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Behavioral Health Care in HUSKY A Before and After Implementation of Connecticut's Behavioral Health Partnership: Children and Adults with Diagnosed Mental Conditions

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KEY FINDINGS

In January 1, 2006, the Connecticut Behavioral Health Partnership, an administered fee-for-service Medicaid program, was created with the goal of improving access to care by providing beneficiaries with a coordinated and effective system of community-based behavioral health services and support for individuals who need care. Prior to 2006, behavioral health services for children and families were provided along with all other health services in a risk-based Medicaid managed care program.

In this report, the prevalence of diagnosed mental disorders among children and adults in HUSKY A (Medicaid) is described for 2012 and 2013 (post-carve-out; study period) and compared to treatment prevalence in 2004 and 2005 (baseline period), the two calendar years preceding the program changes. Between those time periods, enrollment in the HUSKY Program increased significantly. We found that:

Utilization of behavioral health services increased significantly.

- The number and the percentages of children and adults who received behavioral health services were far greater in the study period (2012, 2013) than the baseline period (2004, 2005).
- The increase in utilization was evident in all age, racial/ethnic, primary language, and residential groupings.
- The distribution of diagnosed mental disorders across diagnostic groupings was relatively unchanged except for declines in the proportions of children with diagnosed anxiety disorder and adults with diagnosed mood disorders.

CONCLUSIONS & PLANS FOR FURTHER STUDY

Two important caveats affect interpretation of these findings: First, *treatment prevalence does not equal actual prevalence of mental disorders; only those who received any care are counted for the estimate.* Second, *trends in prevalence or service utilization observed over time may be related to but cannot be directly attributed to program changes.* However, these findings are consistent with anecdotal reports and quantitative data reported by the Connecticut Behavioral Health Partnership that show increased availability of timely, community-based services. These findings are also consistent with results of a recently published study of behavioral health services in 20 other Medicaid programs over roughly the same time period: enrollment increased and mental disorder diagnoses increased. Those researchers documented a similar rise in asthma diagnoses and pointed to the "importance of poverty as a factor contributing to the increasing rates of mental disorders [and asthma] in children."

Next, we will examine and report on behavioral health services in terms of changes in the distribution of services and prescribing patterns, if any, over time for children and adults in HUSKY A.

INTRODUCTION

Good mental health is essential to personal well-being and fulfilling relationships in families and communities.[1] It is fundamental to success in school, in the workplace and in society at large. When individuals and families are faced with change and challenges, good mental health is essential for adaptation and coping.

A significant proportion of the US population, however, suffers from mental, emotional and behavioral disorders that disrupt interpersonal relationships and age-appropriate functioning. Data from the 2007 National Comorbidity Survey show that nationwide, almost one in three adults age 18 and over (32.4%) report diagnosable mental health problems in a given 12-month period. The prevalence of these disorders includes 19 percent with anxiety disorders, 10 percent with mood disorders, 10 percent with problems related to impulse control, and more than 13 percent with any substance abuse problems (alcohol and drug abuse, nicotine dependence).[2] For adolescents in low income families (less than 150 percent of the federal poverty level), the prevalence of these disorders is even higher than it is for all adults: 48 percent report any disorder at all, including 35 percent with anxiety disorders, 12 percent with mood disorders, 29 percent with impulse control disorders, and 9 percent with substance abuse problems.[3] Among the adolescents surveyed, over 18 percent had three or more co-occurring disorders. The prevalence of mental health problems is even greater for children living in poor and low income families and these problems are more likely to be severe.[4]

Mental, emotional and behavioral disorders range from relatively minor or time-limited problems to totally incapacitating chronic disability or death. These impairments can have both direct and indirect effects on physical health by either precipitating or contributing to or exacerbating co-morbid conditions. Mind and body are in fact "inseparable," despite long-held misperceptions that gave rise to separate treatment systems and stigma that linger today.[5]

For those with mental disorders and substance abuse, effective mental health interventions offer hope for recovery.[6] High-quality care should be safe, effective and patient-centered, timely, efficient and equitable. For individuals and families who rely on publicly-funded health care programs, however, these objectives may be elusive. In two recent reports to Congress, the US Government Accountability Office (GAO) described the challenges faced by states in providing mental health services for those seeking care. Federal law requires that State Medicaid programs provide coverage for children's health services, including mental health care, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program; however, physicians report difficulties referring children for mental health services.[7] The GAO's analyses of national survey data show that about 14 percent of children in Medicaid needed mental health services, compared with 9 percent of privately insured children; however, about 80 percent of children who needed services, regardless of coverage type, did not get care.[8] For low income adults, Medicaid is the

[1] US Department of Health and Human Services. Healthy People 2020. Available at: www.healthypeople.gov.
[2] National Comorbidity Survey. Table 2. 12-month prevalence of DSM-IV/WMH-CIDI disorders by sex and cohort (n=9282). Available at: www.hcp.med.harvard.edu/ncs/
[3] National Comorbidity Survey. Appendix 27. Lifetime (LT), 12-month, and 30-day prevalence estimates and 12-month/LT and 30-day/12-month prevalence ratios of DSM-IV/CIDI disorders among adolescents with low family income in the NCS-A (n=1717). Available at: www.hcp.med.harvard.edu/ncs/ Note: low income was defined as less than 1.5 times the official federal poverty line.
[4] Boat TF, Wu JT, Eds. Mental disorders and disabilities among low-income children. Washington, DC: National Academies Press, 2015.
[5] US Department of Health and Human Services. Mental health: A report of the Surgeon General. Rockville, MD: US HHS, 1999; 5.
[6] Institute of Medicine. Improving the quality of health care for mental and substance-use conditions: Quality Chasm Series. Washington, DC: National Academy Press. Available at: www.nap.edu/catalog/11470.html.
[7] US Government Accountability Office. Most physicians serve covered children but have difficulty referring them for specialty care (GAO-11-624. Washington, DC: US GAO, June 2011. Available at: www.gao.gov.
[8] US Government Accountability Office. Children's mental health: Concerns remain about appropriate services for children in Medicaid and foster care (GAO-13-15). Washington, DC: US GAO, December 2012. Available at: www.gao.gov.

largest source of publicly-funded behavioral health treatment (48% of all state mental health spending in FY2013).[9] In six Medicaid expansion states, including Connecticut, state officials reported to the GAO that behavioral health services are more widely available to low-income childless adults than they were prior to 2014; however, access to care is still a concern.

Connecticut's Behavioral Health Partnership

From 1995 to 2005, the Connecticut Department of Social Services (DSS) operated a risk-based managed care program for children and parents enrolled the HUSKY Program. During those years, as many as eleven managed care companies were under contract with DSS to provide all medically necessary medical, dental, pharmacy, behavioral health, and ancillary services for members for a monthly capitation fee.[10] The managed care companies subcontracted for management of behavioral health services for their members. [11]

In a 2000 report to the Connecticut General Assembly, the Department of Social Services and other state agencies characterized the behavioral health service system as "complex and fragmented."[12] The agencies identified major problems with the organization, financing, and delivery of children's mental health services in the HUSKY Program, then recommended adoption of a "system of care" with provision for:

1. Better mechanisms for coordination of care.
2. Enhanced community-based resources and treatment alternatives.
3. Integrated funding.
4. Family involvement in policy as well as services planning for their own children.
5. Redistribution of resources and refinancing of the service system.[13]

In response to concerns that about the administrative and financing arrangements in a risk-based program, behavioral health services were "carved out" of Medicaid managed care, effective January 1, 2006. The Connecticut Behavioral Health Partnership was created with the goal of improving access to care by providing beneficiaries with a more complete, coordinated, and effective system of community-based behavioral health services and support for individuals who need care.[14]

Connecticut's Behavioral Health Partnership (CT BHP) represents a major change in the way that behavioral health services are administered and financed in the Medicaid program. Since 2006, the CT DHP has served children and families in Connecticut's HUSKY Program, including children in foster care and adoption assistance. Responsibility for behavioral health services for HUSKY D (Medicaid for low income adults) and HUSKY C (Medicaid for aged, blind and disabled clients) were added in 2010 and 2011, respectively. Providers are paid fee-

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[9] US Government Accountability Office. Behavioral health: Options for low-income adults to receive treatment in selected states (GAO-15-449). Washington, DC: US GAO, June 2015. Available at: www.gao.gov. Other sources of public funding: state general revenues, federal funding from the Substance Abuse and Mental Health Services Administration mental health and substance use block grants.

[10] In 2004 and 2005, four managed care companies contracted with the Department of Social Services to provide services for HUSKY A members: Anthem BlueCare Family Plan, Community Health Network of Connecticut, Health Net, and Preferred One.

[11] In 2004 and 2005, the following subcontractors managed behavioral health services for HUSKY A managed care plans: Value Options (BlueCare, Health Net), Magellan/Merit Behavioral Health (CHNCT) and CompCare (Preferred One).

[12] Connecticut Department of Social Services. Delivering and Financing Children's Behavioral Health Services in Connecticut. A report to the Connecticut General Assembly pursuant to Public Act 99-279, Section 36. Prepared for the Department of Social Services by the Child Health and Development Institute, February 2000. The system of care was characterized in this report as "complex and fragmented" on p.ES-1.

[13] Connecticut Department of Children and Families and the Department of Social Services. Community KidCare: a plan to reform the delivery and financing of children's behavioral health services. A report to the Connecticut General Assembly pursuant to June Special Session Public Act 00-2, Section 5. Prepared for the Department of Social Services by the Child Health and Development Institute, February 2000.

[14] From the "About Us" page of the ValueOptions website at http://www.ctbhp.com/about.htm.

for-service at a "blended" rate, based on fees paid under managed care. Reimbursement is higher for "enhanced care clinics" that meet specific standards designed to facilitate increased access and quality. Recently, rates for non-hospital clinics were increased. Three state agencies work together to coordinate services: Connecticut's Medicaid agency, the Department of Social Services (DSS); Connecticut's child protection agency, the Department of Children and Families (DCF); and Connecticut's agency that oversees adult services, the Department of Mental Health and Addiction Services (DMHAS).

In 2006, DSS contracted for administrative services with Value Options, a leading behavioral health benefits manager with experience in the HUSKY Program.[15] For the current biennium, the Connecticut General Assembly appropriated $15.2 million (FY16) and $15.5 million (FY17) for these administrative services. Since the end of the risk-based managed care program in January 2012, DSS's medical administrative services organization, Community Health Network of Connecticut, has worked with Value Options to coordinate behavioral health care with medical care and ancillary services.

Key stakeholders have come together with the agencies to build a system of mobile crisis services and community-based support for those with acute needs and those with conditions best managed at home and in their own communities. The Connecticut General Assembly's Behavioral Health Partnership Oversight Council works with the state agencies and key stakeholders to ensure that the program accomplishes its goals and objectives for serving Connecticut's residents.

