurement year by the total number of members in that same cohort.*

Identifying Health Disparities: Pharmacy Analysis

- Carelon BH CT conducted the pharmacy analysis* using HEDIS® measures to analyze demographic, clinical, geographic, and socioeconomic factors affecting adherence to BH medications for HUSKY Health members. Regression models were built to determine the key factors associated with different medication adherence.
- Black HUSKY Health members were 30% less likely to be adherent to antipsychotics (95% CI: 22% to 37%), 33% less likely to adhere to antidepressants (95% CI: 28% to 37%), and 46% less likely to be adherent to MOUD (95% CI: 35% to 56%), when compared to White HUSKY Health members.
- In addition to disparities in adherence, there were disproportionalities in medication prescriptions in the denominator reflecting differences among racial groups compared to membership percentages.

		Antidepressant		Antipsychotics		Medications for Opioid Use (MOUD)	
Race	Proportion of HUSKY Health Members (%)	Denominator Distribution (%)	Adherence Rate (%)	Denominator Distribution (%)	Adherence Rate (%)	Denominator Distribution (%)	Adherence Rate (%)
White	37.2	44.9	53.0	38.9	74.1	53.8	36.7
Black	16.7	13.7	36.0	25.1	60.8	8.4	27.3
Asian	3.4	1.9	48.6	2.1	68.9	0.6	27.5
Another race other than above	0.8	0.8	43.3	0.7	47.4	0.7	30.5
Unknown	41.9	38.7	42.2	33.3	58.1	36.5	34.4

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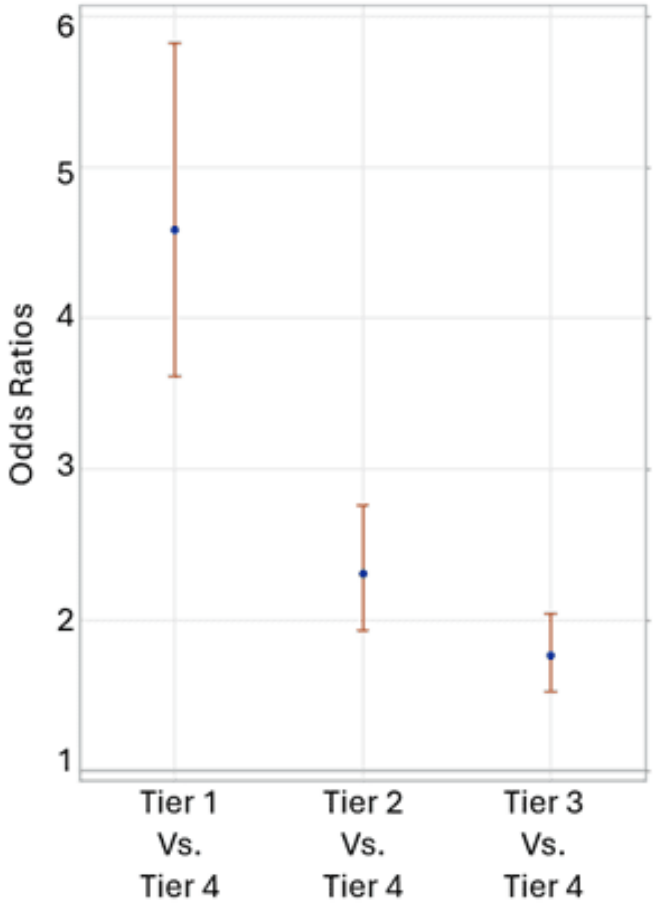
**The results were presented as part of a poster at the 2025 NATCON conference. The poster can be found at https://natcon2025.ipostersessions.com/Default.aspx?s=BD-13-03-41-A5-7B-42-D7-B8-2F-60-09-22-8F-A2-33.*

Identifying Disparities: Follow-up After Hospitalization (FUH)

- Timely follow-up after inpatient psychiatric admission is regarded as a standard of excellence in clinical practice. To inform member, provider, and system interventions, Carelon BH CT developed a predictive model to identify HUSKY Health members at heightened risk of not receiving follow-up care after discharge from inpatient psychiatric care. The model and interventions were informed by input from the Consumer and Family Advisory Council (CFAC) focus groups, including consumers, family members, and member advocates.
- Clinical, demographic, and socioeconomic risk factors linked to lower engagement with care post-discharge were identified for adults and youth using a multivariate logistic regression model. Black HUSKY Health members were 57% (95% CI: 39% to 78%) less likely to receive follow-up care within 7 days of discharge, relative to White HUSKY Health members. Those members with unknown race were 28% (95% CI: 17% to 41%) less likely to receive follow-up care within 7 days.
- Four distinct risk tiers were established to assign members to appropriate interventions. Members classified in the highest-risk tier (Tier 1) exhibited a 4.6-fold increased likelihood of not connecting to care compared to those in the lowest-risk tier, while Tier 2 members were 2.3 times more likely, and Tier 3 members were 1.8 times more likely to experience the same issue.



