



Connecticut Behavioral Health Partnership (CT BHP) 101

Child/Adolescent Quality, Access & Policy Meeting - February 18, 2026

Agenda

1 CT BHP Overview

2 Providers Access & Support

3 Member Engagement

4 Utilization & Clinical Programs

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Chapter

01

CT BHP Overview



Connecticut Behavioral Health Partnership (CT BHP)

- CT BHP was established by Connecticut General Statute to provide a multi-agency approach to problem solving and to address seemingly intractable system concerns, initially high utilization of residential care and long lengths of inpatient hospitalization for youth, with the overriding goals of improving member access and outcomes.
- In 2006, the Departments of Children and Families (DCF) and Social Services (DSS) formed the CT BHP with a focus on children and families enrolled in HUSKY A, HUSKY B, and DCF's Limited Benefit Program.
- In 2010, the state received federal approval to expand its Medicaid program to include low-income, childless adults. In response, DMHAS joined the partnership in 2011, and program eligibility further expanded to include the state's two adult Medicaid populations: HUSKY C and HUSKY D.
- DCF, DMHAS, and DSS are member partners of the CT BHP, and jointly contract with and manage Carelon Behavioral Health as the Administrative Services Organization (ASO).
- Behavioral Health Oversight Council and subcommittees created in statute as an advisory body.
- True provider partnerships developed over the years.

Role of the Administrative Services Organization (ASO)

- To act as the primary vehicle for organizing and integrating behavioral health clinical management processes via utilization and care management
- To support improved access to community-based behavioral health services
- To support the delivery of quality behavioral health services across the system
- To prevent unnecessary institutional care, as we believe the right level of care at the right time for the right amount of time leads to positive outcomes (personal and system)
- To enhance communication and collaboration within the BH delivery system

Carelon Behavioral Health (BH) serves over 47 million lives across 50 states. We share the mission of our parent company, Elevance Health: to improve lives and communities; simplify healthcare, expect more. Our joint purpose is improving the health of humanity.

Carelon BH CT has served as the behavioral health Administrative Services Organization (ASO) since the program's inception in 2006. Working with our partner state-agencies (DCF, DMHAS, DSS), and community providers, we have a tradition of developing and implementing local solutions designed for the people of Connecticut.



Continuous Quality Improvement Framework to Drive Excellence in Performance

CT BHP Standards

- 15 Performance Standards covering call management, timeliness of authorization processes, denials, complaints, and appeals, etc.
- Assessed quarterly and now reported semi-annually.

Performance Over Time

- Since 2006, Carelon BH CT has performed >98% on all contractual standards.

Innovative Programs to Improve Member Care

+95% PT
achievement over
contract life

Performance Targets

1-2 year resource-intensive initiatives aimed at maximizing system reform in priority areas.

1) Integrated System for Treatment of Substance Use Disorders

Support the continued adoption of medication for substance use disorders (MSUD) on a broad scale. Includes Changing Pathways program. Imbed health equity lens in treatment and outcomes of HUSKY Health members with SUD.

2) Managing Systems Throughput

Address delays in accessing appropriate pediatric behavioral health treatment at multiple levels of care.

3) Value-Based Payment (VBP) for Pediatric Inpatient

Promote high-quality care building on prior efforts in the longstanding IP Bypass Programs, in addition to efforts to bolster bed capacity and availability of acute care for youth through add-on payments.

4) CCBHC Outpatient Redesign

Assist the state in securing the planning grant and preparing to submit a four-year demonstration project for Certified Community Behavioral Health Clinics (CCBHCs).

Clinical Studies

Evaluating and reporting on high-need areas of interest mutually agreed upon by Carelon BH CT and the State Partners.

1) Home Health

Analyze the home health population and recommend updates to the longstanding Home Health Bypass Program.

2) Aftercare Follow Up/ Follow Up After Hospitalization (AFU/FUH)

Developed a predictive model to identify members at greatest risk of not connecting to care following an inpatient psychiatric admission and offer targeted Care Management to the member and supporting the provider via Utilization Management (UM) on discharge planning.

Clinical Programs

Programs funded by the CT BHP contract that serve Medicaid members in CT. Several started as Performance Targets.

- Aimed at increasing access and improving outcomes for members through Care Management, Intensive Care Management, Peer Supports, and Care Coordination.
- Inpatient Bypass programs
- Utilization Management for the 1115 SUD Waiver
- Proactive Engagement Program (PEP)
- Co-Management with Medical & Dental ASOs and NEMT broker (integrated care)
- Driven by Health Equity