Purpose of the study

Connecticut Voices for Children conducts independent performance monitoring in the HUSKY Program and tracks provision of health services for children and parents in HUSKY A and B. In this report, we describe behavioral health service provision before and after major changes in the way these services were administered and financed in the HUSKY Program. Trends in prevalence or service utilization observed over time may be related to *but cannot be directly attributed to program changes*. The analyses will generate additional information for agency administrators, policy makers and key stakeholders who need to understand how program changes may have affected access to behavioral health services and utilization.

In studying changes in prevalence and utilization of behavioral health services, we assumed the following:

- Children in low income families with public health insurance coverage are more likely than privately insured children to experience emotional or behavioral problems.[16]
- Children with public health insurance are more likely than privately insured children to have unmet need for mental health treatment or counseling.[17]
- Adults with low income are more likely than higher income adults to experience serious emotional or behavioral problems and substance abuse disorders.[18]

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[15] For more information about the corporation, see www.valueoptions.com. Recently (after the study period), Value Options merged with Beacon Health Strategies (see www.beaconhealthstrategies.com) to become Beacon Health Options.

[16] 2011/12 National Health Interview Survey. National data show that parents report that children with public health insurance are far more likely to have "severe difficulties in emotions, concentration, behavior, or being able to get along with other people" (7.9%, compared with 3.6% of children with private health insurance and 4.4% of uninsured children). Connecticut-specific rates were not available. Data available at http://childhealthdata.org.

[17] 2011/12 National Survey of Children's Health. National data show that parents report that children with public health insurance are more likely to have needed mental health treatment or counseling in the past months but did not receive care (40.8%, compared to 34.0% of children with private health insurance). Data for Connecticut show the same trend: 35.9% of children with public health insurance needed but did not receive mental health treatment or counseling, compared with 30.5% of privately insured children; however the difference was not statistically significant.

- Children (and adults) in Connecticut's Medicaid managed care program were likely underserved by risk-based financing and delivery arrangements that fostered "serious bottlenecks" and "fragmentation" in the treatment system, insufficient allocation of resources, undue reliance on hospital care and residential treatment, ineffective care coordination, and lack of support for community-based services and family involvement in service planning.[19]

The goal of Connecticut's Behavioral Health Partnership is to increase access to coordinated, individualized behavioral health services.[20] Major program changes should result in increased access to timely, high quality behavioral health care. The impact of increased access to care should be evident in measurable increased utilization, especially for subgroups that were relatively underserved in the risk-based program. Therefore, the aim of this study is to describe treatment prevalence (penetration) based on utilization of services before and after the program changes in 2006. The findings will add to other information about access to care.[21]

METHODS

Study design

Using a retrospective cohort design, we described the prevalence of mental health conditions for which children and adults received treatment before and after major changes in the way that behavioral health services were administered and financed in the HUSKY Program (Medicaid for children, parents and relative caregivers, pregnant woman). Specifically, we identified children and adults who were continuously enrolled in the HUSKY Program in each of four one-year periods before program changes (2004 and 2005 baseline period, just prior to program change from risk-based managed care to administered fee-for-service program) and after program changes (2012 and 2013 study period for which complete HUSKY Program data were available). We report trends in the number and percentage of individuals with care—"treatment prevalence'—using the same methods for the study period as were used for establishing the risk-based managed care baseline.[22]

We compared prevalence of diagnosed mental conditions in the study period (2012 and 2013) to findings from the baseline period (2004 and 2005) to test the following hypothesis: More children and adults received behavioral health services in the study period (program model: administered fee-for-service), compared with the baseline period (program model: risk-based managed care)**.** We arbitrarily decided before beginning the study that an increase in of 20 percent or more would indicate a significant increase in access to care. In the interest of determining how the program serves all its beneficiaries, we did not limit our focus to those with intensive care needs.

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[18] Weissman J, Pratt LA, Miller EA, Parker JD. Serious psychological distress among adults: United States, 2009-2013. NCHS Data Brief, 203, May 2015. Available at: http://www.researchgate.net/profile/Judith_Weissman/publication/278410177_Serious_psychological_distress_among_adults_United_States_20092013._NCHS_data_brief_no_203._Hyattsville_MD_National_Center_for_Health_Statistics._2015/links/5580757308aed40dd8cd2748.pdf.

[19] Connecticut Department of Social Services. Delivering and Financing Children's Behavioral Health Services in Connecticut. A report to the Connecticut General Assembly pursuant to Public Act 99-279, Section 36. Prepared for the Department of Social Services by the Child Health and Development Institute, February 2000.

[20] "The [Connecticut Behavioral Health Partnership] is designed to create an integrated behavioral health service system for Connecticut's Medicaid populations, including children and families who are enrolled in HUSKY Health…. The Partnership's goal is to provide access to a more complete, coordinated, and effective system of community based behavioral health services and support. This goal is achieved by making enhancements to the current system of care in order to … Improve network access and quality [and] recruit and retain traditional and non-traditional providers." http://www.ctbhp.com/about.htm

[21] The next report will focus on services, including hospital admissions, emergency care and prescription medication use.

[22] See, "Behavioral Health and Health Care in HUSKY A: 2004 and 2005 Baseline," New Haven, CT: Connecticut Voices for Children. July 2007. Available upon request.

Data

For each of the calendar years, enrollment data were used to identify all adults and children who were continuously enrolled in HUSKY A for the 12 month period with no break in coverage. Enrollment trends over the study period were likely affected by changes in income eligibility for HUSKY A (Medicaid) coverage for parents/relative caregivers and pregnant women.

To identify HUSKY A adults and children with behavioral health disorders, HUSKY A encounter (2004-2005) and claims (2012-2013) data were searched for records with a behavioral health primary diagnosis (ICD-9-CM 291-316).

Analytic approach

Our estimate of the prevalence of mental disorders was based on the percentage of continuously children and adults with care for diagnosed mental conditions ("treatment prevalence"). We counted the number of adults and children who received treatment for a mental disorder or substance abuse (expressed in terms of the number of cases per 100 persons). "Treatment prevalence" is likely to be an underestimate of actual prevalence since by definition the counts and rates do not include those whose disease is under control and those who encounter systemic barriers to needed care. We focused on continuously enrolled adults and children who had uninterrupted uniform periods of coverage, without the gaps that make it difficult for individuals and their providers and HUSKY Program administrators to ensure access to and utilization of needed care.

Unadjusted rates (expressed as number of persons with care per 100 in the program or the subgroup) were determined overall and by age group (0-5, 6-10, 11-15, 16-18, 19-20, 21-29, 30-39, 40-49, $\geq$ 50), gender, race/ethnicity (mutually exclusive, self-reported groups of White, Black/African American, Hispanic/Latino, and all other racial/ethnic groups), primary household language (English, Spanish, other languages), and residence (Bridgeport, Hartford, New Haven and all other towns).

For reporting purposes, we used single year and two-year averages to report on treatment prevalence for children 18 and under and adults 19 and over.[23] Actual counts and rates are shown in the Appendix tables by individual year (2004, 2005; 2012, 2013) and in the report (text, tables and figures) using single year or two-year averages (indicated by "2004/2005" and "2012/2013.")

Measures

The following measures were used to summarize the data:

- **Estimated treatment prevalence:** Single-year and two-year average percentages (2004/2005; 2012/2013) overall, by sociodemographic subgroups, based on counts for continuously enrolled adults and children who received any care for a primary diagnosis of mental disorder (ICD-9 diagnosis codes 291-316) during the baseline (2004, 2005) and the study periods (2012, 2013).

- **Distribution across leading diagnoses**: Distribution for all primary diagnoses for children and adults for major diagnostic categories and percentage point differences in distribution over time (baseline compared to study period).

[23] Because federal requirements for EPSDT apply to children under age 21, so we described behavioral health services in detailed tables for children 18 and under, children/young adults age 19 to 20, and adults 21 and over.

Limitations

The following limitations affect the methods, analytic approach and interpretation of the findings:

- This study is descriptive and observational, so the findings do not indicate that the program changes caused changes in treatment prevalence estimates or any other change over time;
- This study is based on a secondary analysis of administrative data used for paying claims;
- The data were not independently audited for completeness or accuracy;
- Prevalence estimates are based on claims data for treatment rather than actual prevalence of behavioral health disorders among the children and adults in HUSKY A;
- The treatment prevalence may be underestimated if services were not billed to Medicaid or were provided by primary care providers who submitted claims with other diagnoses listed;
- The treatment experience of continuously enrolled children and adults may not be the same as that of other children and adults for whom access to care was interrupted by gaps in coverage;
- No data on severity of conditions or appropriateness of treatment were available;
- No data on unmet needs for behavioral health services were available;
- No data on ancillary services (transportation, home care, care coordination, case management, emergency mobile crisis services, etc.) or residential treatment were available;
- Individuals may have received care for a behavioral health diagnosis in one or more years of the study;
- Children with HUSKY A coverage who qualified for SSI payments or were involved with the Connecticut Department of Children and Families (foster care, adoption assistance, voluntary service)s could not be identified for this study;[24]
- No data for HUSKY B (CHIP) were available for analysis in 2004 and 2005, so HUSKY B data from 2012 and 2013 cannot be compared to assess prevalence and utilization trends;
- Children or adults who filled prescriptions for psychotropic medications were not included in the prevalence estimates unless they had also had hospital, clinic or office-based care with a behavioral health diagnosis.

Two important caveats affect interpretation of these findings: *Treatment prevalence does not equal actual prevalence of mental disorders; only those who received care were counted for the estimate. Trends in prevalence or service utilization observed over time may be related to but cannot be directly attributed to program changes.* Nevertheless, these data provide agency administrators, policy makers and key stakeholders with some additional information with which to understand how program changes may have affected access to behavioral health services and utilization.

RESULTS

HUSKY A enrollment

Over the study period, the Connecticut General Assembly enacted a number of changes in income eligibility for adults (parents and relative caregivers, pregnant women) (Table 1). Undoubtedly, these changes affected enrollment trends overall.

[24] The Department's BHP contractor, Value Options, has these data for program administration and care management; however, the Department did not provide Connecticut Voices with the data for independent performance monitoring.

