Connecticut Behavioral Health Partnership (CT BHP) 101

Behavioral Health Partnership Oversight Council – March 11, 2026

Introductions

Carrie Bourdon, LCSW

Chief Executive Officer, CT BHP Division

Carelon BH CT

Paulo Correa, MD

Medical Director,

Carelon BH CT

Erika Sharillo, LCSW

SVP, Clinical Operations & Recovery,

Carelon BH CT

Bonni Hopkins, PhD

SVP, Quality, Analytics & Innovation,

Carelon BH CT

Agenda

1 CT BHP Overview

2 Providers Access & Support

3 Member Engagement

4 Utilization

5 Quality Analytics & Innovation

6 Impact: Examples of Outcomes

7 Key Takeaways

8 Questions

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).

- The Behavioral Health Partnership Oversight Council and its subcommittees have been codified in statute as an advisory body.

- Through this work, true provider partnerships have 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 behavioral health (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 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 substance use disorder (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 Inpatient Psychiatric Bypass Programs, in addition to efforts to bolster bed capacity and availability of acute care for youth through add-on payments.

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 (CM), intensive care management (ICM), 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

Innovative Clinical Offerings

CURRENT OFFERINGS

Proactive Engagement Program (PEP)

In October 2025, Carelon BH CT became the first Carelon contract to implement PEP, 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, program staff assess and identify the acute needs and make appropriate referrals to programs and providers within the member's community.

Intensive Care Management

- Child ICM continues to 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 levels of care (LOC)

Specialty Populations

- Continued development of specialty population management and UM via predictive analytics

Integrated Physical Health/ Behavioral Health Care

- Additional integrated care strategies/ programs

Chapter

02

Provider Access & Support

CT BHP Behavioral Health Provider Types and Specialties

380+ Facilities, 1,600+ Practice Locations

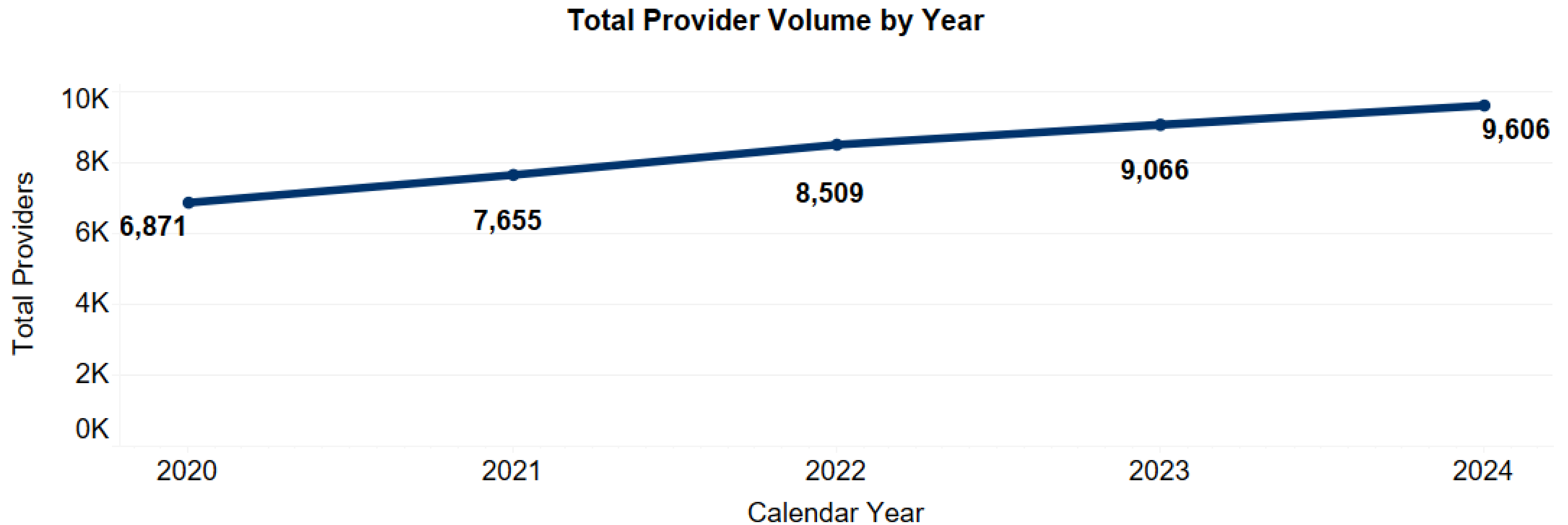
- hospitals
- mental health/medical outpatient clinics (including enhanced care clinics (ECCs)), rehabilitation centers, school-based service centers, and youth urgent crisis centers (UCCs)
- alcohol and drug treatment centers (including withdrawal management, intensive outpatient (IOP) programs, outpatient)
- 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)

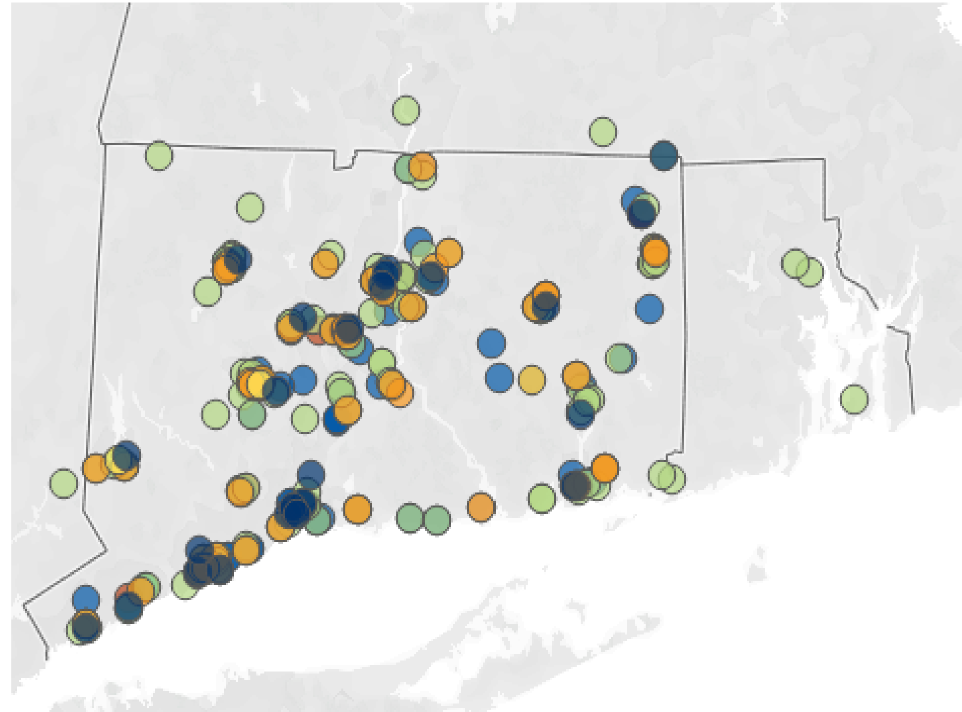
CT BHP Provider Network Growth

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 Network for Medications for 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.