Chapter

02

Provider Access & Support

CT BHP Behavioral Health Provider Types and Specialties

380+ Facilities, 1,600+ Practice Locations

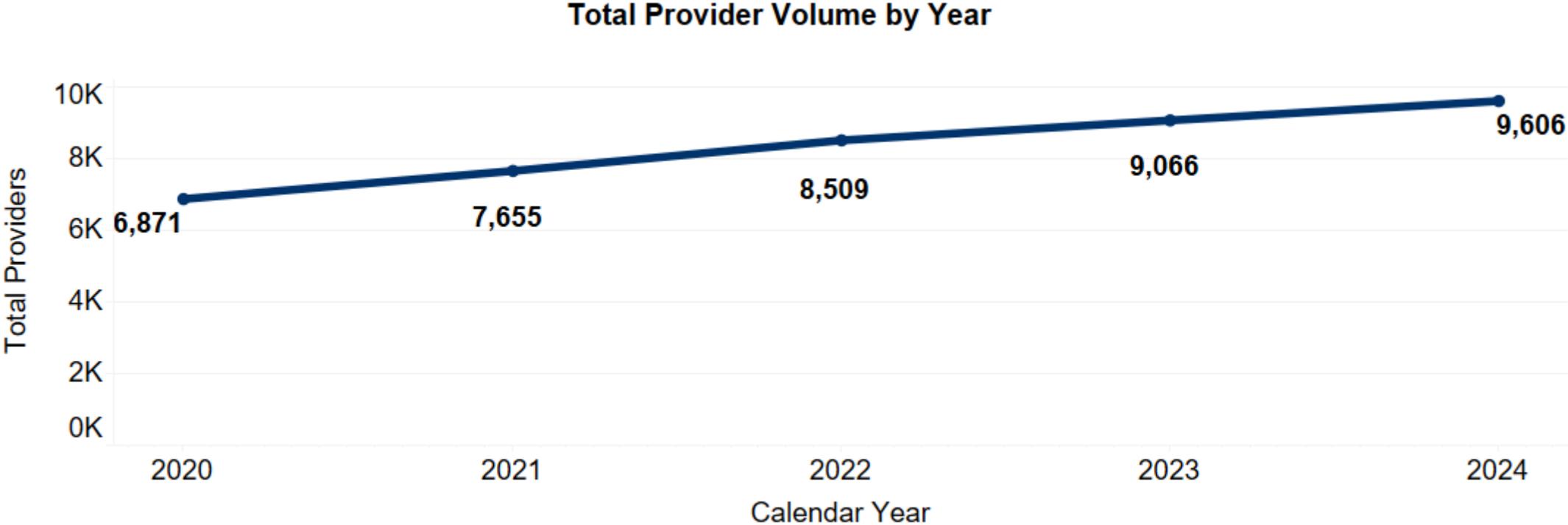
- hospitals
- mental health/medical outpatient clinics (including enhanced care clinics (ECCs)), rehabilitation centers, school-based service centers, and youth urgent crisis centers (UCCs)
- alcohol and drug treatment centers (including withdrawal management, intensive outpatient (IOP) programs, outpatient)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

9,200+ Individual Practitioners and Group Practices

- psychiatrists
- psychologists
- advanced practice registered nurses (APRN)
- licensed clinical social workers (LCSW)
- licensed marriage and family therapists (LMFT)
- licensed professional counselors (LPC)
- licensed alcohol and drug counselors (LADC)
- board certified behavior analysts (BCBA)

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.



CT BHP Provider Education and Support

Communications

- Bulletins, newsletters
- User manual
- Provider & member handbooks
- ProviderConnect registration
- Level of Care Guidelines
- Find providers feature
- Member brochures
- Regional & national esources
- FAQs
- Achieve Solutions member articles

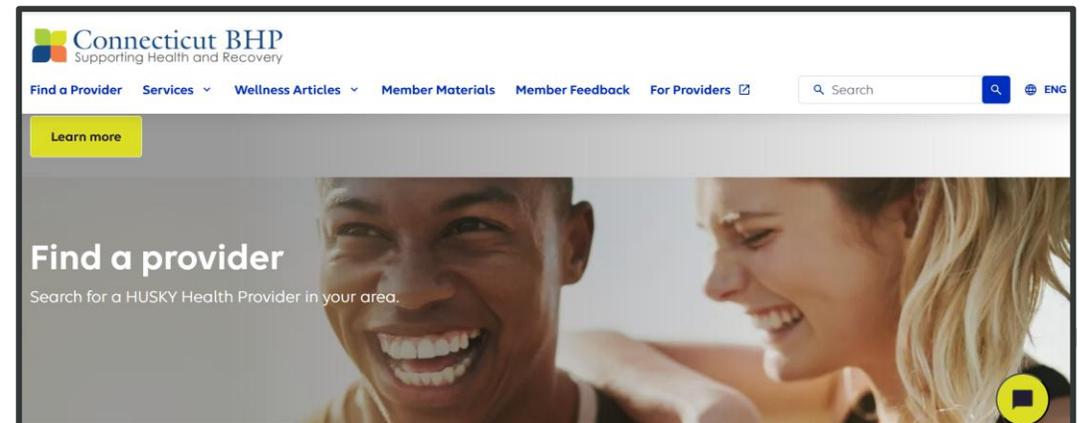


Training

- ProviderConnect, ClientConnect, BedTracking/MTPPR's
- Telephonic assistance
- Web conferencing
- **CT BH(e)P Desk** – A monthly session dedicated to discussing ProviderConnect, authorization parameters and any technical questions.

Network

- Assist providers with credentialing process
- Maintain provider file
- Create ProviderConnect User ID's
- Verify active enrollment and referral status