Table 1. HUSKY Program Eligibility: Changes in income eligibility levels

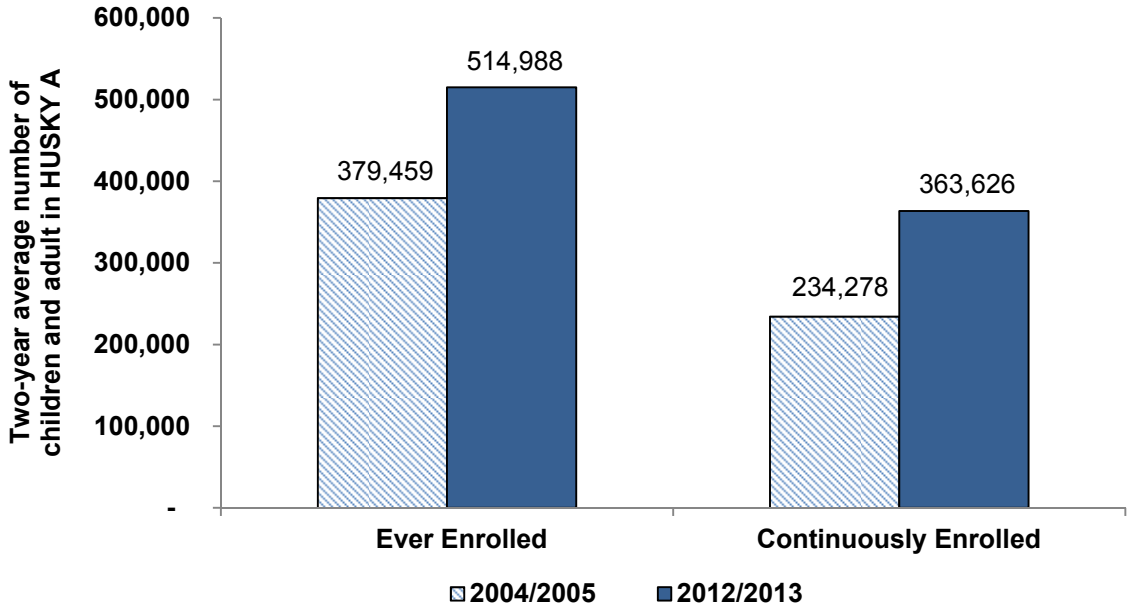
Time period	HUSKY A Income Eligibility Level	Relationship to Study Period
Children:		
1998 January – present	185% FPL[a]	Unchanged during baseline and study periods
Parents/relative caregivers:		
2001 July – 2003 June	150% FPL	Prior to baseline period
2003 July – 2005 June	100% FPL	Changed during baseline period (2004, 2005)
2005 July – 2007 June	150% FPL	Changed during baseline period (2004, 2005)
2007 July – 2015 July	185% FPL[a]	Unchanged during study period (2012, 2013)
2015 August – present	150% FPL[a]	After study period
Pregnant women:		
1989 January – 2007 December	185% FPL	Changed after baseline period (2004, 2005)
2008 January – present	250% FPL[a]	Changed before study period (2012, 2013)

[a] Income eligibility level, not including income disregards, expressed as percent of federal poverty level for each year during the baseline and study periods. The way that income is counted changed in January 2014, with implementation of modified adjusted income counting rules under the Affordable Care Act.

Source: Connecticut Voices for Children summary of HUSKY Program policy changes.

In fact, the number of children and adults in HUSKY A increased remarkably between the two periods (Figure 1). These enrollment trends were likely to have had an effect on access to care and utilization as potentially more people needed and sought behavioral health services in the study period. The percentage of ever enrolled children and adults who were continuously enrolled increased from 62 percent on average in the baseline period (2004/2005) to about 71 percent in the study period (2012/2013). The two-year average number of continuously enrolled children and adults increased by 55 percent between the two periods. HUSKY A enrollment data are described in greater detail in Appendix Table 1 (a, b).

Figure 1. Children and Adults Ever Enrolled and Continuously Enrolled in HUSKY A, 2004/2005 and 2012/2013

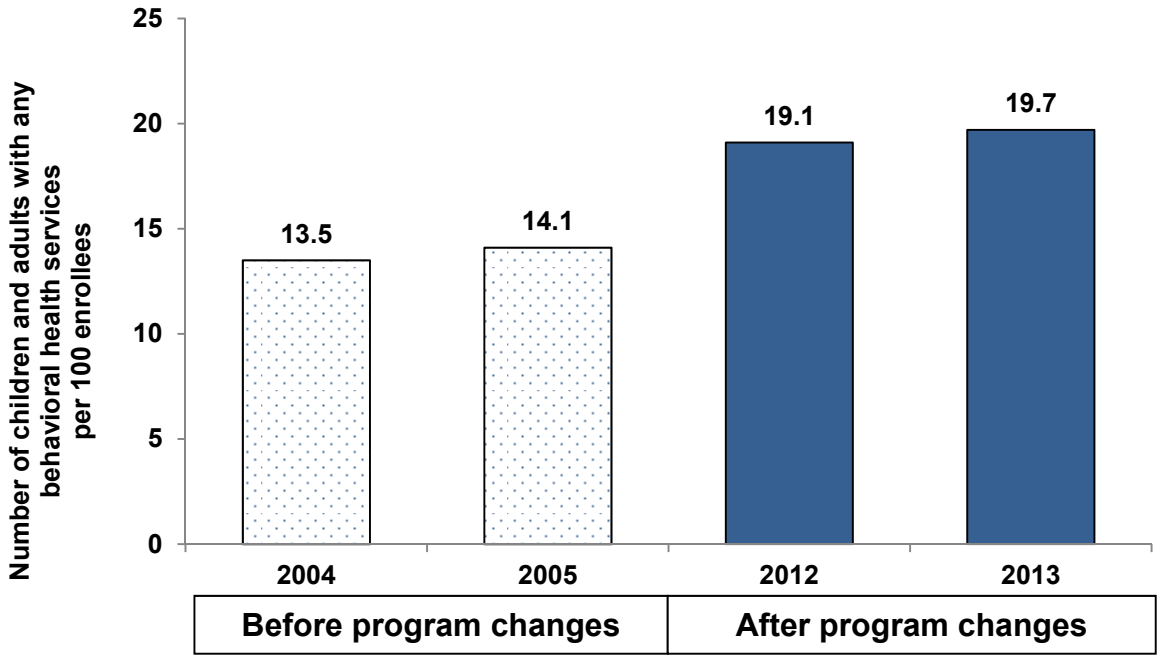


Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Treatment prevalence

In 2012 and 2013, nearly one of every five continuously enrolled individuals received care for a diagnosis of a behavioral health disorder (19.1% in 2012 and 19.7% in 2013) (Figure 2). These single-year rates were substantially increased over 2004 and 2005. Moreover, the average number of people who were treated for a diagnosed mental disorder more than doubled. Data on HUSKY A members with a behavioral health diagnosis for 2004, 2005, 2012, and 2013 are shown by selected demographic characteristics in Appendix Tables 2 (a, b).

Figure 2. Children and Adults with Care for Diagnosed Mental Conditions (treatment prevalence), 2004 and 2005, 2012 and 2013



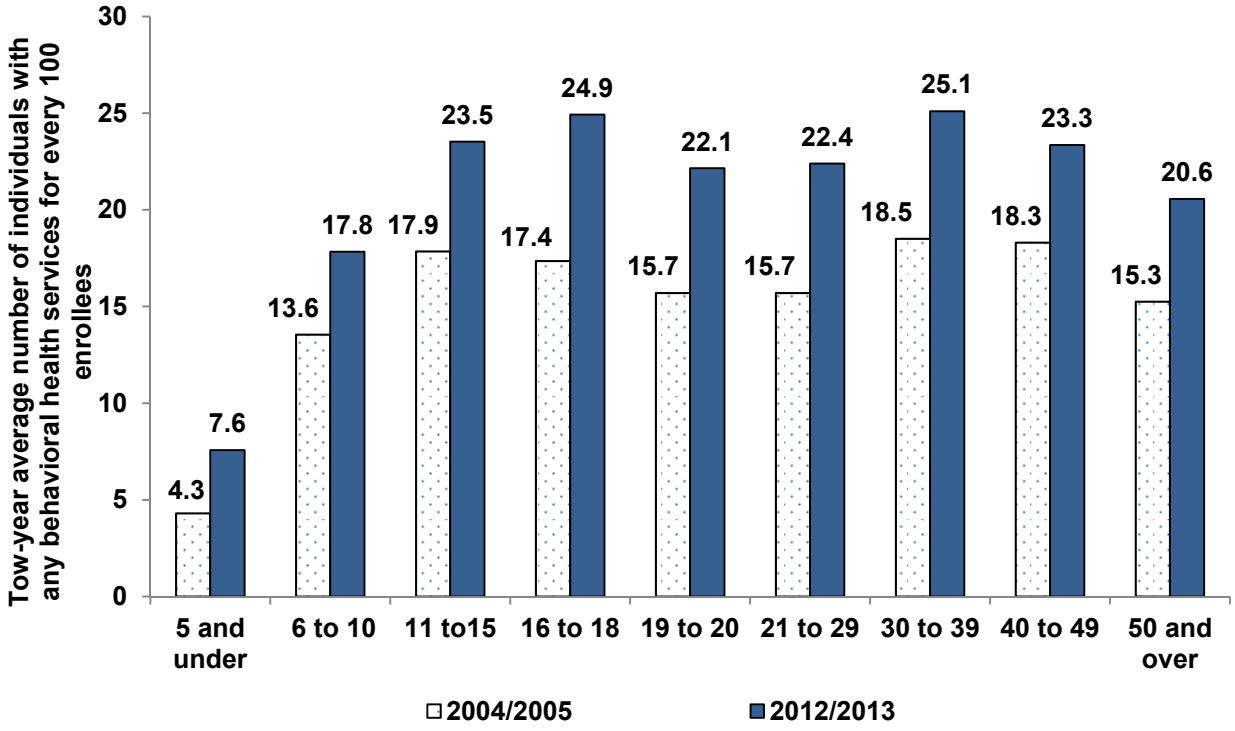
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Overall, the two-year average treatment prevalence increased by over 40 percent for continuously enrolled individuals in 2012/2013 in comparison to 2004/2005. The increase was evident in every age, racial/ethnic, primary language, and residential grouping:

Age: Treatment prevalence increased for both children and adults, compared with the baseline period (2004/2005) and was higher for adults before and after the program changes (Figure 3). Young children under 5 were by far the least likely age group to receive treatment for mental health disorders; however, the greatest increase in treatment prevalence percentage-wise was for very young children (Figure 4).