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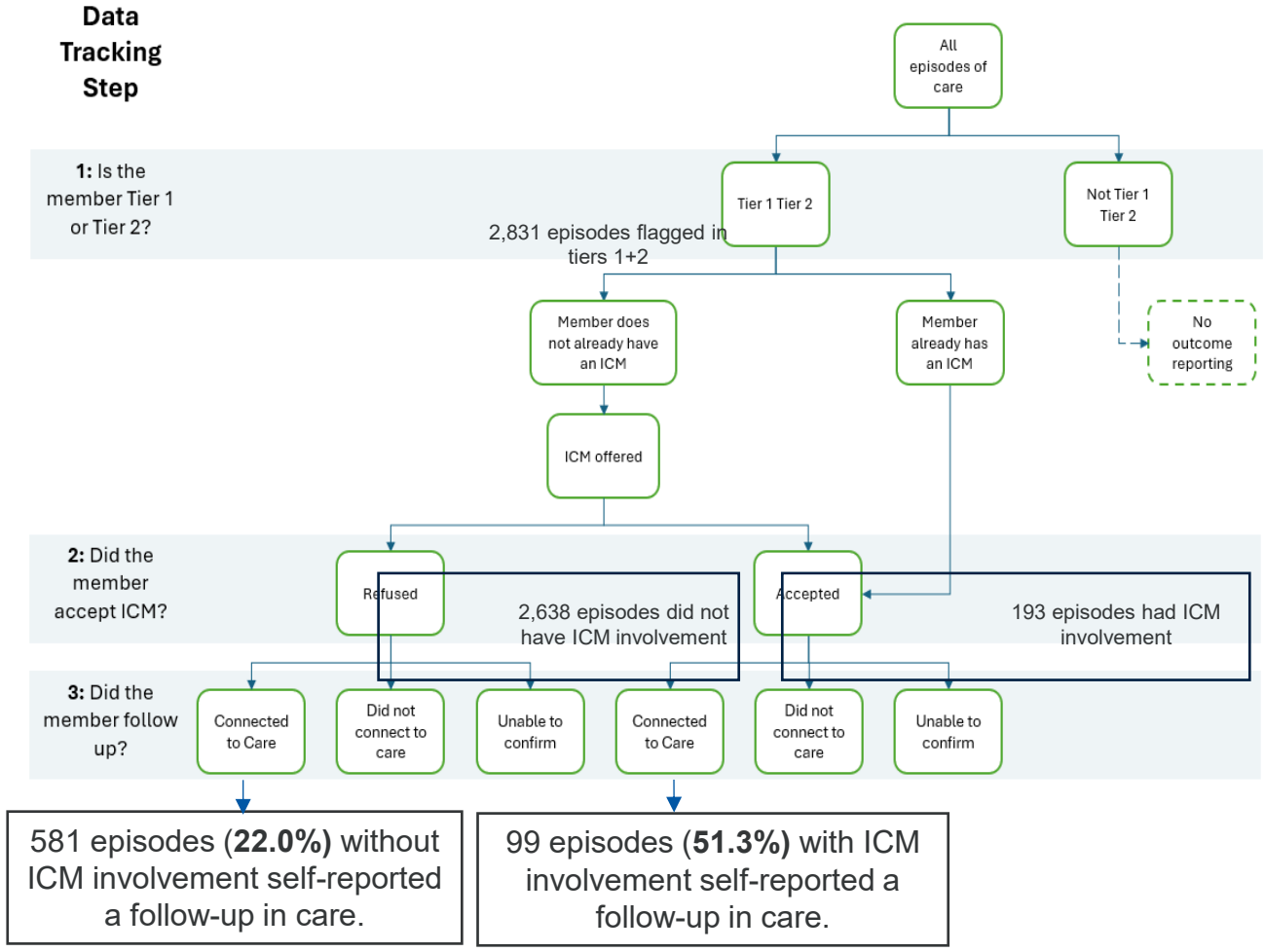
Addressing Disparities: Aftercare Follow-up (AFU) Program

HUSKY Health members with inpatient utilization from 5/8/2024-5/8/2025



Carelon BH CT launched the AFU member-level intervention program on May 1st, 2024.