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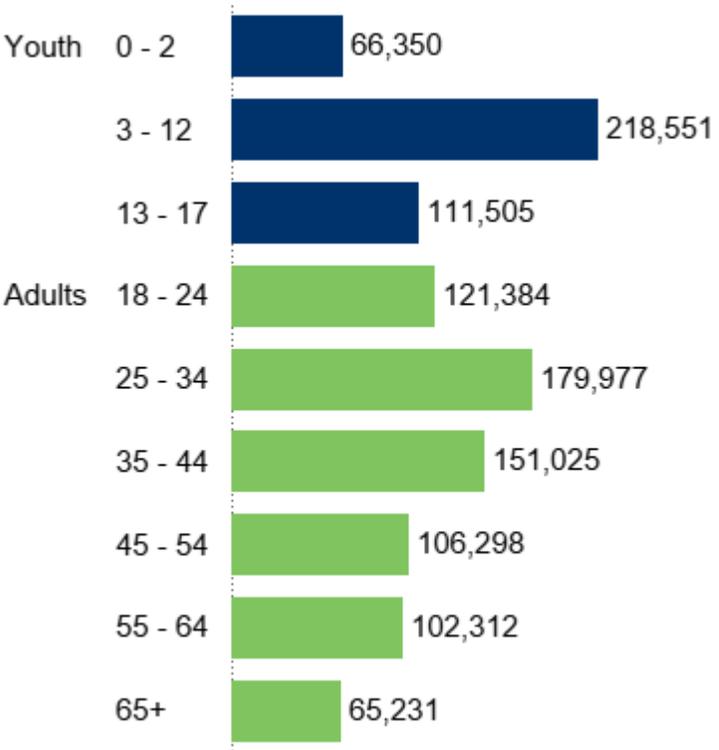
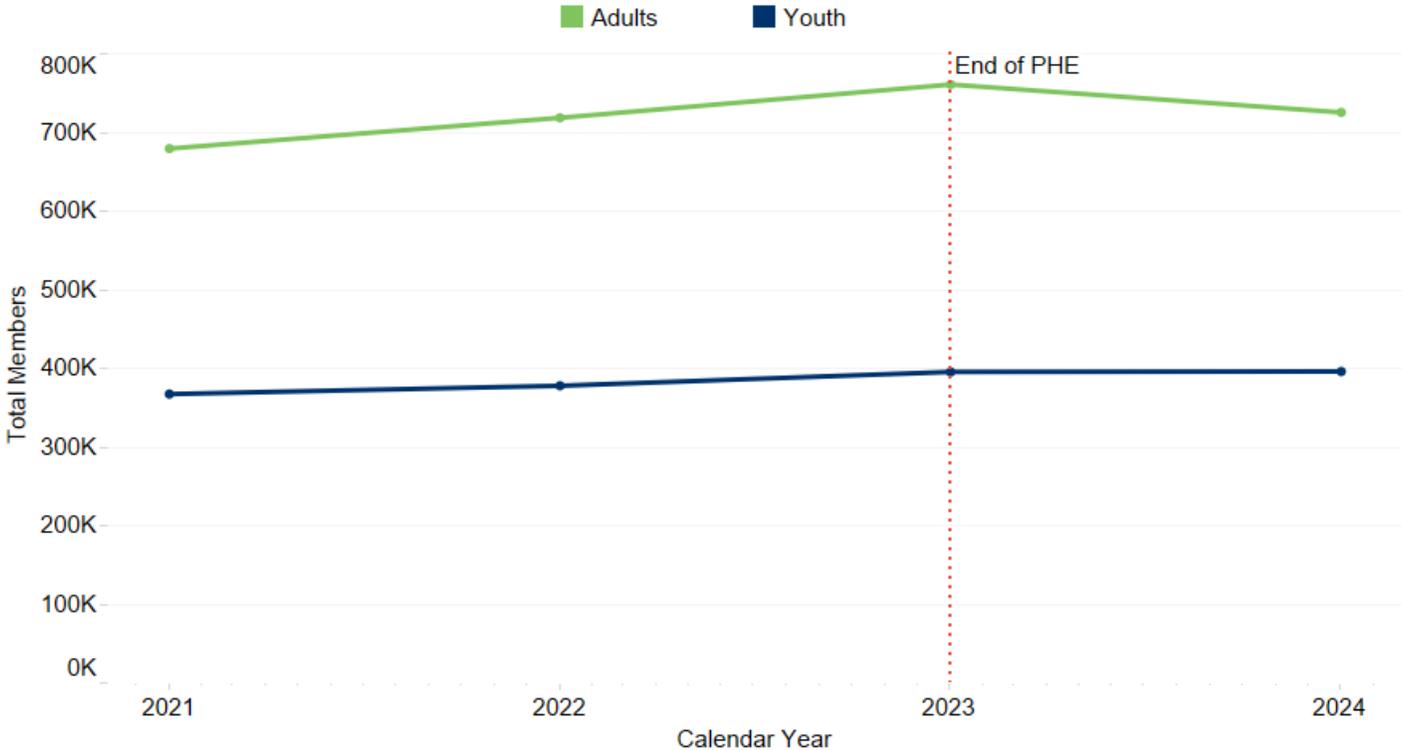
Member Engagement

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 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%).



Member and Community Engagement

Consumer & Family



Advisory Council

Where Consumers Are True Partners

Connecticut BHP
Supporting Health and Recovery

Administered by
carelon
Behavioral Health

Community
Health Network
of Connecticut, Inc.



HUSKY Health Program – Community Meeting



Autism Services & Resources Connecticut
at Clifford Beers Community Health Partners

Connecticut BHP
Supporting Health and Recovery

Administered by
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Behavioral Health



Chapter

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Utilization & Clinical Programs