- Methadone Clinic
- Partial Hospital/IOP with Housing
- Intensive Outpatient (IOP)
- Behavioral Health Outpatient
- Behavioral Health Outpatient/Intensive Outpatient (IOP)
- Partial Hospitalization (PHP)
- 3.1 Clinically Managed Low-Intensity Residential Services
- 3.5 Clinically Managed High-Intensity Residential Services
- 3.5 Resi Pregnant & Parenting Women and Children's Programs
- 3.7 Co-Occurring Enhanced
- 3.7 Medically Monitored Intensive Inpatient Services
- Walk-In Access Center
- Medical
- SA 3.1R - Halfway House (3 to 4 months)

[Medications for Substance Use Disorders Medicaid Provider Locator Map | Tableau Public]

CT BHP Provider Education and Support

Communications

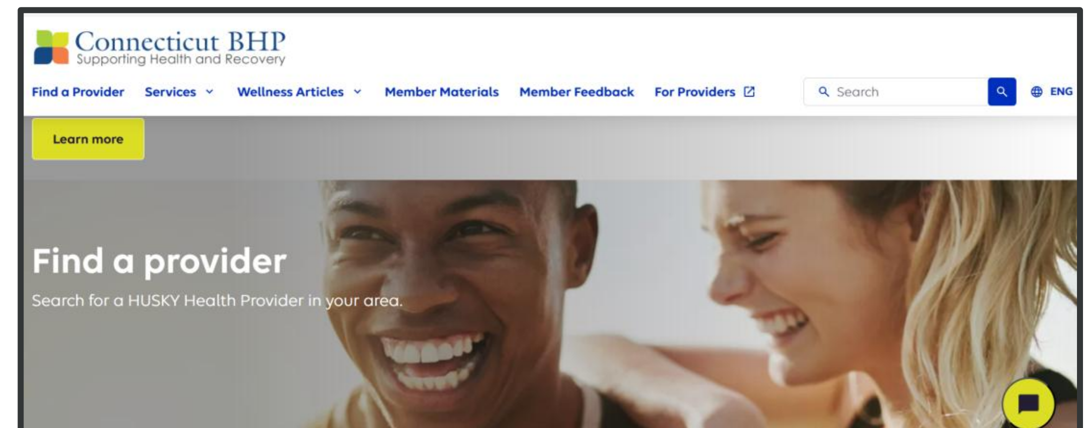
- Bulletins, newsletters
- User manual
- Provider & member handbooks
- ProviderConnect registration
- Level of care guidelines
- Find providers feature
- Member brochures
- Regional & national resources
- FAQs
- Achieve Solutions member articles

Training

- ProviderConnect, ClientConnect, BedTracking/MTPPR (Multi-Tiered Prior Authorization Process)
- Telephonic assistance
- Web conferencing
- **CT BH(el)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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Chapter

03

Member Engagement

CT HUSKY Health Membership Context

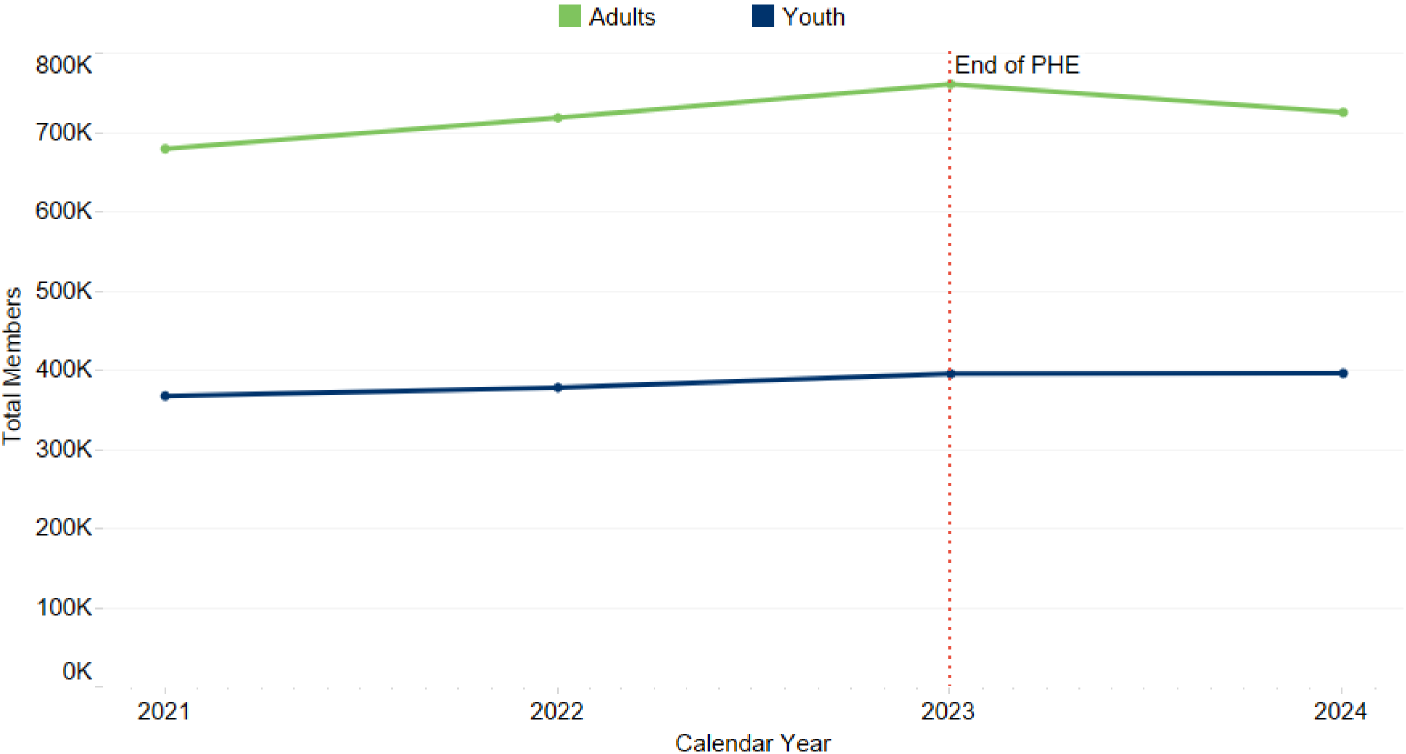
- HUSKY Health had 1,122,632 members in 2024, including those who were dually eligible for Medicaid and Medicare/commercial. This was a slight decrease (-3.0%) compared to 2023, when there were 1,157,582 HUSKY Health members.