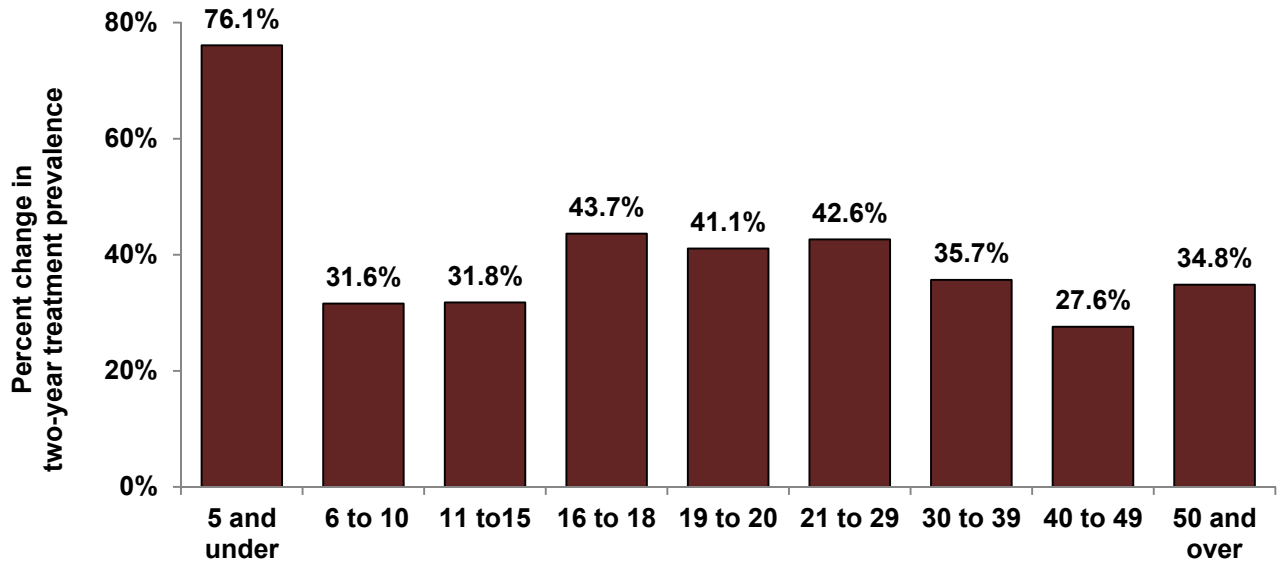
Gender: In both study periods, before and after program changes, treatment prevalence for HUSKY A members with a behavioral health diagnosis was essentially the same for females and males.

Figure 3. Estimated Treatment Prevalence by Age
2004/2005 and 2012/2013



Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Figure 4. Increase in Estimated Treatment Prevalence by Age
2004/2005 to 2012/2013

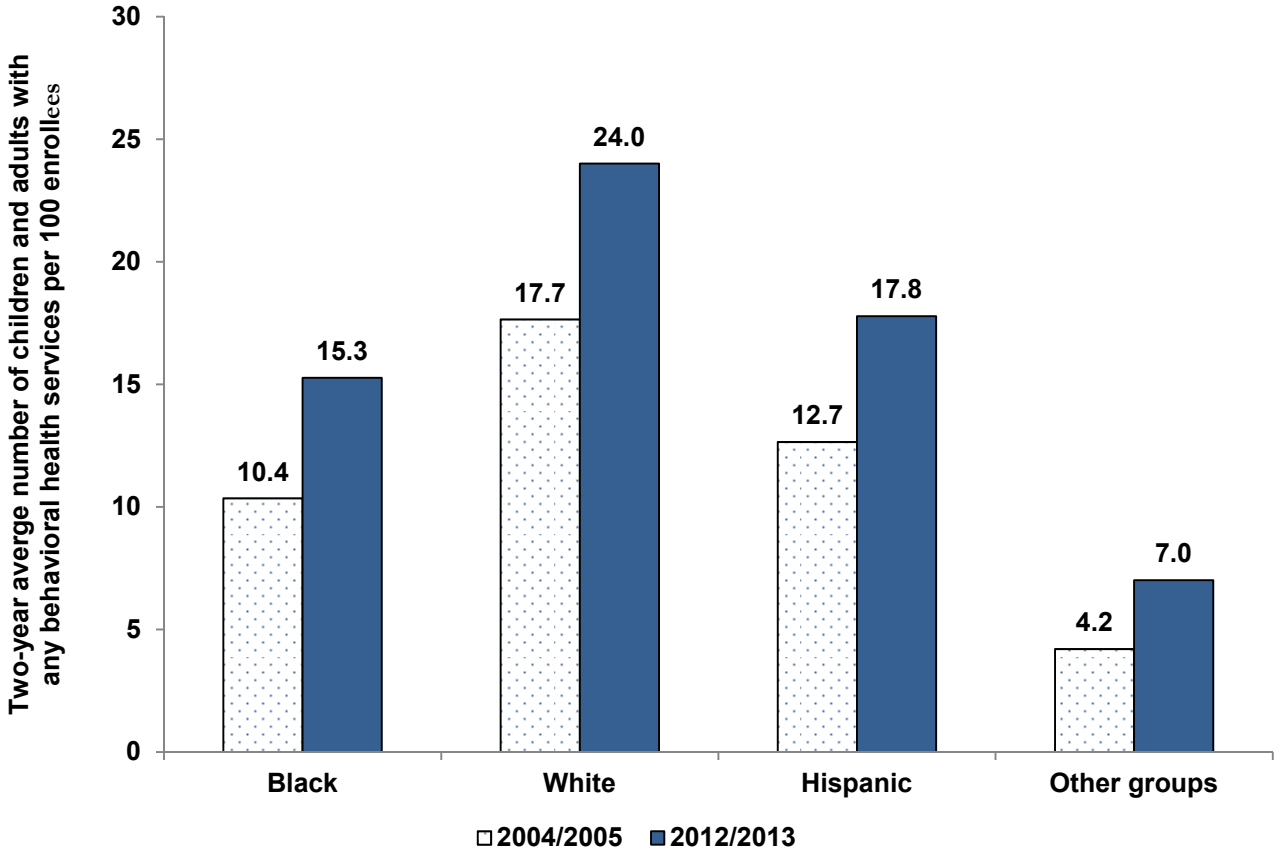


Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

- **Race/ethnicity:** Treatment prevalence increased for HUSKY A enrollees in every racial/ethnic group (Figure 5). In both the baseline and the study periods, White enrollees were most likely to receive mental health

services and HUSKY A enrollees of other racial/ethnic groups (smallest in number overall and with treatment) were least likely (Figure 5).

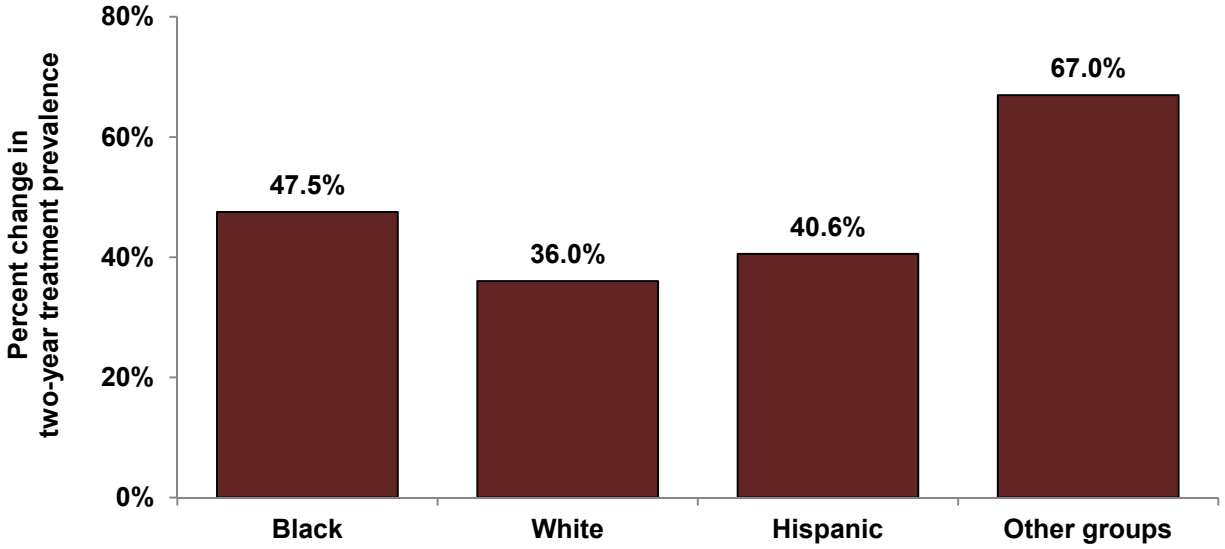
Figure 5. Estimated Treatment Prevalence by Racial/Ethnic Group 2004/2005 and 2012/2013



Note: Mutually exclusive, self-reported racial/ethnic groups, based on analyses of HUSKY A enrollment data. Those with treatment in racial/ethnic groups other than White, Black or Hispanic were relatively few in number (average 267 in 2004/2005 and 907 in 2012/2013).
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

The percentage of HUSKY A enrollees who received treatment increased more for Black, Hispanic, and other racial/ethnic group enrollees than for White enrollees (Figure 6). The greatest increase was observed among the relatively very small number of HUSKY enrollees categorized as "other" (non-White, non-Black, non-Hispanic).

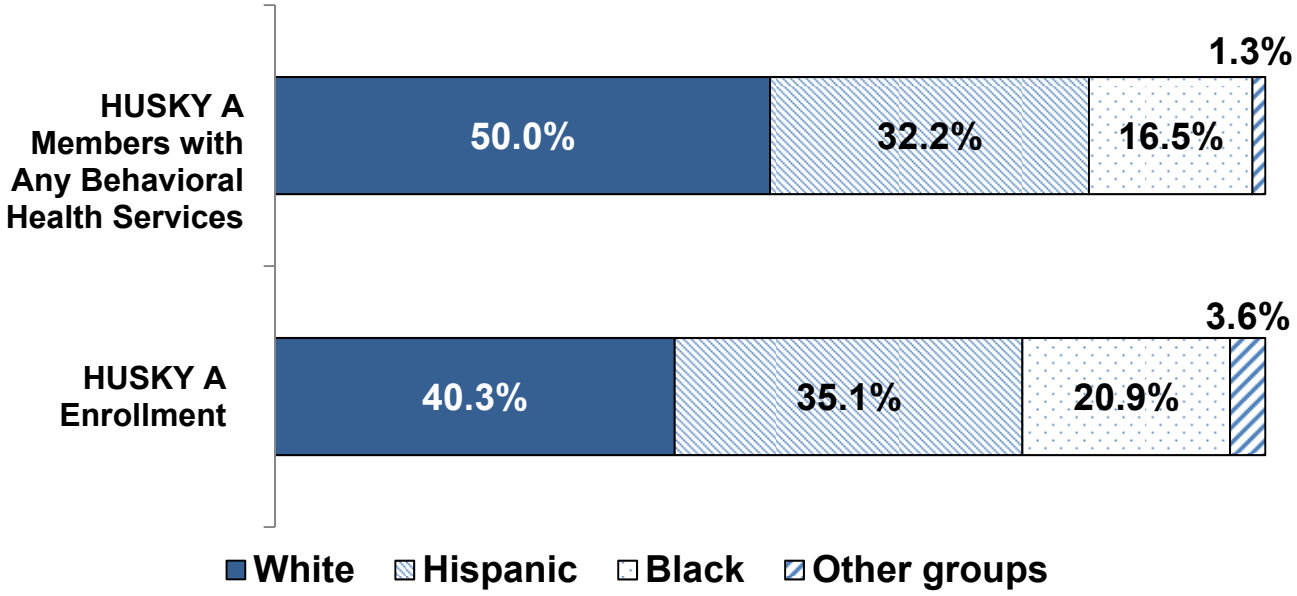
Figure 6: Increased in Estimated Treatment Prevalence by Racial/Ethnic Group 2004/2005 to 2012/2013



Note: Mutually exclusive, self-reported racial/ethnic groups, based on analyses of HUSKY A enrollment data. Those with treatment in racial/ethnic groups other than White, Black or Hispanic were relatively few in number (average 267 in 2004/2005 and 907 in 2012/2013).
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

In both time periods, White enrollees received treatment at rates disproportionate to their representation among enrollees in HUSKY A (data for 2012/2013 shown in Figure 7).