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

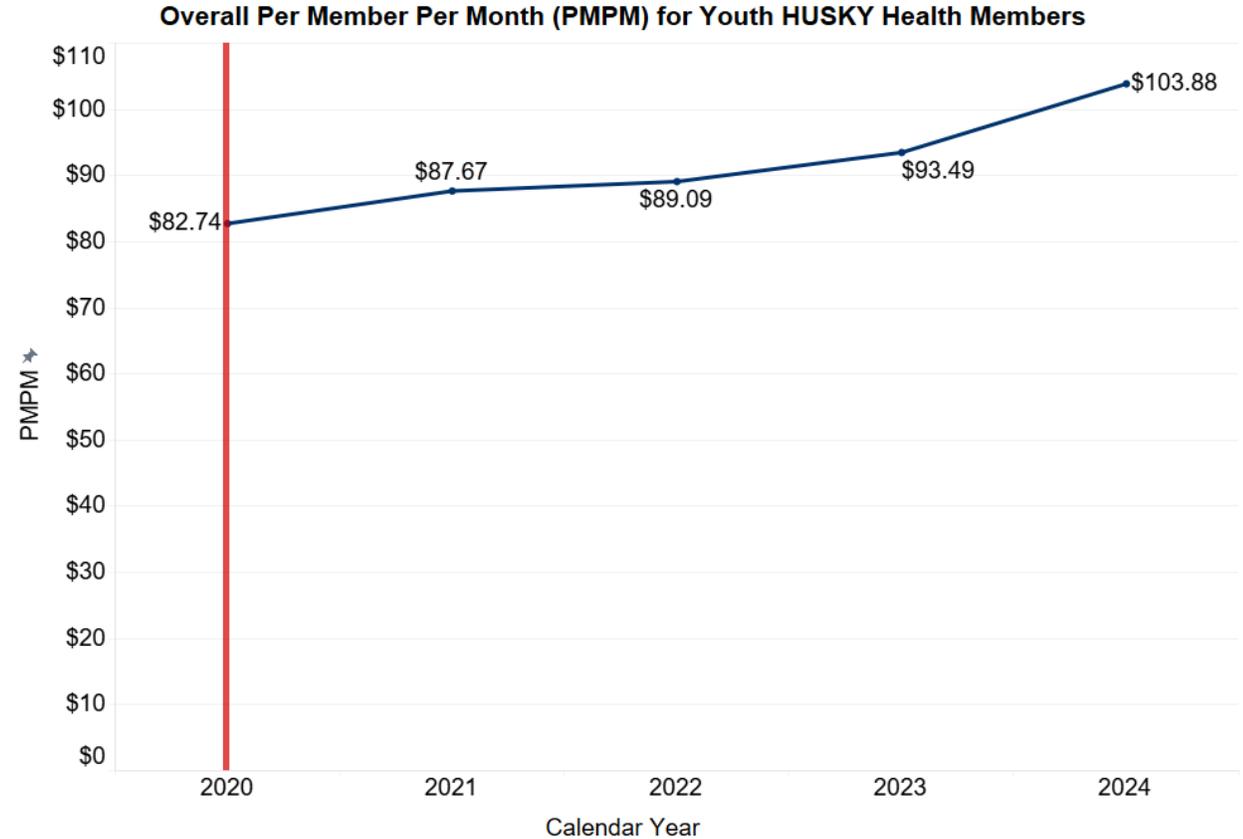
- Overall, 30.0% of HUSKY Health members aged 3+ (excluding members with dual eligibility) utilized a BH service at least once in 2024.
- Among HUSKY Health youth members, 29.3% utilized a BH service, compared to 30.3% among adults.

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 Behavioral Health (BH) Cost*

- The total expenditure for BH services by all HUSKY Health members increased 11.8% from \$345.02M in 2023 to \$385.76M in 2024. For HUSKY Health youth aged 3 to 17, 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.

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)

Innovative Clinical Offerings

CURRENT OFFERINGS

Proactive Engagement Program (PEP)

In October 2025, Carelon BH CT became the first Carelon contract to implement the PEP programs, including:

- **Wellness Resource Line**
 - Identifies members at risk for a suicidal event in the next 12 months.
 - Telephonic case management focused on safety planning, risk reduction, family support, and connection to community resources.
- **RISE (Resilience through Intervention, Support, and Education)**
 - Identifies members at risk of Opioid and Alcohol related negative health outcomes
 - Includes case management, peer support, and a single point of CM contact.
- **BH Services Health Stress Score**
 - Through telephonic case management, the program staff will assess and identify the acute needs and make appropriate referrals to programs and providers within the member's community.

Intensive Care Management

- Child ICM continue focus on addressing system throughput and maintaining discharge delay rates and ED stuck Average Length of Stay (ALOS).

Peer Support Services

- Peer Support Specialists are available via warm-line for real-time support
- Support members in clinical programs
- Member education and outreach, treatment engagement, and assistance in navigating the BH system.

Addressing SUD Crisis

- Changing Pathways Programs: supports adoption of MOUD and MAUD by inpatient providers since 2018, resulting in improved outcomes for members, including a significant reduction in overdose rates.

Autism Spectrum Disorders (ASD)

- Peers and care coordinators help members and their families understand available ASD Medicaid benefits, assess needs, and navigate the system.

Follow up Care After Hospitalization

- Identifying members at high risk for not engaging in follow-up care. Allocates targeted interventions aimed at improving transitions of care and enhancing clinical outcomes.

FUTURE STATE

SUD Systems Change

- 1115 monitoring of utilization across the SUD continuum & recommendations for bed capacity needs at different LOC

Specialty Populations

- Continued development of Specialty Population Management and UM via predictive analytics