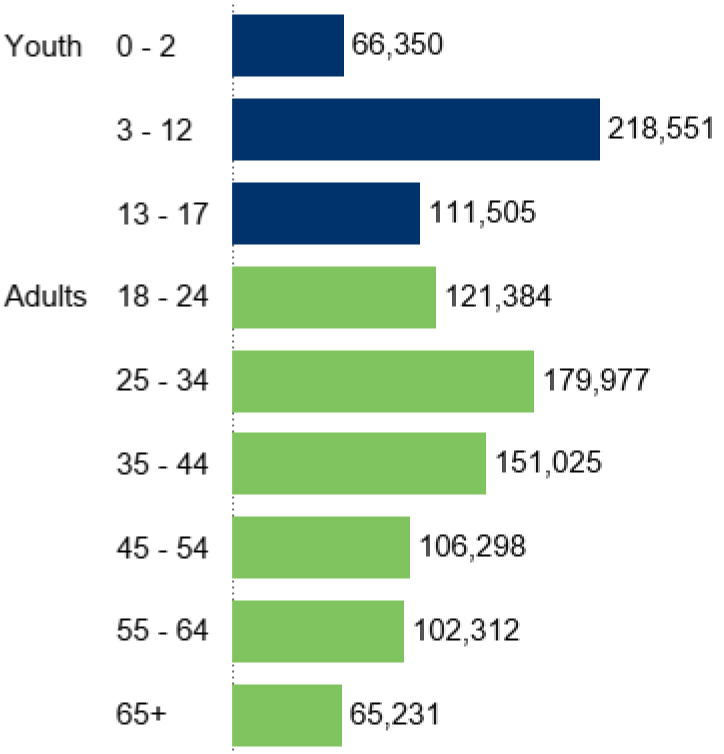
- The membership in 2024 was still 12.6% higher than in 2019 (*N* = 996,921) before the COVID-19 pandemic and declaration of the Public Health Emergency (PHE).

- 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, 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

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Community
Health Network
of Connecticut, Inc.™

HUSKY Health Program – Community Meeting

Autism Services & Resources Connecticut
at Clifford Beers Community Health Partners

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Chapter

04

Utilization

Behavioral Health 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.*

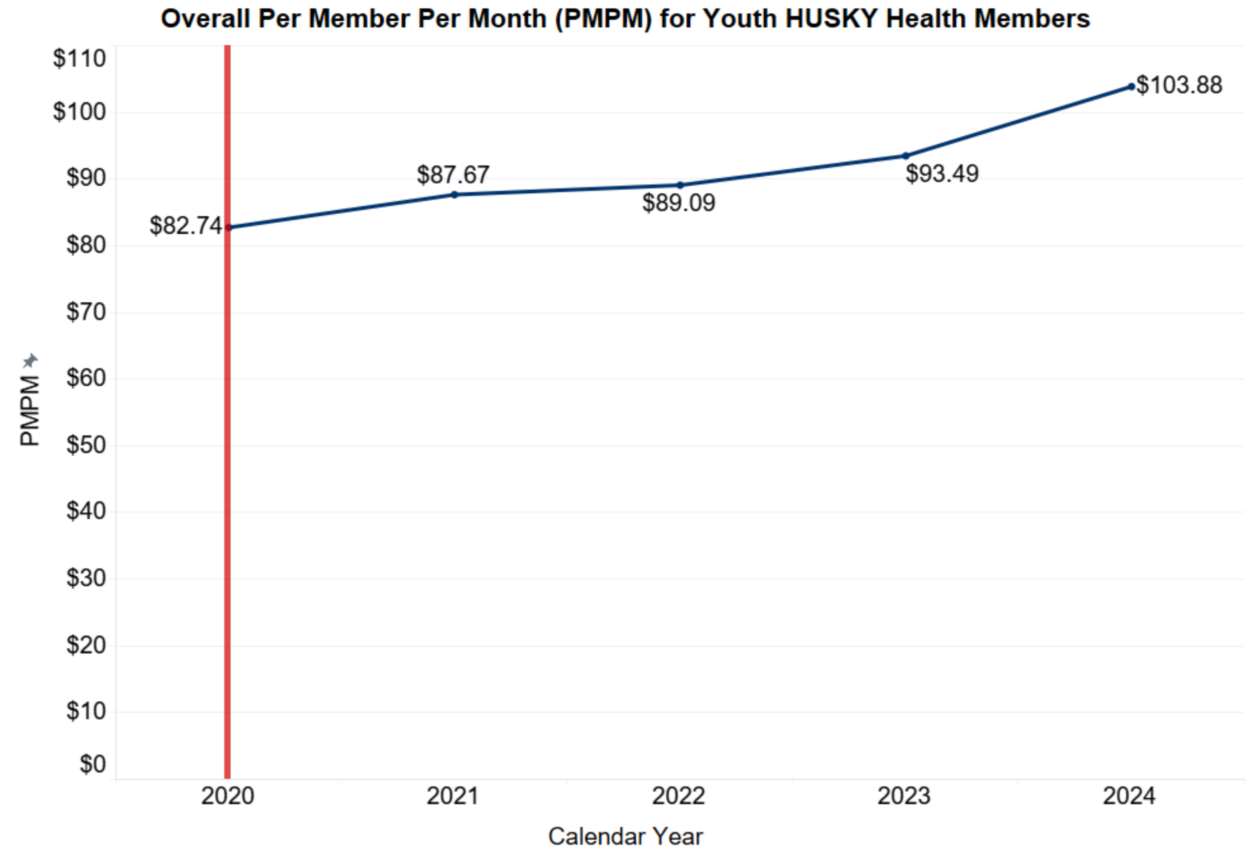
Behavioral Health Utilization Management (UM)

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

- inpatient psychiatric facilities
- psychiatric residential treatment facilities
- 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
- mental health group homes
- partial hospitalization (SUD-PHP and MH-PHP)
- intensive outpatient (SUD-IOP and MH-IOP)
- methadone maintenance treatment
- outpatient treatment
- extended day treatment
- enhanced care clinics
- autism spectrum disorder services
- home health services
- intensive in-home services
  - IICAPS (intensive in-home child and adolescent psychiatric services)
  - MDFT (multidimensional family therapy)
  - MST (multisystemic therapy)
  - FFT (functional family therapy)

Youth Behavioral Health Cost*

- The total expenditure for BH services by all HUSKY Health youth 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.