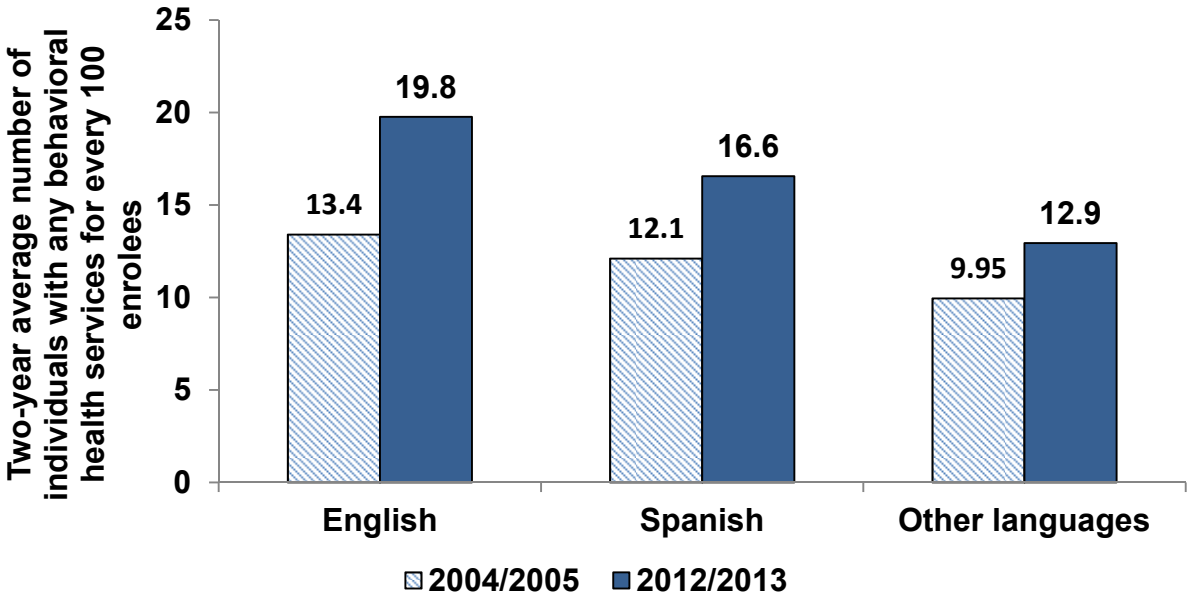
Figure 7: Enrollment and Estimated Treatment Prevalence by Racial/Ethnic Group 2012/2013



Note: Mutually exclusive, self-reported groups, based on analyses of HUSKY A enrollment data.
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

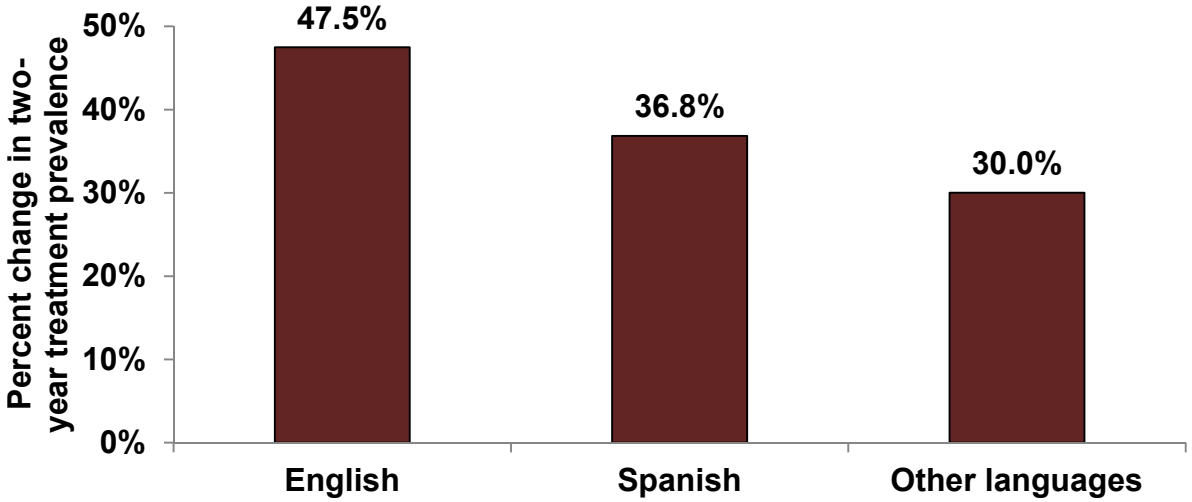
- **Primary language:** Treatment prevalence increased for HUSKY A enrollees in every primary language group (Figure 8). In both the baseline and the study periods, English-speaking enrollees were most likely to receive mental health services and were most likely to have experienced an increase in treatment prevalence (Figure 9).

Figure 8. Estimated Treatment Prevalence by Primary Language 2004/2005 and 2012/2013



Note: Overall, nearly 90% of all HUSKY enrollees each year were English-speaking, based on analyses of HUSKY A enrollment data.
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

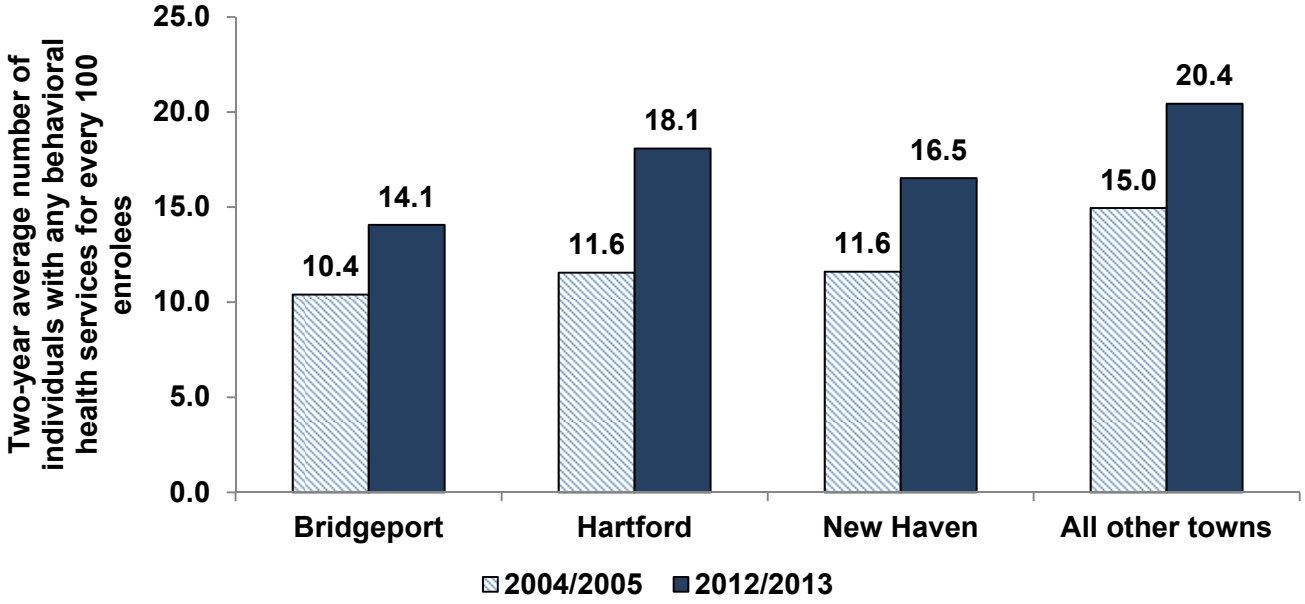
Figure 9: Increased in Estimated Treatment Prevalence by Primary Language 2004/2005 compared to 2012/2013



Note: Overall, nearly 90% of all HUSKY enrollees each year were English-speaking, based on analyses of HUSKY A enrollment data.
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

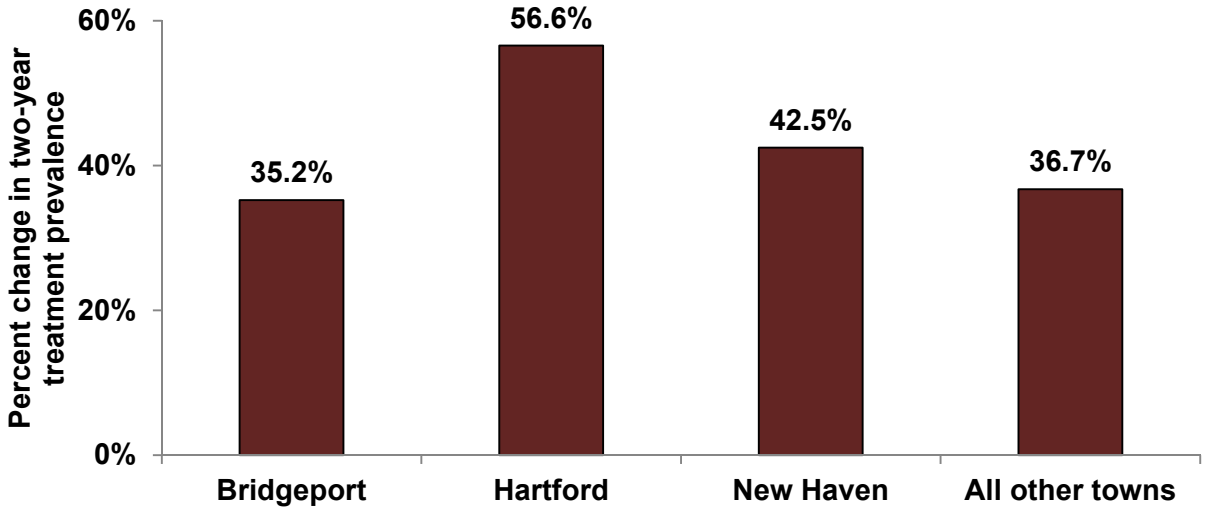
- **Residence:** In both 2004/2005 (baseline) and 2012/2013, the rate of treatment for mental health disorders was lowest for residents of Bridgeport, Hartford, and New Haven, compared with residents of other Connecticut towns (Figure 10). Treatment prevalence increased over the study period in all residential groupings, but especially in Hartford (Figure 11).

Figure 10. Estimated Treatment Prevalence by Residence 2004/2005 compared to 2012/2013



Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Figure 11. Increase in Estimated Treatment Prevalence by Residence 2004/2005 compared to 2012/2013



Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Leading diagnoses

The distributions of mental disorders for which continuously enrolled children and adults received care in 2004 and 2005 and in 2012 and 2013 are shown as two-year average percentages by diagnostic group in Tables 2 and 3. Counts of HUSKY A enrollees with behavioral health care by primary diagnoses for each year are shown in Appendix Tables 3 (a-d).