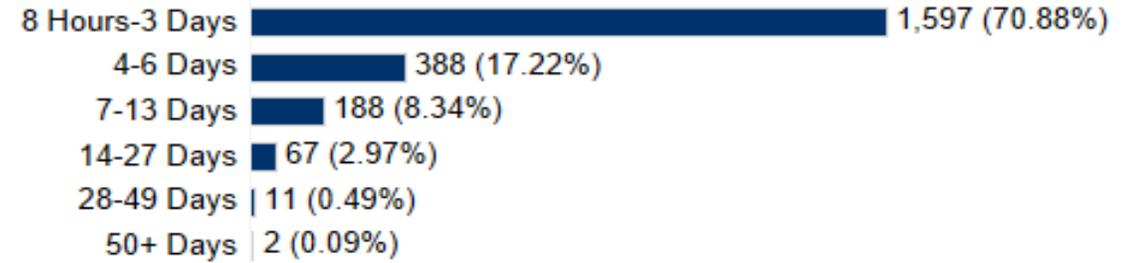
Integrated PH/BH Care

- Additional integrated care strategies/ programs

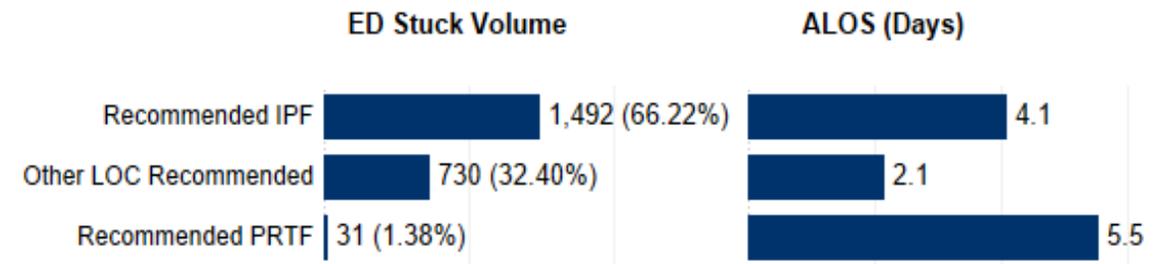
Youth Emergency Department (ED) Visits: ED Stuck

- "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.

Length of Stay Distribution for ED Stuck Members Discharged from the ED in 2024



ED Stuck Volume and Average Length of Stay (ALOS) by Recommended Level of Care (LOC) in 2024



Chapter

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Impact: Examples of Outcomes

Discharge Delay

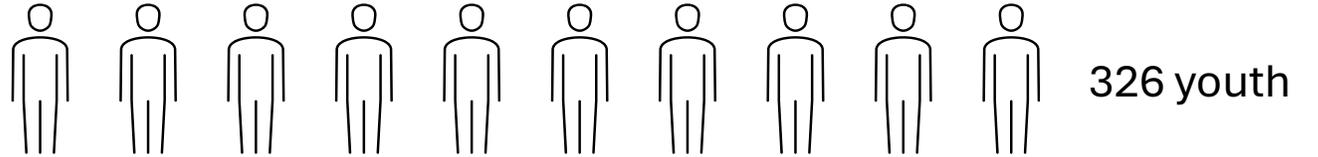
Reduced Discharge Delay

When a child is ready to leave a psychiatric hospital, but a needed service is not immediately available, the child's discharge is delayed.

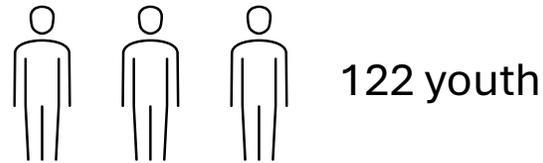
Carelon, DCF and DSS staff, and providers work together to identify available services while removing barriers to accessing treatment. As a result, the time youth wait unnecessarily in hospitals has been greatly reduced as seen below.

Fewer Youth Waiting to Discharge from the Hospital

2008



2024



62.6% REDUCTION

Reduction in
D/D as % of
Inpatient Days



76.2% REDUCTION

Child Inpatient Average Length of Stay

2008
17.8 Days

2024
13.5 Days

24.2% ALOS Reduction Since 2008

**2008 7-Day
Readmission**
4.0 %

**2024 7-Day
Readmission**
3.3 %

While Average Length of Stay has decreased by 24.2% since 2008, 7-day readmission rates have also decreased, suggesting shorter stays have not resulted in increased early returns to care.

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

- 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 Follow-Up Care for Children Prescribed ADHD Medication (ADD) initiation, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP), Initiation and Engagement of Substance Use Disorder Treatment (IET) subsets, and Pharmacotherapy for Opioid Use Disorder (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 Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) subsets, Use of Opioids at High Dosages (HDO), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (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**