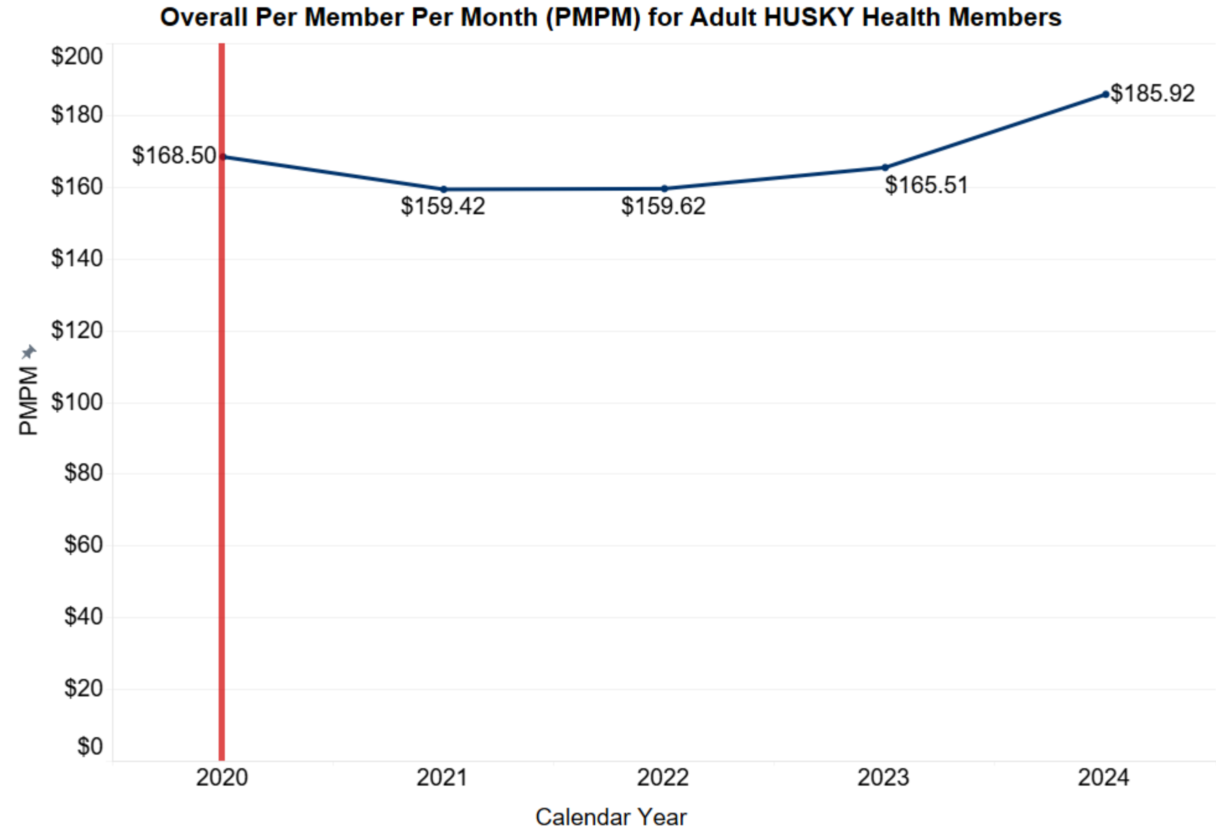


The red line represents the start of the COVID-19 pandemic effects in Connecticut.

**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.*

Adult Behavioral Health Cost*

- The overall BH 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 at a state institution or psychiatric hospital, 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

05

Quality Analytics & 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.

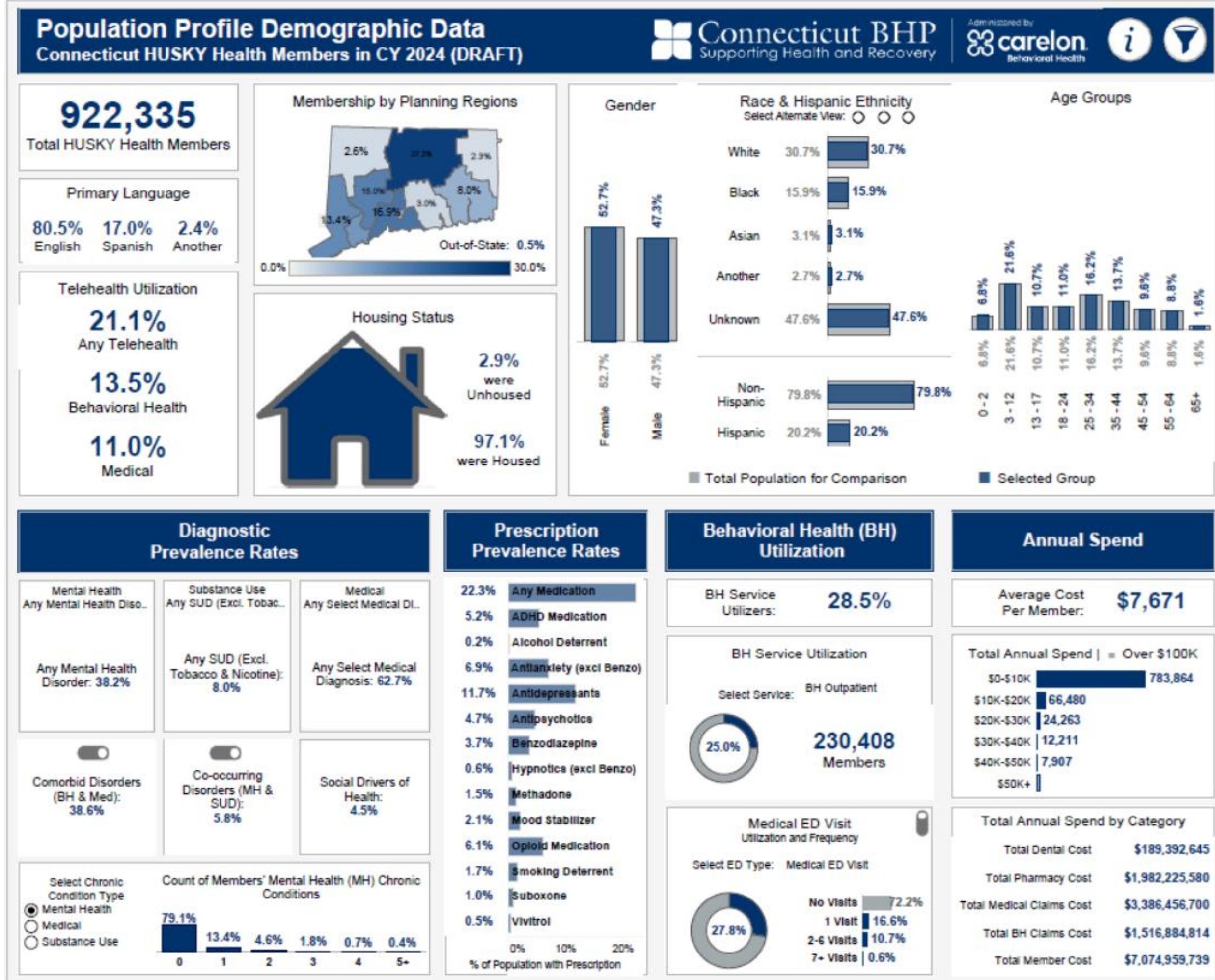
Operational Responsibility	Description
Quality Metrics and Utilization Indicators	Implements standardized quality measures, including the Healthcare Effectiveness Data and Information Set (HEDIS®) and those required by the Centers for Medicare & Medicaid Services (CMS). This responsibility also involves tracking key utilization indicators such as admissions, discharges, average length of stay, 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*. 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.