The leading diagnoses for children in all four years in the study fell into three categories: attention-deficit/conduct/disruptive behavior disorders, adjustment disorders, and anxiety disorders. The two-year average proportion of children diagnosed with anxiety disorders and substance-related disorders fell somewhat in 2012/2013 in comparison to 2004/2005, while the share of children with disorders usually diagnosed in infancy/childhood/adolescence and developmental disorders increased slightly. While the number of claims and number of children with care *doubled* from the baseline to the study period, the average number of claims per child was essentially unchanged (1.42 on average in 2004/2005 and 1.47 on average in 2012/2013).

Table 2: Change in Distribution of Diagnosed Mental Disorders among Children in HUSKY A

	2004/2005	2012/2013	Percentage Point Difference
Adjustment disorders	22.6%	22.1%	(0.4)
Anxiety disorders	19.4%	14.9%	(4.5)
Attention-deficit/conduct/disruptive behavior disorders	29.8%	29.3%	(0.5)
Delirium/dementia/amnestic/other cognitive disorders	0.3%	1.1%	0.8
Developmental disorders	3.5%	5.6%	2.1
Disorders usually diagnosed in infancy/childhood/adolescence	4.8%	6.7%	1.8
Miscellaneous mental disorders	0.2%	0.1%	(0.1)
Mood disorders	13.3%	13.5%	0.2
Personality disorders	0.5%	0.8%	0.3
Schizophrenia and other psychotic disorders	2.1%	3.4%	1.2
Substance-related disorders	3.4%	2.4%	(1.0)
Total diagnoses	100.0%	100.0%	

Note: Primary diagnoses on average 29,106 claims for 20,486 children (1.42 per child) in 2004/2005 and average 60,282 for 40,962 children (1.47 per child) in 2012/2013. One person may have had more than one diagnosis in a year and may have been treated in more than one year.
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

The leading diagnoses for adult parents or relative caregivers in all four years in the study fell into four categories: mood disorders, anxiety disorders, substance-related disorders, and adjustment disorders. The two-year average proportion of adults with mood disorder diagnoses declined from 2004/2005 to 2012/2013. While the number of

claims and number of adults with care nearly tripled from the baseline to the study period, the average number of claims per person changed very little (1.31 on average in 2004/2005 and 1.41 on average in 2012/2013).

Table 3: Change in Distribution of Diagnosed Mental Disorders among Adults in HUSKY A

	2004/2005	2012/2013	Percentage Point Difference
Adjustment disorders	14.4%	16.1%	1.7
Anxiety disorders	22.4%	23.0%	0.6
Attention-deficit/conduct/disruptive behavior disorders	2.1%	3.7%	1.6
Delirium/dementia/amnestic/other cognitive disorders	0.7%	1.0%	0.3
Developmental disorders	0.1%	0.1%	0.0
Disorders usually diagnosed in infancy/childhood/adolescence	3.0%	2.3%	(0.7)
Miscellaneous mental disorders	0.6%	0.7%	0.0
Mood disorders	34.4%	30.2%	(4.2)
Personality disorders	0.4%	0.4%	0.0
Schizophrenia and other psychotic disorders	1.7%	2.7%	1.0
Substance-related disorders	20.3%	19.9%	(0.4)
Total diagnoses	100.0%	100.0%	

Note: Primary diagnoses on average 15,417 claims for 11,799 adult parents or relative caregivers in 2004/2005 (1.31 per adult) and average 41,654 claims for 29,531 adult parent or relative caregivers in 2012/2013 (1.41 per adult). One person may have had more than one diagnosis in a year and may have been treated in more than one year.
Source: Connecticut Voices for Children analysis of HUSKY A program data from the Department of Social Services.

Discussion

This analysis of enrollment and claims data for behavioral health services shows that the number and percentages of children and adults with care increased significantly over the study period, compared with the period just before the program changes. These effects were evident in every age, racial/ethnic, language, and residential group. The greatest increases were observed among children under 5, older adolescents and young adults, the relatively few non-White/non-Hispanic/non-Black individuals of other races and ethnic groups, English-speaking enrollees, and residents of Hartford, relative to other age, race/ethnicity, language, and residential groups. While increased access to care, based on prevalence estimates, cannot be solely attributed to the Connecticut Behavioral Health Partnership, these findings are generally consistent with utilization trends reported by the Department of Social Services and its behavioral health services administrative services contractor.[25] Increased utilization may be related to the increased likelihood that children and adults stay enrolled throughout the year, without the gaps in coverage that impede access or disrupt ongoing care.

Family poverty can be both a risk factor for child disability and a consequence of child disability. A special focus committee convened by the Institute of Medicine (IOM) recently reported on the prevalence of mental disorders

[25] See reports from Connecticut Behavioral Health Partnership at http://www.ctbhp.com/reports.html. See minutes from deliberations of the Connecticut General Assembly's Behavioral Health Partnership Oversight Council at https://www.cga.ct.gov/ph/bhpoc/.

and disabilities among children in low income families.[26] As part of its investigation, the committee commissioned a 10-year multistate analysis of Medicaid enrollment and claims data, using methods similar to the methods employed for this study (Table 4).[27] Based on analysis of Medicaid data from 20 states, the IOM committee concluded that:

> Overall, these data indicate an increasing prevalence of mental disorder diagnoses among children enrolled in Medicaid….[28]
>
> [T]he number of child Medicaid enrollees grew substantially between 2001 and 2010. This growth may reflect increases in child poverty as well as other policy or program changes that affect child Medicaid enrollment. The large increases in the number of enrollees observed from 2008 to 2010 coincide with the period of recession and growth in child poverty, In addition, the numbers of uninsured children decreased during the 10-year period, as the numbers enrolled in Medicaid and the Children's Health Insurance Program increased, likely the result of policies incentivizing the enrollment of eligible children in Medicaid.[29]
>
> [M]ental disorder diagnoses increased at roughly similar rates among all eligibility categories and at rates that paralleled increases in asthma diagnoses. Children in low-income households have higher rates of both mental disorders and asthma; thus, the finding of increased rates of asthma reinforces the importance of poverty as a factor contributing to the increasing rates of mental disorders in children.[30]

Taken together, both studies suggest that the increased prevalence of diagnosed mental disorders in children is part of a larger national trend related to changing demographics, increased participation in government-sponsored health insurance, and other changes in the US health care landscape. Over the 10-year time periods studied in these two reports, science has advanced, reliance on evidence-based care has increased, and pharmacologic management of mental disorders has improved.

In Connecticut, changes to the administration and financing of behavioral health services in Medicaid coincided with and may have contributed to increased utilization (treatment prevalence) for children and parents of all ages, every racial/ethnic and primary language group, and every residential area. In addition, significant increases in diagnosed mental conditions among young children, older adolescents and young adults, Black children and adults, as well as residents of Hartford suggest that program improvements can increase access to care and utilization among HUSKY A enrollees who may have been relatively underserved in the risk-based managed care program.

Implications/Next Steps/Future Study

- Describe changes in service utilization by comparing the distribution of behavioral health services (inpatient, outpatient, prescription medications) in the study period to the baseline period (study in progress);

- With direction from the Behavioral Health Partnership Oversight Council and other key stakeholders, continue independent monitoring of behavioral health services in the HUSKY Program.

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[26] Boat TF, Wu JT, Editors. Mental Disorders and Disabilities Among Low-Income Children. Washington DC: National Academy Press, December 2015.

[27] Data for 2001-2010 from the following states with predominantly fee-for-service youth Medicaid populations or relatively complete and usable managed care encounter data for youth population: AK, AL, AR, CA, FL, ID, IL, In, LA, MI, MS, MT, NC, ND, NH, NM, SD, VA, VT, WY.

[28] Boat & Wu, op.cit., p. 324.

[29] Ibid., p. 325.

[30] Ibid., p. 325-326.

Table 4. Prevalence of Mental Disorders among Children in Medicaid: Comparison of methods and findings

	Medicaid Analytic eXtract Study	Connecticut Voices for Children Study of Connecticut's Behavioral Health Partnership
Purpose	Compare trends in the number of children with mental disorders in the Supplemental Security Income (SSI) program with trends among children in low-income households in Medicaid. Describe kinds of treatments received by children with mental disorders in the SSI population.	Describe behavioral health service provision before and after major changes in the way services were administered and financed in the HUSKY Program. Describe trends in terms of treatment prevalence and service utilization over time that *may be related to but cannot be directly attributed to program changes.*
METHODS		
Study years	10-year multistate analysis: 2000-2010	Single-state analysis of 4 years' data in 10 year period: 2004 and 2005 (baseline); 2012 and 2013 (study)
Study population	Medicaid-eligible children ages 3-17 years (age as of July 1) in 20 selected states [a] Enrolled at least 11 months in the year	Medicaid-eligible children ages birth-18 (age as of December 31) in Connecticut Continuously enrolled for 12 months in the year
Medicaid subsets	Children with SSI Children in foster care All other children in low-income households (generally <200% FPL)	No subsets: all children in low-income households (<185% FPL), including children with SSI and in foster care[b]
Data	Medicaid enrollment, claims and prescription drug-fill data, submitted by states and compiled by the Centers for Medicare & Medicaid Services (CMS) Data from states with predominantly fee-for-service youth Medicaid populations or relatively complete and usable managed care encounter data for youth population.	HUSKY A (Medicaid) enrollment, claims and prescription drug-fill data, compiled by the Connecticut Department of Social Services and provided for state-funded independent HUSKY Program performance monitoring. Data for Medicaid-enrolled youth from participating managed care plans (2004 and 2005; baseline) and Connecticut's administered fee-for-service program (2012 and 2013; study period).
Diagnostic criteria	Diagnosis listed for one or more inpatient claims or two or more outpatient claims for one or more of the following diagnoses: ADHD, conduct disorders, emotional disturbances, oppositional defiant disorder, depression, bipolar disorders, anxiety disorders, intellectual disorders, learning disorders, autism spectrum disorders.	Diagnosis listed as basis for any inpatient and/or any outpatient care for one or more diagnoses (ICD-9-CM 291-316)
Measure	Prevalence: number of children with diagnosis/number of enrolled children, overall and for specific diagnoses; expressed as rate	Treatment prevalence: single year and two-year average number of children with diagnosis/number of enrolled children, overall and by age, race/ethnicity, primary language, residence; rate expressed as number per 100 children