Chapter

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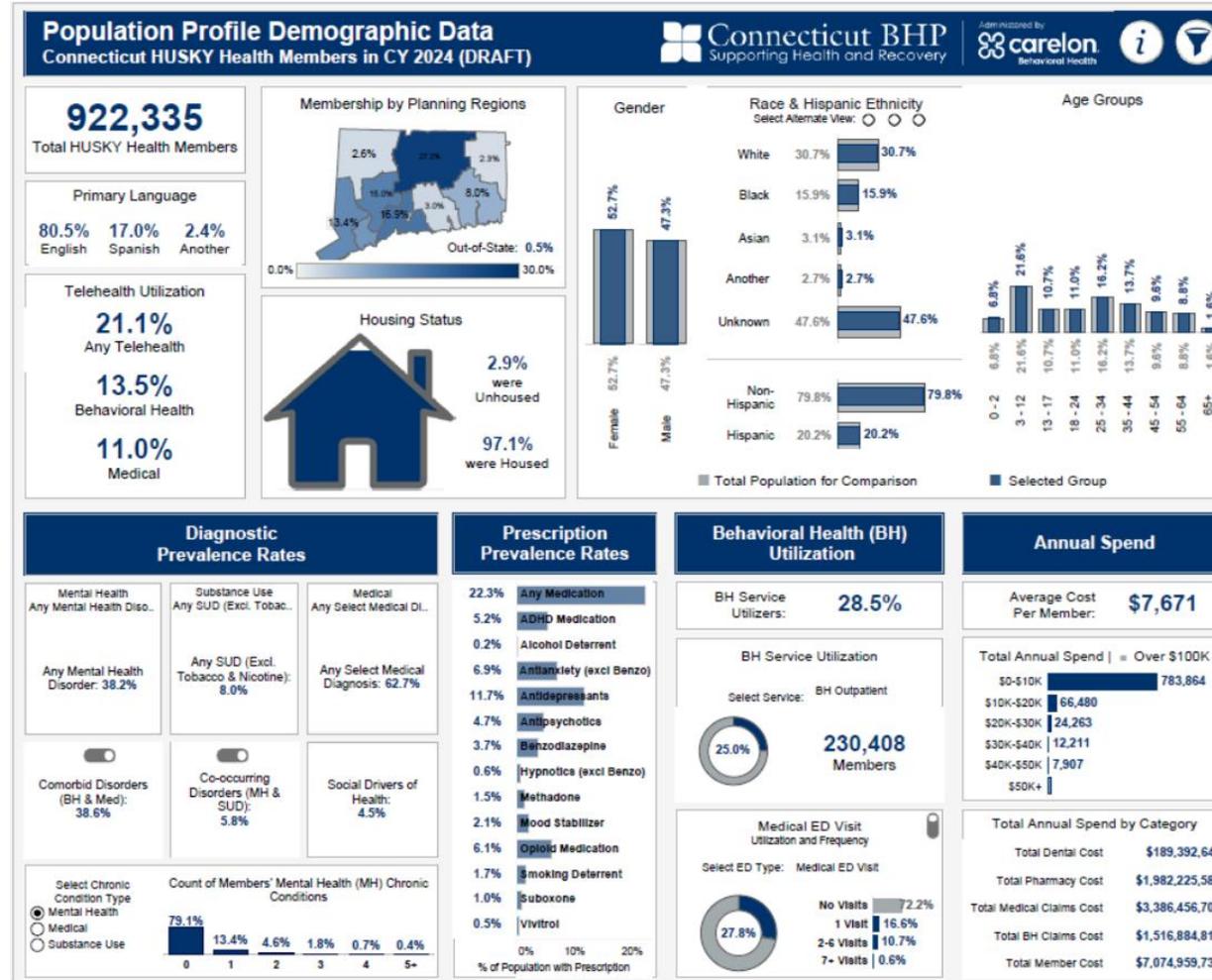
Quality Analytics and Innovation

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.

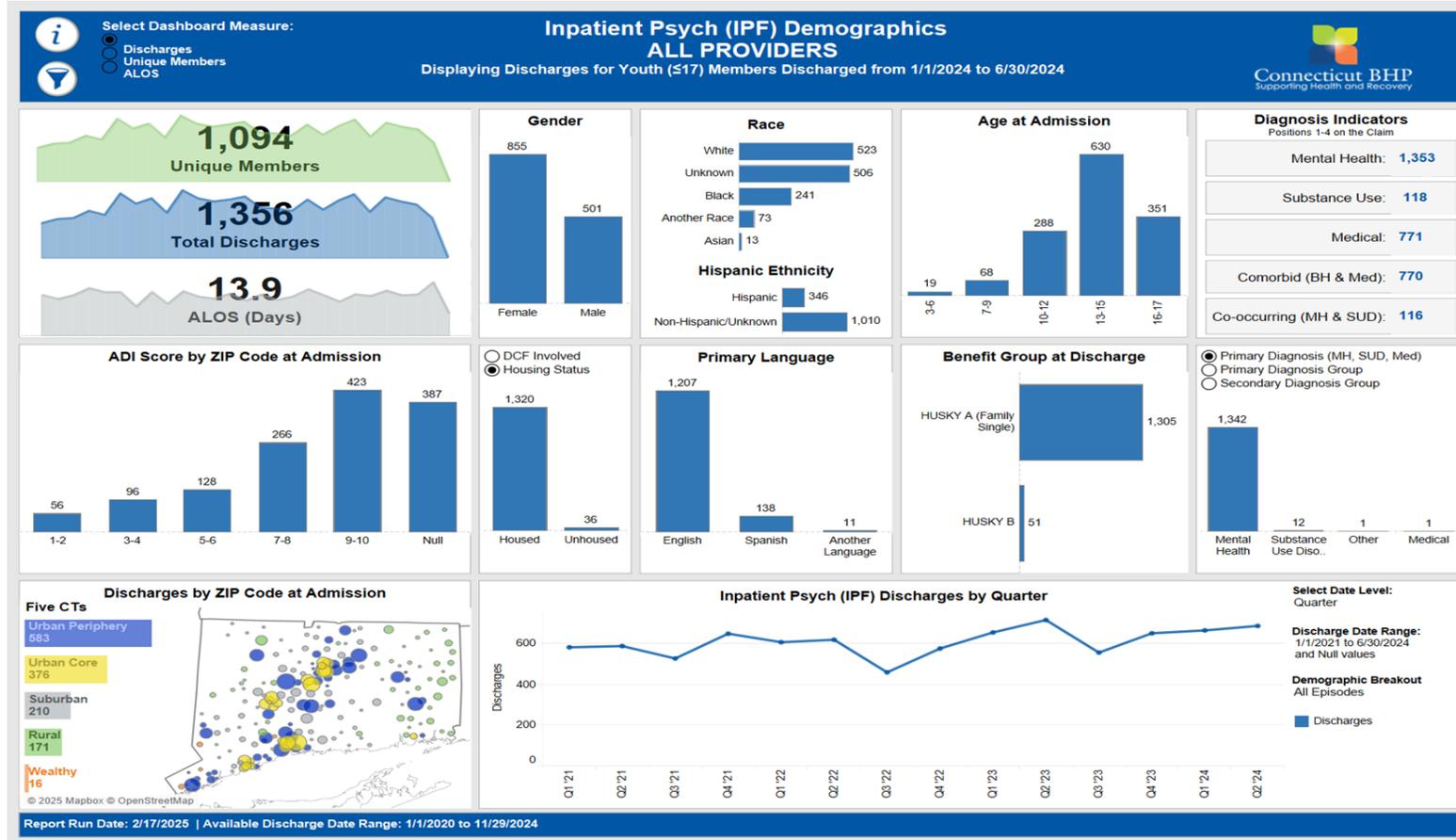
Population Profile: Interactive dashboard providing an annual snapshot of CT Medicaid diagnoses, utilization, and costs with a health equity lens