**In 2024, Carelon BH CT shifted from "social determinants of health" to "social drivers of health" to emphasize that the conditions and environments where someone lives affect their health and quality of life but are not fixed or unchangeable.*

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 and medications for alcohol use disorder 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

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



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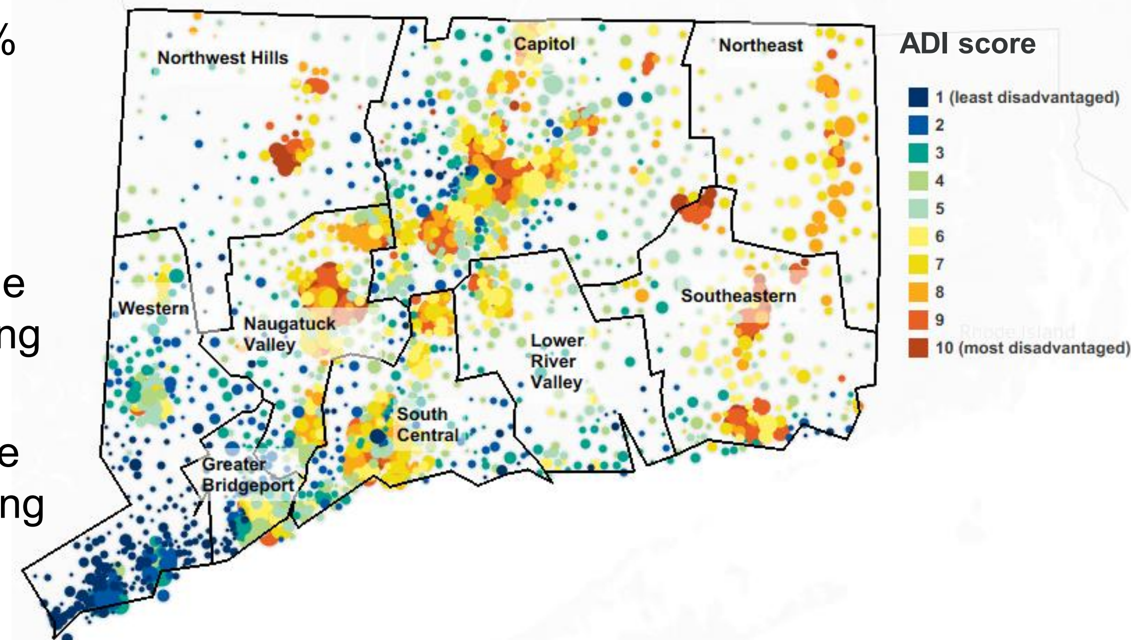
Promoting Health Equity: Area Deprivation Index (ADI)

- **ADI Scoring System:**
  - The ADI is a scientifically validated tool maintained 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 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.