FINDINGS		
Child enrollment	Increased 57%	Increased 43%
Prevalence trends	Number with care for diagnosed mental conditions increased 120% Single-year rate increased 7.9% in 2001 to 11.1% of children in 2010 Percent with care for diagnosed mental conditions increased 42% (3.2 percentage points)	Number with care for diagnosed mental conditions increased 100% Two-year average rate increased 13.3 (2004/2005) to 18.5 per 100 children (2012/2013) Percent with care for diagnosed mental conditions increased 39% (5.2 percentage points)
Leading diagnoses	**Attention deficit hyperactivity disorder** (single-year rate increased from 3.0% in 2001 to 5.5% in 2010) **Depression** (single-year rate increased from 1.7% to 2.2% overall)	**Attention deficit/conduct/disruptive behavior disor**ders (two-year average rate increased from 5.2% in 2004/2005 to 7.4% in 2012/2013) **Adjustment disorders** (two-year average rate increased from 4.0% in 2004/2005 to 5.6% in 2012/2013) **Mood disorders** (two-year average rate increased from 2.3% in 2004/2005 to 3.4% in 2012/2013)
Additional findings		Percent of children and adults who were continuously enrolled increased from 62% to 71% Prevalence estimates increased for children and adults of all ages, all racial/ethnic and primary language groups, and residential groups. Greatest increases were for young children, older adolescents and young adults, Black children and adults, and residents of Hartford
SOURCE		
Citation	Boat TF, Wu JT, Eds. Mental Disorders and Disabilities Among Low-Income Children. Part IV. Medicaid Analytic eXtract Study. Washington, DC: National Academies Press, 2015, p. 311-347. Available at: www.nap.edu.	Lee MA, Iverson S, Langer S. Behavioral Health Care in HUSKY A Before and After Implementation of Connecticut's Behavioral Health Partnership: Trends for Children and Adults with Diagnosed Mental Conditions. New Haven, CT: Connecticut Voices for Children, 2016. Available at: www.ctvoices.org.
Commissioned by	National Academy of Sciences' Institute of Medicine Committee to Evaluate the Supplemental Security Income Disability Program for Children with Mental Disorders	Connecticut Voices for Children, acting as state-funded independent monitor of Connecticut's HUSKY Program performance
Conducted by	**Rutgers University Institute for Health:** Scott Bilder, Cassandra Simmel, Stephen Crystal (director)	**Connecticut Voices for Children:** MaryAlice Lee, Sarah Iverson, Sharon Langer

[a] The 20 states selected for inclusion were determined to have provided CMS with relatively complete diagnosis and treatment detail for Medicaid beneficiaries: AK, AL, AR, CA, FL, ID, IL, IN, LA, MI, MS, MT, NC, ND, NH, NM, SD, VA, VT, WY.

[b] Enrollment data for available for study of Connecticut Behavioral Health Partnership do not include indicators on enrollment records for SSI or for involvement with the Department of Children and Families (foster care, adoption assistance, voluntary services).

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Table 1a. HUSKY A Enrollees: 2004 and 2005 (before program change)

	2004			2005		
	Number	Distribution	Percent of Ever Enrolled	Number	Distribution	Percent of Ever Enrolled
Total	236,599	100.0%	63.1%	231,957	100.0%	60.4%
Age						
5 and under	52,322	22.1%	57.5%	51,161	22.1%	55.8%
6 to 10	46,722	19.7%	70.3%	46,498	20.0%	69.1%
11 to15	46,073	19.5%	72.1%	45,473	19.6%	70.7%
16 to 18	21,240	9.0%	65.1%	22,047	9.5%	63.7%
19 to 20	4,580	1.9%	32.5%	4,401	1.9%	29.3%
21 to 29	22,107	9.3%	55.9%	21,354	9.2%	52.4%
30 to 39	25,526	10.8%	65.0%	23,705	10.2%	59.1%
40 to 49	15,038	6.4%	65.3%	14,307	6.2%	57.7%
50 and over	2,991	1.3%	60.6%	3,011	1.3%	53.3%
Gender						
Male	97,513	41.2%	62.9%	94,274	40.6%	60.9%
Female	138,878	58.7%	64.3%	134,352	57.9%	61.9%
Unknown	208	0.1%	5.8%	3,331	1.4%	26.8%
Race/ethnicity						
African American	59,024	24.9%	65.5%	57,925	25.0%	64.2%
White	93,273	39.4%	62.7%	89,297	38.5%	60.2%
Latino	77,978	33.0%	63.6%	78,494	33.8%	62.5%
Other groups	6,324	2.7%	47.9%	6,241	2.7%	30.9%
Primary language						
English	208,858	88.3%	74.4%	207,709	89.5%	68.7%
Spanish	18,892	8.0%	74.6%	19,134	8.2%	68.5%
Other languages	1,827	0.8%	79.6%	1,745	0.8%	71.8%
Unknown	7,022	3.0%	10.6%	3,369	1.5%	6.6%
Managed care plan						
BlueCare	93,317	39.4%	65.2%	91,998	39.7%	61.4%
CHNCT	37,281	15.8%	61.0%	38,010	16.4%	58.9%
HealthNet	70,664	29.9%	64.1%	65,000	28.0%	61.0%
Preferred One	15,264	6.5%	55.4%	18,797	8.1%	56.4%
Changed plans	20,073	8.5%	61.6%	18,152	7.8%	60.6%
Residence						
Bridgeport	23,244	9.8%	63.5%	22,349	9.6%	61.9%
Hartford	28,730	12.1%	64.3%	27,483	11.8%	62.2%
New Haven	21,954	9.3%	66.0%	21,731	9.4%	65.2%
All other towns	162,671	68.8%	62.5%	160,394	69.1%	59.3%

Note: These HUSKY A members were continuously enrolled for 12 months in the calendar year; the count is expressed as a percent of all those who were enrolled at least one month in the calendar year (ever enrolled).

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 1b. HUSKY A Enrollees: 2012 and 2013 (after program change)

	2012			2013		
	Number	Distribution	Percent of Ever Enrolled	Number	Distribution	Percent of Ever Enrolled
Total	359,285	100.00%	70.8%	367,966	100.0%	70.4%
Age						
5 and under	72,123	20.1%	66.1%	71,780	19.5%	65.4%
6 to 10	67,672	18.8%	81.8%	70,615	19.2%	80.8%
11 to15	62,753	17.5%	82.3%	64,404	17.5%	81.0%
16 to 18	32,460	9.0%	76.7%	33,544	9.1%	76.1%
19 to 20	6,296	1.8%	34.8%	5,888	1.6%	33.4%
21 to 29	31,584	8.8%	58.8%	31,530	8.6%	58.2%
30 to 39	44,535	12.4%	69.0%	46,446	12.6%	68.9%
40 to 49	31,288	8.7%	70.1%	32,428	8.8%	70.9%
50 and over	10,574	2.9%	66.6%	11,331	3.1%	66.6%
Gender						
Male	150,049	41.8%	71.0%	153,719	41.8%	70.2%
Female	208,724	58.1%	70.8%	214,247	58.2%	70.5%
Unknown Gender	512	0.1%	55.6%	0	0.0%	0.0%
Race/ethnicity						
Black	75,500	21.0%	71.9%	76,833	20.9%	72.0%
White	144,800	40.3%	69.5%	148,543	40.4%	69.0%
Hispanic	125,580	35.0%	72.0%	129,497	35.2%	71.3%
Other groups	12,830	3.6%	70.1%	13,026	3.5%	68.5%
Unknown Race/Ethnicity	575	0.2%	55.2%	67	0.0%	40.6%
Primary language						
English	320,614	89.2%	73.6%	329,629	89.6%	73.2%
Spanish	34,281	9.5%	76.1%	35,181	0.9%	76.3%
Other languages	2,900	0.8%	73.5%	3,133	9.6%	73.8%
Unknown Primary Language	1,490	0.4%	6.6%	23	0.0%	0.1%
Managed care plan						
BlueCare						
CHNCT						
HealthNet		NA			NA	
Preferred One						
Changed plans						
Residence						
Bridgeport	29,545	8.2%	71.5%	30,568	8.3%	70.7%
Hartford	35,012	9.7%	71.9%	36,026	9.8%	72.7%
New Haven	27,846	7.8%	75.1%	28,019	7.6%	73.6%
All other towns	266,882	74.3%	70.2%	273,353	74.3%	69.8%

NA: There were no managed care plans operating in HUSKY A in 2012 and 2013.

Note: These HUSKY A members were continuously enrolled for 12 months in the calendar year; the count is expressed as a percent of all those who were enrolled at least one month in the calendar year (ever enrolled).

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 2a. HUSKY A Enrollees Treated for Behavioral Health Conditions: 2004 and 2005 (before program change)

	2004			2005		
	Number	Distribution	Treatment Prevalence[a] (per 100 persons)	Number	Distribution	Treatment Prevalence[a] (per 100 persons)
Total	31,951	100.0%	13.5	32,618	100.0%	14.1
Age						
5 and under	2,224	7.0%	4.3	2,211	6.8%	4.3
6 to 10	6,282	19.7%	13.4	6,391	19.6%	13.7
11 to15	8,069	25.3%	17.5	8,265	25.3%	18.2
16 to 18	3,600	11.3%	16.9	3,930	12.0%	17.8
19 to 20	694	2.2%	15.2	711	2.2%	16.2
21 to 29	3,344	10.5%	15.1	3,475	10.7%	16.3
30 to 39	4,637	14.5%	18.2	4,449	13.6%	18.8
40 to 49	2,662	8.3%	17.7	2,711	8.3%	18.9
50 and over	439	1.4%	14.7	475	1.5%	15.8
Gender						
Male	13,419	42.0%	13.8	13,203	40.5%	14.0
Female	18,506	57.9%	13.3	18,130	55.6%	13.5
Unknown	26	0.1%	<1.0%	1,285	3.9%	38.6
Race/ethnicity						
African American	5,948	18.6%	10.1	6,124	18.8%	10.6
White	16,028	50.2%	17.2	16,145	49.5%	18.1
Latino	9,701	30.4%	12.4	10,090	30.9%	12.9
Other groups	274	0.9%	4.3	259	0.8%	4.1
Primary language						
English	26,908	84.2%	12.9	28,845	88.4%	13.9
Spanish	2,302	7.2%	12.2	2,300	7.1%	12.0
Other languages	171	0.5%	9.4	184	0.6%	10.5
Unknown	2,570	8.0%	36.6	1,289	4.0%	38.3
Managed Care Plan[b]						
BlueCare	12,233	38.3%	13.1	13,100	40.2%	14.2
CHN	4,547	14.2%	12.2	4,770	14.6%	12.5
HealthNet	10,342	32.4%	14.6	9,807	30.1%	15.1
Preferred One	1,576	4.9%	10.3	1,997	6.1%	10.6
Changed plan	3,253	10.2%	16.2	2,944	9.0%	16.2
Residence						
Bridgeport	2,377	7.4%	10.2	2,380	7.3%	10.6
Hartford	3,226	10.1%	11.2	3,266	10.0%	11.9
New Haven	2,512	7.9%	11.4	2,554	7.8%	11.8
All other towns	23,836	74.6%	14.7	24,418	74.9%	15.2

Note: Treatment prevalence is based on those who were continuously enrolled in the calendar year.

[a] Had care with behavioral health primary diagnosis ICD-9-CM 291 - 316.