Overview of Provider Analysis Reporting (PAR) Dashboard: IPF

Provider Analysis Reporting (PAR) Dashboards:

- Dynamic responsive filters include demographics for a health equity lens
- Demographics pulled from Medicaid eligibility, service data pulled from authorizations
- Quality RNMs partner with providers to review interactive PAR dashboards and share profiles to drive engagement through data and improve clinical quality consistency
- Collaborative insight-oriented data presentations delivered through a cross-departmental collaboration
- Outcomes from PAR include reduction of 7-day and 30-day IP readmission rates for youth, and decreased volume of youth awaiting placement from IP



Chapter

07

Health Equity

Promoting Health Equity Highlights

- **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:**
 - development of the ASO's health equity strategy and monitoring of related activities

Chapter

08

Key Takeaways

Key Takeaways

- **During the annual review period ending 2024, HUSKY Health membership exceeded 1,100,000.** Of these, approximately 65% were adults and 35%, youth.
- **Approximately 30% of HUSKY Health members accessed behavioral health (BH) services in 2024.**
- **PMPM costs rose by over 10% for both youth and adults in 2024.**
- **Despite expansion of the CT BHP provider network by nearly 40% from 2020 to 2024, members still experience access issues.** This highlights the need for increased capacity by the network.
- **There is a significant portion of members with unknown race and ethnicity information. In order to address health disparities in BH access, Carelon BH CT will continue to research and seek ways to enhance its data such as incorporating Area Deprivation Index (ADI) (see Appendix).**
- **We will continue to enhance service accessibility and the efficiency of care** through utilization management (UM) initiatives, care management (CM) activities, inpatient/ED provider workgroups, and the PAR programs to manage system throughput.

Chapter

09

Questions

Thank You

Contact Us

- Krista Noam, PhD, AVP of Analytics and Innovation
 - KristaNoam@carelon.com
- Erika Sharillo, LCSW, SVP of Clinical Operations and Recovery
 - Erika.Sharillo@carelon.com

 877-552-8247

 www.ctbhp.com

 CTBHP@carelonbehavioralhealth.com

Chapter

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Appendix

- HEDIS
- Health Equity

2023 Annual HEDIS® Rates Summary (1 of 2)

How is Connecticut HUSKY Health performing year-over-year?										Comparison to National/New England Rates		
Measure Abbr & Measure Name	Measure Subset	Measure Age Group	2021	2022	2023	CT Annual Change			2021	2022	2023	
						2021	2022	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

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			Comparison to National/New England Rates		
			2021	2022	2023	2021	2022	2023	2021	2022	2023	2021	2022	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

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- ↓ Declined Rate from Previous Year*
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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

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/>

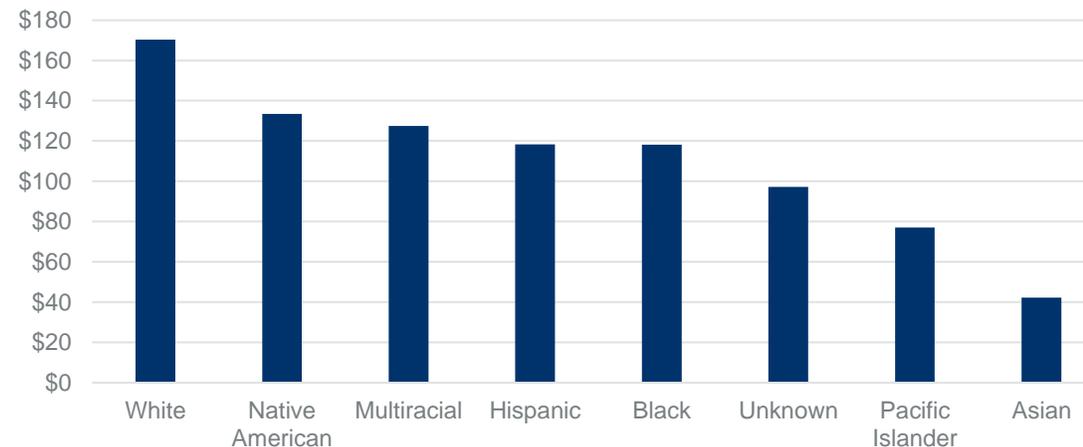
Identifying Health Disparities: Data Analysis

- 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.

Membership vs. BH Claims Cost by Race



PMPM (\$)