CT Planning Regions Map with HUSKY Health Members by ADI Score

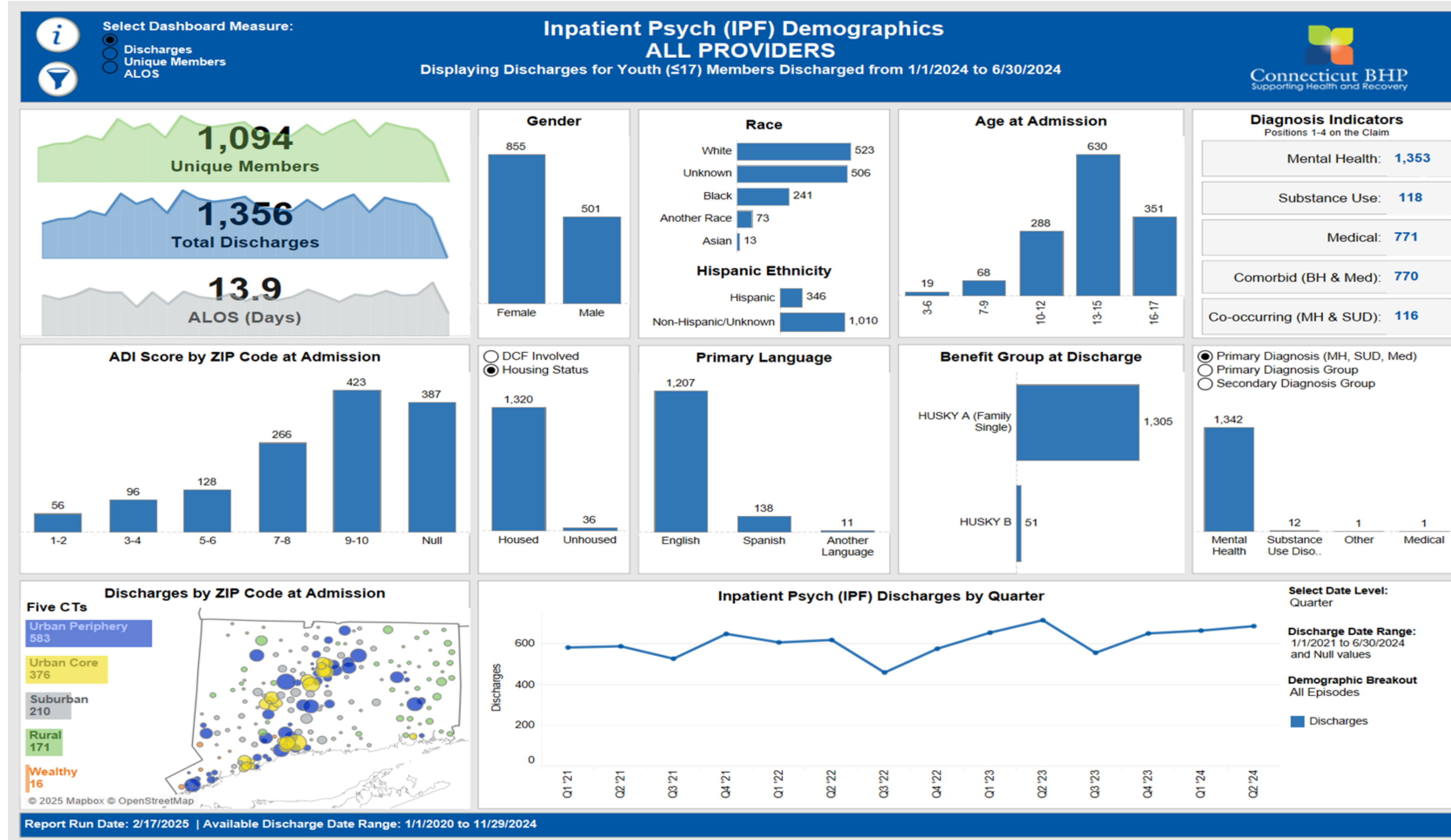


* https://www.neighborhoodatlas.medicine.wisc.edu/

Overview of Provider Analysis Reporting 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 regional network managers (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 inpatient psychiatric (IP) readmission rates for youth, and decreased volume of youth awaiting placement from IP



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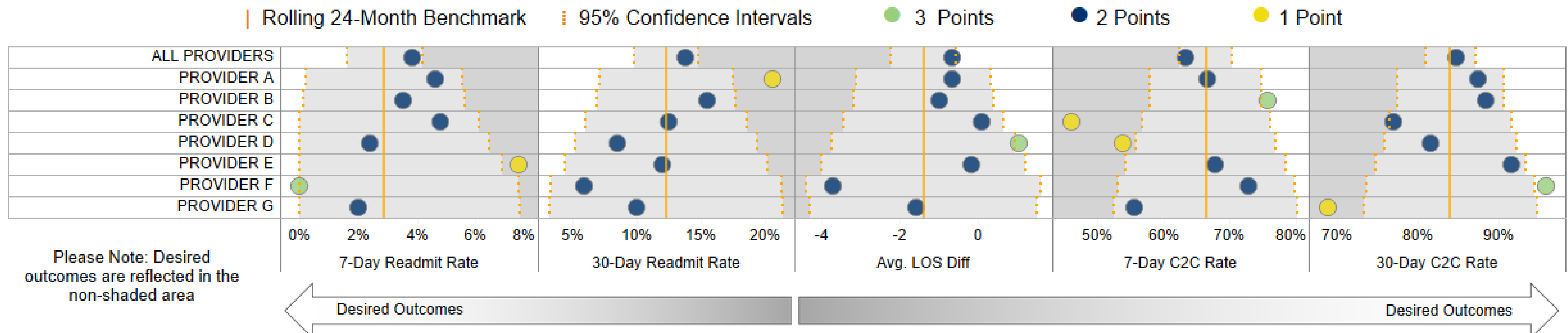
Pediatric Inpatient Psychiatric Value-Based Payment (VBP): Building on Bypass Program and Quality Metric Performance

- **Program Overview**
  - The goal of the voluntary CT VBP for pediatric inpatient psychiatric (IP) services is to incentivize providers to enhance the quality of care they provide, to reduce unnecessary costs, and to improve the members' health outcomes.
  - The VBP model is based on the principle that providers are reimbursed according to the quality of care delivered, rather than the number of services provided.
  - Carelon BH CT developed a proposed methodology based on a tiered system that reflects providers' performance on five key quality measures, building on the longstanding CT Bypass Program.
  - Providers' performance will be measured against the statewide average, with scores allocated for each metric, leading to an annual tier assignment based on the scores they earned.
  - In the proposed model, performance from a prior period will determine upside-only enhanced payment in a future period. https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb2024_67.pdf&URI=Bulletins/pb2024_67.pdf



Standardized Quality Measures: CMS Adult and Child Core Sets

- CMS developed a standardized group of health care quality measures used by states to monitor and improve the quality of care for people on Medicaid or the Children's Health Insurance Program (CHIP). They incorporate measures from the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA).
- In 2025, Carelon BH CT transitioned its voluntary audit from a HEDIS®-based approach to a CMS-based approach, and we adopted CMS age-group breakouts to better align with the CMS Adult and Child Core Sets and enable more accurate rate comparisons. We retained one HEDIS measure—POD—to continue monitoring medication-assisted treatment (MAT) adherence among our members.
- We create an annual dashboard to compare performance to the regional New England rates and the national rates, and allows trending across time with a health equity lens.
- A pharmacy analysis* using standardized 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 (please visit link for details: https://natcon2025.ipostersessions.com/Default.aspx?s=BD-13-03-41-A5-7B-42-D7-B8-2F-60-09-22-8F-A2-33)*

2024 Annual CMS Adult and Child Core Sets Summary (1 of 2)

How is Connecticut HUSKY Health performing year-over-year? | CT Annual Change | Comparison to HEDIS National / New England Rates