- Based on the FUH model run daily, every HUSKY Health member admitted to an inpatient mental health unit is assigned to a risk tier at the time of admission. Hospitals are informed when they admit a member in Tiers 1 and 2.
- The members in Tiers 1 and 2 are offered an intensive care manager (ICM) to help support their transition back to the community and connect to care after discharge.
- When a HUSKY Health member declines the ICM support services, the utilization management clinical care manager (CCM) continues to work closely with the hospital to identify an appropriate discharge plan and resolve any barriers which might impede connection to care after discharge.
- Self-reported aftercare follow-up outcomes were recorded as one of three categories for all Tier 1 and Tier 2 members:

  1. Connected to care

  2. Did not connect to care

  3. Unable to confirm

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AFU ICM Involvement Descriptive Analysis

Key high-level takeaways:

- Episodes with ICM involvement had a higher rate of self-reported follow-up.
  - Members who engaged with ICMs showed a clear intent to address their behavioral health needs, but follow-up might not occur without ICM support.
- Descriptive analysis indicated lower acceptance of ICM involvement.
  - Hispanic members and members whose primary language was not English had lower ICM involvement rates.
- Future iterations or updates to the intervention could take these descriptive analytic findings into consideration to expand outreach and encourage participation from those offered support.
- An outcome study using claims data in the future would likely uncover the effects of the ICM intervention.

- **Overall ICM Involvement: 6.8% (193/2831)**
- **Demographic Stratifications of ICM Involvement:**
  - Race
    - Asian: 0% (0/20)
    - Black: 8.3% (70/840)
    - White: 6.2% (53/856)
    - Unknown race: 6.4% (70/1095)
    - Another race: 0% (0/20)
  - Hispanic Ethnicity
    - Hispanic: 4.8% (24/496)
    - Non-Hispanic/Unknown: 7.2% (169/2335)
  - Gender
    - Male: 6.7% (136/2040)
    - Female: 7.2% (57/791)
  - Primary Language
    - English: 7.1% (190/2685)
    - Spanish/Another: 2.1% (3/146)

Recommendations

- HUSKY Health membership is expected to continue to decline due to policy changes on eligibility requirements. This makes it even more important to continue to educate members on Medicaid changes and support members in the enrollment process.
- There is a significant portion of members with unknown race and ethnicity information. Carelon BH CT will continue to research and seek ways to enhance its data such as incorporating historical information on member's race and ethnicity when available. It is also recommended to enhance data collection efforts through member education and guidance.
- The ADI is a valuable tool for assessing and addressing socioeconomic challenges among HUSKY Health members. As a composite social driver of health (SDoH), the ADI provides a deeper insight into the socioeconomic drivers impacting health outcomes. Future data analyses and reporting dashboards should incorporate ADI scores to further improve the assessment and mitigation of health disparities.
- Youth ED stuck and inpatient discharge delays, particularly for youth waiting for community-based services or state-operated PRTFs, highlighted access issues. Continue to enhance service accessibility and the efficiency of care through UM initiatives, CM activities, inpatient/ED provider workgroups, and the PAR programs to manage system throughput.
- In 2024, HUSKY Health adult members experienced increased readmission rates and a rise in ED visits per 1,000 eligible member months. To address these challenges, it is recommended that the CT BHP continue to focus on ensuring timely access to outpatient services and enhancing post discharge connections to care, including through the AFU program.
- The strategic enhanced care clinic (ECC) model has great potential in reducing inpatient admissions, readmissions, and ED visits. Continuing to improve the referral pathways to ECCs is crucial in realizing its full potential.

Thank You

Contact Us

For any inquiries and comments, please contact

Cindy Li, Chief Analytic Consultant at Cindy.Li@carelon.com.

Bonni Hopkins, SVP Quality, Analytics & Innovation at Bonni.Hopkins@carelon.com

www.ctbhp.com | www.carelonbehavioralhealth.com