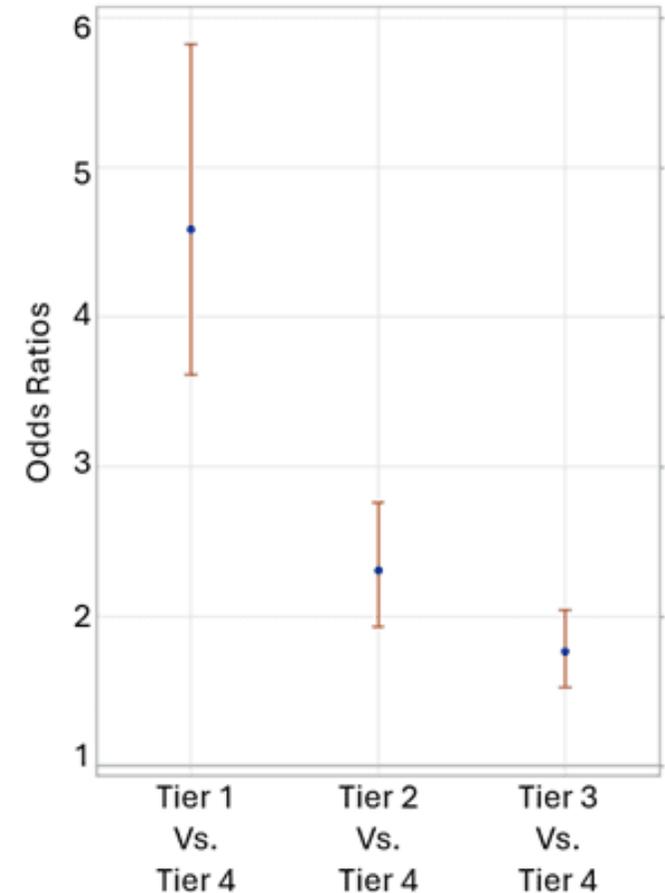
Identifying Health Disparities: Pharmacy Analysis

- 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.

Race	Proportion of HUSKY Health Members (%)	Antidepressant		Antipsychotics		Medications for Opioid Use (MOUD)	
		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

Identifying Disparities: Follow-up After Hospitalization (FUH)

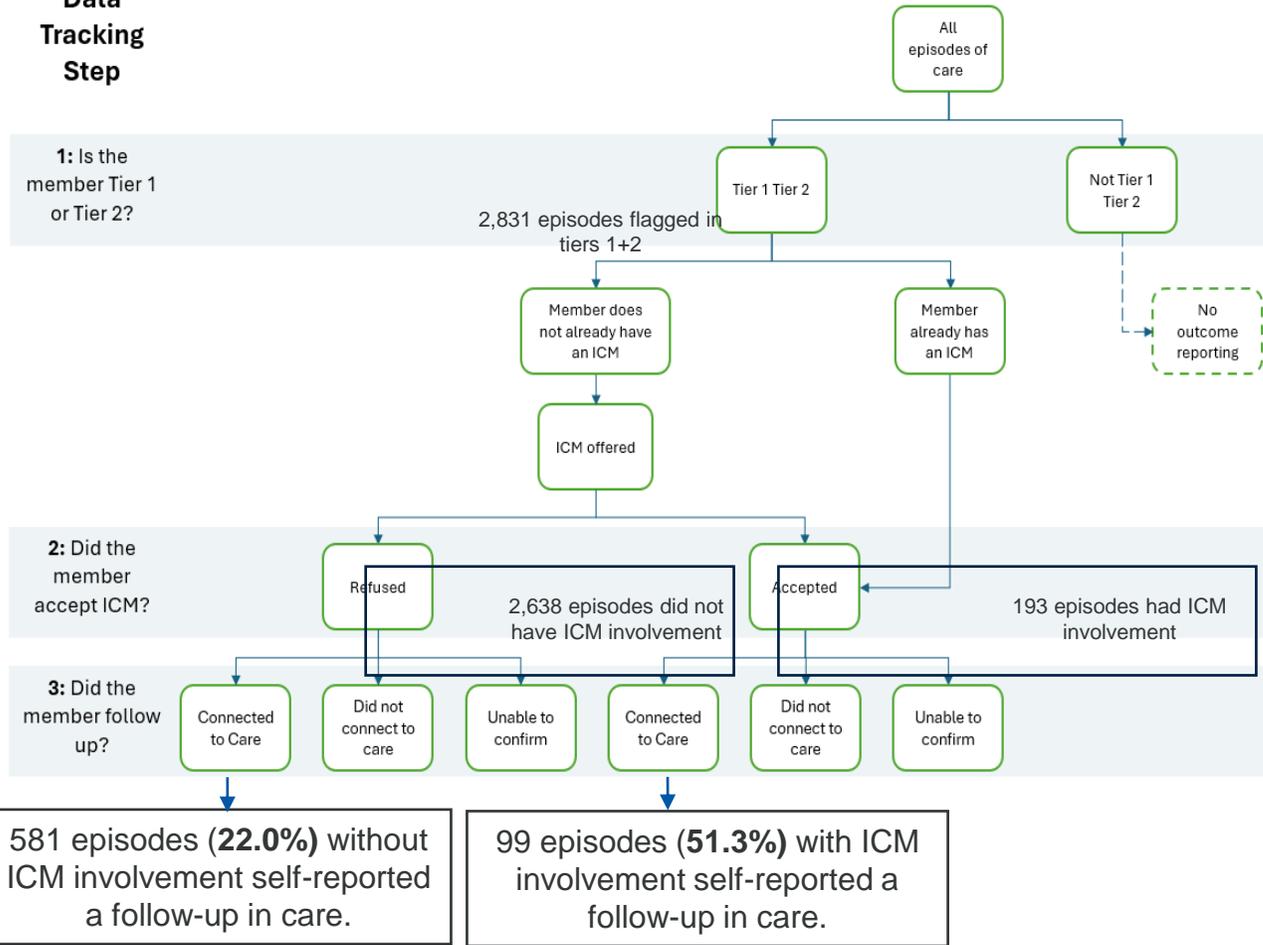
- Timely follow-up after inpatient psychiatric admission is regarded as a standard of excellence in clinical practice. To inform member, provider, and system interventions, Carelon BH CT developed a predictive model to identify HUSKY Health members at heightened risk of not receiving follow-up care after 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.



Addressing Disparities: Aftercare Follow-up (AFU) Program

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

Data Tracking Step



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**