Measure Abbr & Measure Name	Measure Subset1	Measure Age Group	2022	2023	2024	CT Annual Change 2022	CT Annual Change 2023	CT Annual Change 2024	Comparison 2022	Comparison 2023	Comparison 2024
ADD: Follow-up for Children Prescribed ADHD Medication	Initiation	6-12	46.3%	45.4%	44.8%	↑	↓	↓	● (green)	● (green)	● (red)
	Continuation	6-12	54.8%	49.9%	50.8%	↑	↓	↑	● (green)	◑	● (red)
AMM: Antidepressant Medication Management	Effective Acute Phase Treatment	Total (18+)	64.0%	64.9%	66.7%	↓	↑	↑	◑	◑	◑
	Effective Continuation Phase Treatment	Total (18+)	46.3%	47.5%	49.3%	↓	↑	↑	◑	◑	◑
APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics	Blood Glucose Testing	Total	49.7%	49.6%	52.4%	✱	◆	↑	● (red)	● (red)	● (red)
	Cholesterol Testing	Total	34.5%	35.7%	37.7%	✱	↑	↑	● (red)	● (red)	● (red)
	Blood Glucose and Cholesterol Testing	Total	32.7%	33.6%	35.3%	✱	↑	↑	● (red)	● (red)	● (red)
APP: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Total Rate	Total	78.4%	75.2%	79.1%	↓	↓	↑	● (green)	● (green)	● (green)
CDF: Screening for Depression and Follow Up Plan	Total Rate	Total (12-17)	4.3%	10.7%	12.5%	✱	↑	↑			○
		Total (18+)	1.6%	2.9%	5.0%	✱	↑	↑			○
FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	7-Day	Total	36.0%	31.4%	35.0%	↑	↓	↑	◑	◑	◑
	30-Day	Total	50.6%	44.1%	47.4%	↑	↓	↑	◑	◑	◑
FUH: Follow-Up After Hospitalization for Mental Illness	7-Day	Total (6+)	45.8%	44.2%	45.4%	↓	↓	↑	● (green)	◑	◑
	30-Day	Total (6+)	66.8%	65.0%	66.9%	↓	↓	↑	● (green)	◑	◑

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

- ● (green) 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
- ● (red) CT was less favorable than both comparison rates
- ◆ Either the regional or national comparison rates was unavailable
- ○ Comparison rates unavailable

Please note:
NCQA does not publish regional and national benchmarks for last year's measures.

2024 Annual CMS Adult and Child Core Sets Summary (2 of 2)

How is Connecticut HUSKY Health performing year-over-year? | CT Annual Change | Comparison to HEDIS National / New England Rates

Measure Abbr & Measure Name	Measure Subset1	Measure Age Group	2022	2023	2024	CT Annual Change 2022	CT Annual Change 2023	CT Annual Change 2024	Comparison 2022	Comparison 2023	Comparison 2024
FUM: Follow-Up After Emergency Department Visit for Mental Illness	7-Day	Total (6+)	47.0%	47.8%	51.3%	↓	↑	↑	◑	◑	◑
	30-Day	Total (6+)	61.5%	62.3%	65.6%	↓	↑	↑	◑	◑	◑
HPCMI: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1C (HBA1C) Poor Control (>9.0%)	Total Rate	Total (18-75)	95.9%	93.5%	88.5%	✳	↓	↓			○
IET: Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	Initiation	Adolescents (13-17)	39.7%	39.6%	40.0%	↓	◆ (orange)	◆ (orange)	◑	◑	◑
		Adults (18-64)	44.3%	45.9%	53.9%	✳	↑	↑	● (red)	◑	● (green)
		Adults (65+)	39.2%	41.9%	36.8%	✳	↑	↓	◆	◑	◆
		Total	44.1%	45.6%	53.3%	↑	↑	↑	● (red)	◑	● (green)
	Engagement	Adolescents (13-17)	21.5%	22.5%	21.4%	↓	↑	↓	● (green)	● (green)	● (green)
		Adults (18-64)	24.9%	25.4%	33.6%	✳	↑	↑	● (green)	● (green)	● (green)
		Adults (65+)	9.7%	9.7%	8.3%	✳	◆ (orange)	↓	◆	● (green)	◆
		Total	24.6%	25.1%	32.9%	↑	↑	↑	● (green)	● (green)	● (green)
OUD: Use of Pharmacotherapy for Opioid Use Disorder	Total Rate	Total (18+)	72.2%	73.8%	76.5%	✳	↑	↑			○
POD: Pharmacotherapy for Opioid Use Disorder	Total Rate	Total	35.0%	33.6%	32.5%	↓	↓	↓	● (green)	● (green)	◑
SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Total Rate	Total (18-64)	65.1%	66.2%	68.1%	◆ (orange)	↑	↑	◑	◑	◑
SSD: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Total Rate	Total	74.6%	75.9%	78.2%	✳	↑	↑	● (red)	● (red)	● (red)

Key for Connecticut Trend Comparisons
- ↑ Improved Rate from Previous Year*
- ↓ Declined Rate from Previous Year*
- ◆ (orange) No Change from Previous Year (less than 0.5% change)
- ✳ Previous Year Not Available For Comparison

Key for National & New England Average Rate Comparisons
- ● (green) 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
- ● (red) 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:
NCQA does not publish regional and national benchmarks for last year's measures.

Chapter

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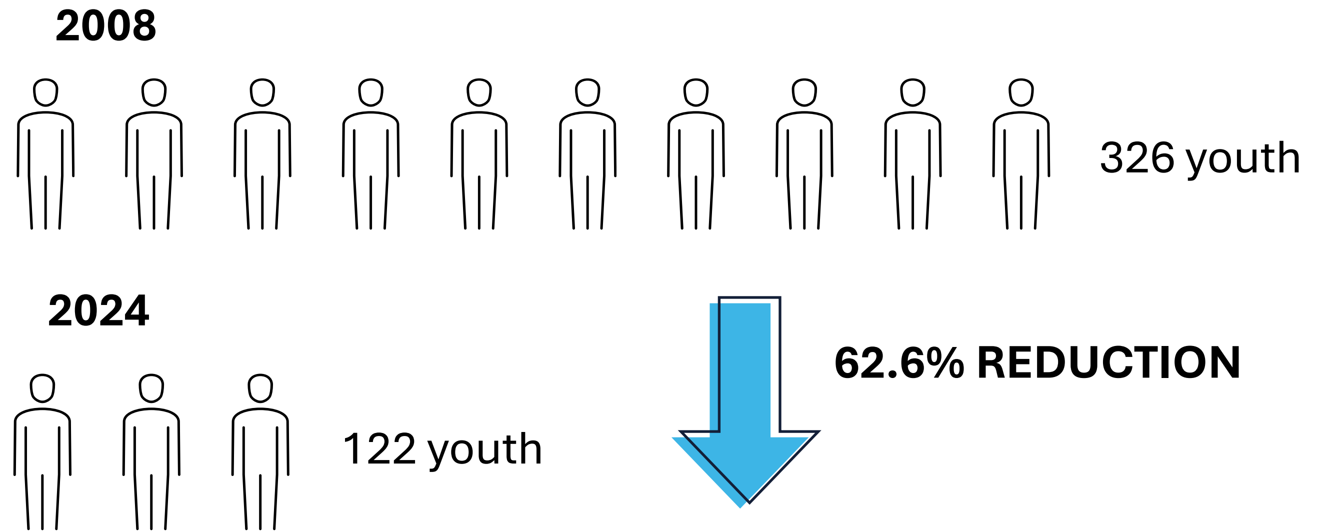
Impact: Examples of Outcomes

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.