[b] Behavioral health care subcontractors: BlueCare (Value Options), CHNCT (Magellan/Merit Behavioral Health), Health Net (Value Options), Preferred One (Comp Care)

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 2b. HUSKY A Enrollees Treated for Behavioral Health Condition: 2012 and 2013 (after program change)

	2012			2013		
	Number	Distribution	Treatment Prevalence[a] (per 100 persons)	Number	Distribution	Treatment Prevalence[a] (per 100 persons)
Total	68,612	100.0%	19.1	72,374	100.0%	19.7
Age						
5 and under	5,150	7.5%	7.1	5,745	7.9%	8.0
6 to 10	12,007	17.5%	17.7	12,654	17.5%	17.9
11 to15	14,610	21.3%	23.3	15,305	21.1%	23.8
16 to 18	8,015	11.7%	24.7	8,438	11.7%	25.2
19 to 20	1384	2.0%	22.0	1314	1.8%	22.3
21 to 29	7,073	10.3%	22.4	7,062	9.8%	22.4
30 to 39	11,008	16.0%	24.7	11,834	16.4%	25.5
40 to 49	7,223	10.5%	23.1	7,657	10.6%	23.6
50 and over	2,142	3.1%	20.3	2365	3.3%	20.9
Gender						
Male	28,603	41.7%	19.1	30,063	41.5%	19.6
Female	39,930	58.2%	19.1	42,311	58.5%	19.7
Unknown Gender	79	0.1%	15.4	0	0.0%	0.0
Race/ethnicity						
Black	11,423	16.6%	15.1	11,839	16.4%	15.4
White	34,191	49.8%	23.6	36257	50.1%	24.4
Hispanic	22,002	32.1%	17.5	23,364	32.3%	18.0
Other groups	908	1.3%	7.1	905	1.3%	6.9
Unknown Race/Ethnicity	88	0.1%	15.3	9	0.0%	13.4
Primary language						
English	62,433	91.0%	19.5	66,097	91.3%	20.1
Spanish	5,639	8.2%	16.4	5,864	8.1%	16.7
Other languages	369	0.5%	12.7	412	0.6%	13.2
Unknown Primary Language	171	0.2%	11.5	1	0.0%	4.3
Managed Care Plan[b]						
BlueCare						
CHN						
HealthNet		NA			NA	
Preferred One						
Changed plan						
Residence						
Bridgeport	4,138	6.0%	14.0	4,317	6.0%	14.1
Hartford	6,263	9.1%	17.9	6,585	9.1%	18.3
New Haven	4,483	6.5%	16.1	4,750	6.6%	17.0
All other towns	53,728	78.3%	20.1	56,722	78.4%	20.8

Note: Treatment prevalence is based on thosewho were continuously enrolled in the calendar year.

[a] Had care with behavioral health primary diagnosis ICD-9-CM 291 - 316.

[b] Value Options administers behavioral health services under a no-risk contract with the Department of Social Services

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 3a. Primary Diagnoses for Behavioral Health Disorders by Age Group, 2004

	Age Group		
Diagnostic Group	Total	Children 0-18	Adults 19+
Adjustment disorders	8,712	6,569	2,143
Anxiety disorders	9,224	5,682	3,542
Attention-deficit/conduct/disruptive behavior disorders	8,431	8,131	300
Delirium/dementia/amnestic/other cognitive disorders	214	96	118
Developmental disorders	967	960	7
Disorders usually diagnosed in infancy/childhood/adolescence	1,796	1,304	492
Miscellaneous mental disorders	156	60	96
Mood disorders	9,068	3,779	5,289
Personality disorders	197	143	54
Schizophrenia and other psychotic disorders	832	584	248
Substance-related disorders	4,013	912	3,101
Total diagnoses	**43,610**	**28,220**	**15,390**

Note: One person can have more than one diagnosis for care received in 2004
Diagnoses (n=28,220) for 20,175 children under who received care while continuously enrolled in HUSKY A in 2004.
Diagnoses (n=15,390) for 11,776 adults 19 and over who received care while *continuously* enrolled in HUSKY A in 2004.
Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 3b. Primary Diagnoses for Behavioral Health Disorders by Age Group, 2005

	Age Group		
Diagnostic Group	Total	Children 0-18	Adults 19+
Adjustment disorders	8,857	6,575	2,282
Anxiety disorders	8,977	5,618	3,359
Attention-deficit/conduct/disruptive behavior disorders	9,592	9,232	360
Delirium/dementia/amnestic/ other cognitive disorders	186	96	90
Developmental disorders	1,080	1,070	10
Disorders usually diagnosed in infancy/childhood/adolescence	1,960	1,518	442
Miscellaneous mental disorders	166	65	101
Mood disorders	9,275	3,965	5,310
Personality disorders	186	127	59
Schizophrenia and other psychotic disorders	936	664	272
Substance-related disorders	4,221	1,062	3,159
Total diagnoses	**45,436**	**29,992**	**15,444**

Note: One person can have more than one diagnosis for care received in 2005
Diagnoses (n=29,992) for 20,797 children under who received care while continuously enrolled in HUSKY A in 2005.
Diagnoses (n=15,444) for 11,821 adults 19 and over who received care while continuously enrolled in HUSKY A in 2005.
Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 3c. Primary Diagnoses for Behavioral Health Disorders by Age Group, 2012

	Age group		
Diagnostic Group	Total	Children 0-18	Adults 19+
Adjustment disorders	**19,528**	**13,060**	**6,468**
Adjustment reaction (309)	19,528	13,060	6,468
Anxiety disorders	**17,791**	**8,655**	**9,136**
Anxiety, dissociative, and somatoform disorders (300)	14,677	5,739	8,938
Acute reaction to stress (308)	415	188	227
Disturbance of emotion specific to childhood and adolescence (313)	3,317	3,248	69
Attention-deficit/conduct/disruptive behavior disorders	**18,819**	**17,360**	**1,459**
Disturbance of conduct, not elsewhere classified (312)	4,980	4,686	294
Hyperkinetic syndrome of childhood (314)	15,334	14,156	1,178
Delirium/dementia/amnestic/other cognitive disorders	**1,013**	**621**	**392**
Transient mental disorders due to other conditions (293)	567	288	279
Persistent mental disorders due to other conditions (294)	196	149	47
Specific nonpsychotic mental disorders due to brain damage (310)	258	189	69
Developmental disorders	**3,120**	**3,093**	**27**
Specific delays in development (315)	3,120	3,093	27
Disorders usually diagnosed in infancy /childhood/adolescence	**4,728**	**3,825**	**903**
Pervasive developmental disorders (299)	2,041	1,985	56
Special symptoms or syndromes, not elsewhere classified (307)	2,802	1,954	848
Miscellaneous mental disorders	**320**	**68**	**252**
Sexual and gender identity disorders (302)	162	26	136
Physiological malfunction arising from mental factors (306)	76	35	41
Psychic factors associated with other diseases (316)	82	7	75
Mood disorders	**20,267**	**7,894**	**12,373**
Episodic mood disoders (296)	14,712	5,423	9,289
Depressive disorder, not elsewhere classified (311)	8,340	3,754	4,586
Personality disorders	**577**	**450**	**127**
Personality disorders (301)	577	450	127
Schizophrenia and other psychotic disorders	**3,056**	**1,934**	**1,122**
Schizophrenic disorders (295)	513	117	396
Delusional disorders (297)	40	10	30
Other nonorganic psychoses (298)	2,682	1,877	805
Substance-related disorders	**9,539**	**1,469**	**8,070**
Alcohol-induced mental disorders (291)	116	10	106
Drug-induced mental disorders (292)	314	89	225
Alcohol dependence syndrome (303)	948	78	870
Drug dependence (304)	4,906	566	4,340
Nondependent abuse of drugs (305)	4,971	977	3,994
Total diagnoses	**98,758**	**58,429**	**40,329**

Note: One person can have more than one diagnosis for care received in 2012.

Diagnoses (n=58,429) for 42,142 children under who received care while continuously enrolled in HUSKY A in 2012.

Diagnoses (n=40,329) for 28,830 adults 19 and over who received care while continuously enrolled in HUSKY A in 2012.

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services

Table 3d. Primary Diagnoses for Behavioral Health Disorders by Age Group, 2013

	Age group		
Diagnostic Group	Total	Children 0-18	Adults 19+
Adjustment disorders	**20,570**	**13,635**	**6,935**
Adjustment reaction (309)	20,570	13,635	6,935
Anxiety disorders	**19,311**	**9,323**	**9,988**
Anxiety, dissociative, and somatoform disorders (300)	16,306	6,514	9,792
Acute reaction to stress (308)	456	220	236
Disturbance of emotion specific to childhood and adolescence (313)	3,153	3,098	55
Attention-deficit/conduct/disruptive behavior disorders	**19,627**	**18,002**	**1,625**
Disturbance of conduct, not elsewhere classified (312)	4,951	4,662	289
Hyperkinetic syndrome of childhood (314)	16,262	14,914	1,348
Delirium/dementia/amnestic /other cognitive disorders	**1,154**	**717**	**437**
Transient mental disorders due to other conditions (293)	671	373	298
Persistent mental disorders due to other conditions (294)	174	122	52
Specific nonpsychotic mental disorders due to brain damage (310)	319	227	92
Developmental disorders	**3,692**	**3,672**	**20**
Specific delays in development (315)	3,692	3,672	20
Disorders usually diagnosed in infancy /childhood/adolescence	**5,270**	**4,229**	**1,041**
Pervasive developmental disorders (299)	2,375	2,311	64
Special symptoms or syndromes, not elsewhere classified (307)	3,030	2,050	980
Miscellaneous mental disorders	**416**	**104**	**312**
Sexual and gender identity disorders (302)	182	47	135
Physiological malfunction arising from mental factors (306)	111	51	60
Psychic factors associated with other diseases (316)	123	6	117
Mood disorders	**21,146**	**8,354**	**12,792**
Episodic mood disoders (296)	15,265	5,812	9,453
Depressive disorder, not elsewhere classified (311)	8,853	3,984	4,869
Personality disorders	**706**	**526**	**180**
Personality disorders (301)	706	526	180
Schizophrenia and other psychotic disorders	**3,281**	**2,137**	**1,144**
Schizophrenic disorders (295)	500	119	381
Delusional disorders (297)	42	14	28
Other nonorganic psychoses (298)	2,882	2,070	812
Substance-related disorders	**9,940**	**1,435**	**8,505**
Alcohol-induced mental disorders (291)	125	8	117
Drug-induced mental disorders (292)	358	93	265
Alcohol dependence syndrome (303)	981	72	909
Drug dependence (304)	5,366	562	4,804
Nondependent abuse of drugs (305)	5,180	976	4,204
Total diagnoses	**105,113**	**62,134**	**42,979**

Note: One person can have more than one diagnosis for care received in 2013.

Diagnoses (n=62,134) for 39,782 children under who received care while continuously enrolled in HUSKY A in 2013.

Diagnoses (n=40,329) for 30,232 adults 19 and over who received care while continuously enrolled in HUSKY A in 2013.

Source: Connecticut Voices for Children analysis of HUSKY Program data from Connecticut Department of Social Services