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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 %

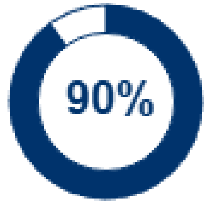
2024 7-Day Readmission

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.

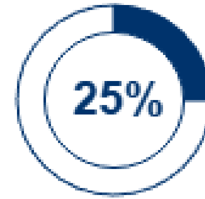
Changing Pathways

- Launched in 2018, Changing Pathways is designed to start individuals with Opioid Use Disorder (OUD) on Medications for Opioid Use Disorder (MOUD) during withdrawal management and connect them to an MOUD provider prior to discharge. In 2024, there were seven ASAM 3.7 WM alcohol and drug treatment center providers, and all have adopted the Changing Pathways model.
- Members who were initiated and adhered to 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.*

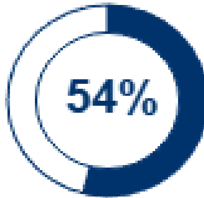


reduction in the percent of members with an overdose

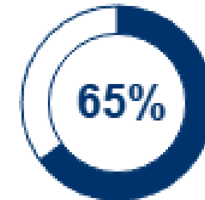
The percent of members with overdose was 0.8% in the 90 days after treatment initiation compared to 8.2% in the 90 days prior.



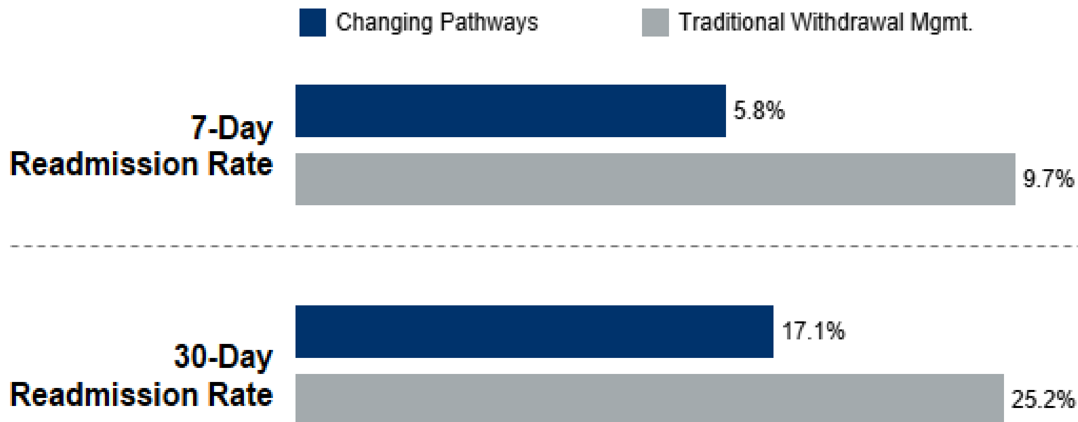
reduction in the average number of inpatient days per member



reduction in the average number of BH ED visits per member



reduction in the average number of withdrawal management episodes per member



MOUD Adherence Rate of Members Initiated vs. Non-Initiated During an IPF Episode in 2024

*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.

1115 Substance Use Disorder (SUD) Demonstration Waiver

- The 1115 SUD waiver is a special Medicaid program approved by CMS-allowing CT to expand and redesign how Medicaid covers SUD treatment. With it, the state covers the full continuum of SUD treatment, aligned with ASAM Levels of Care 1-4, including:
  - Outpatient and intensive outpatient (ASAM 2.1)
  - Partial hospitalization (ASAM 2.5)
  - Inpatient/residential treatment (ASAM 3.7- 3.1)
  - Inpatient withdrawal management (ASAM 4.0)

- Inpatient/residential providers can be reimbursed if they meet waiver standards. Programs must meet certification and quality requirements tied to ASAM criteria.
- CT BHP is supporting this exciting program in these ways, and more: 1) developing data analytic capabilities to report on the utilization of inpatient and residential levels of care for SUD treatment; 2) implementing a new Provider Analysis and Reporting (PAR) program for the levels of care newly covered under HUSKY Health; and 3) promoting and supporting provider education and public awareness on topics related to SUD.
- Through this work, the Partnership is helping translate federal waiver authority into practical support, education, and resources that enable providers to deliver, document, and get reimbursed for high-quality SUD care under the expanded Medicaid benefit.

Adult ASAM 3.7 to 3.1 Inpatient/Residential Service Utilization

- Carelon BH CT authorized six different inpatient/residential services (ASAM 3.7 to 3.1) under the implementation of the 1115 SUD waiver.
- While the ALOS for ASAM 3.7 service remained stable, the ALOS for the other services decreased between 2023 and 2024.

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

Inpatient/Residential Service	CY 2023 Discharges	CY 2024 Discharges	CY 2023 ALOS	CY 2024 ALOS
Medically monitored co-occurring enhanced inpatient services (ASAM 3.7 E)	561	767	28.6	19.7
Medically monitored intensive inpatient services (ASAM 3.7)	2,750	2,901	20.5	20.4
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

Chapter

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Key Takeaways

Key Takeaways

- **Approximately 30% of HUSKY Health members accessed behavioral health 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).
- **We will continue to enhance service accessibility and the efficiency of care** through utilization management initiatives, care management activities, inpatient/ED provider workgroups, and the PAR programs to manage system throughput.
- **Changing Pathways helped to transform the treatment approach of OUD**, promoting early adoption of MOUD in the process of recovery. This has resulted in better outcomes for individual members and the overall utilization of SUD services.
- **The implementation of the 1115 SUD waiver created a comprehensive continuum of SUD services for HUSKY Health members**, integrating key inpatient and residential levels of care into the network.

Chapter

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Questions

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Thank You

- Carrie Bourdon, LCSW, CEO, CT BHP Division
    - Carol.Bourdon@carelon.com
- Erika Sharillo, LCSW, SVP, Clinical Operations & Recovery
    - Erika.Sharillo@carelon.com
- Paulo Correa, MD, Medical Director
    - Paulo.Correa@carelon.com
- Bonni Hopkins, PhD, SVP, Quality, Analytics & Innovation
    - Bonni.Hopkins@carelon.com

877-552-8247

www.ctbhp.com

CTBHP@carelonbehavioralhealth.com