



REPORT TO THE LEGISLATURE

Predicting Court Orders for Competency Evaluation

As required per Engrossed Substitute Senate Bill 5092, Section 202(g)(i)

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Executive Summary

Engrossed Substitute Senate Bill 6032 (Chapter 299, Laws of 2018) directed the Department of Social and Health Services to develop and implement a predictive modeling tool to identify people with behavioral health needs who are at high risk of future involvement with the criminal legal system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report¹ submitted in 2018. This report describes the subsequent operational enhancement of the predictive modeling approach, its implementation and use.

The operationalized approach reflects several considerations including:

- The predominance of Medicaid beneficiaries in the population of people with behavioral health needs involved in the criminal legal system,
- The potential for Medicaid-contracted integrated managed care plans and Behavioral Health Administrative Services Organizations or ASOs to implement behavioral health interventions to reduce the likelihood of arrest for their high-risk enrollees, and
- The priority of improving outcomes for Trueblood class members who are at risk of further involvement in the forensic mental health system.²

The original predictive model was developed using a machine-learning methodology applied to risk factors derived from several data sources to predict the target outcome of a competency evaluation court order within the following six months. Following exploration of model performance in a validation sample, an alternative method was developed for operational use. The alternative approach provides:

- Higher predictive accuracy in validation samples,
- More equitable risk scoring for people without prior enrollment in medical, food, or cash assistance programs,
- More timely data for operational use, and
- More accurate identity management in a programmatic context where it is highly desirable to avoid “false positives” that might arise through inaccurate linkage of individual-level information from multiple data systems.

¹ Available at <https://www.dshs.wa.gov/ffa/rda/research-reports/predicting-referrals-competency-evaluation-required-engrossed-substitute-senate-bill-6032-chapter-299-laws-2018>

² In April 2015, a federal court found in the case of Trueblood v DSHS that DSHS was taking too long to provide competency evaluation and restoration services. As a result, the State has been ordered to provide court-ordered competency evaluation and restoration services within specified timeframes. The Trueblood class includes individuals detained in local jails awaiting competency evaluation and restoration services, and individuals previously receiving competency evaluation or restoration services who were released and at-risk for re-arrest or re-hospitalization.

In the model currently in place, DSHS Research and Data Analysis Division or RDA, identifies individuals with two or more competency evaluation orders, with different cause numbers, with different sign dates, in the past 24 months – a population at relatively high risk of future interaction with the criminal legal system. Lists of these clients are then matched with contact information to support targeted outreach and engagement in a service model called Forensic Projects for Assistance in Transition from Homelessness, referred to as FPATH.

Under this approach:

- RDA identifies clients at high risk for involvement with the criminal legal system and for future forensic competency evaluation court orders,
- RDA creates monthly datasets of names and contact information for these clients, by Managed Care Organization or MCO and ASO region,
- RDA transfers the datasets to DSHS forensic navigators and the Health Care Authority, who then distribute them to MCO and ASO staff and FPATH providers,
- MCOs and ASOs conduct outreach activities and employ other methods of improving care coordination for these individuals at high risk.

This report will provide a description of the processes currently in place, information on the number of clients identified for outreach, and a description of how MCOs and ASOs use this information to improve care coordination.

Scope and Purpose

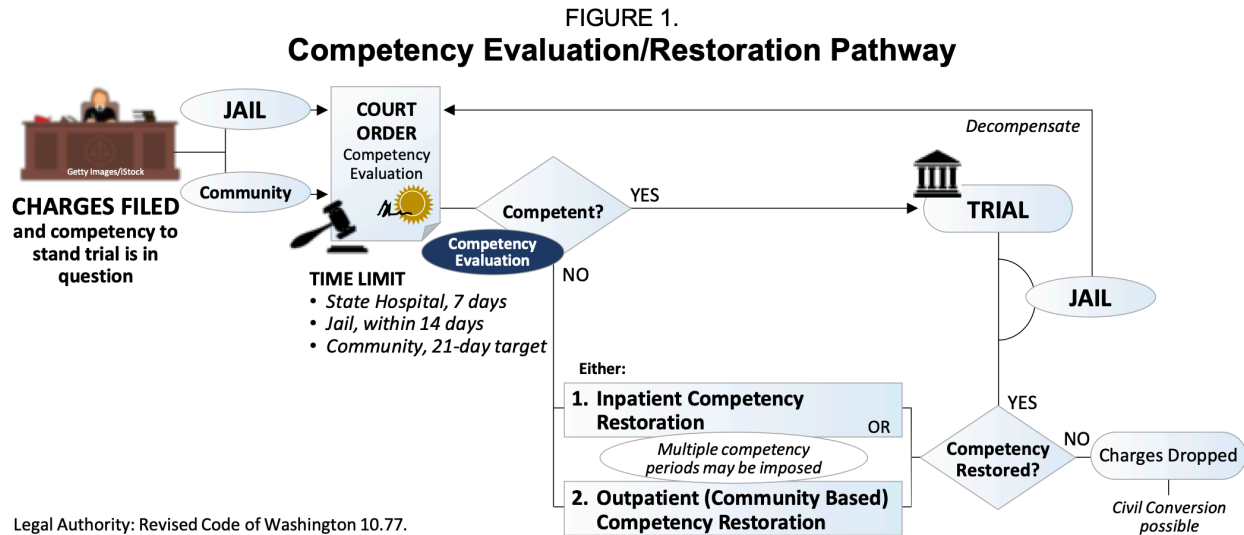
Engrossed Substitute Senate Bill (ESSB) 6032 (Chapter 299, Laws of 2018) directed the DSHS to develop and implement a predictive modeling tool which identifies persons with behavioral health needs who are at high risk of future involvement with the criminal legal system. This report is in accordance with the budget proviso (ESSB 5167, Chapter 424, Laws of 2025):

(i) By the first day of each December during the biennium, the department, in coordination with the health care authority, must submit a report to the office of financial management and the appropriate committees of the legislature which summarizes how the predictive modeling tool has been implemented and includes the following: (A) The numbers of individuals identified by the tool as having a high risk of future criminal justice involvement; (B) the method and frequency for which the department is providing lists of high-risk clients to contracted managed care organizations and behavioral health administrative services organizations; (C) a summary of how the managed care organizations and behavioral health administrative services organizations are utilizing the data to improve the coordination of care for the identified individuals; and (D) a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level.

The first section of this report introduces the FPATH program and background on the development and refinement of the predictive modeling tool. The following section provides information about numbers of clients identified and related administrative data. The closing section describes the methods of providing information to MCOs and ASOs, and how those organizations use the information.

Background

The forensic mental health system operates at the intersection of the legal and behavioral health care systems, providing competency evaluation services when a court believes a mental health condition may prevent a criminal defendant from assisting in their own defense, and restoration services when the evaluation finds the defendant is not competent to assist in their own defense. Figure 1 provides a high-level overview of the operation of the forensic mental health system.



The Trueblood v. DSHS lawsuit challenged unconstitutional delays in competency evaluation and restoration services for people detained in city and county jails. The Trueblood Contempt Settlement Agreement establishes a plan for providing services to people with behavioral health conditions involved in the criminal legal system and for providing restoration services and connections to treatment to reduce the likelihood of future involvement.

Forensic Projects for Assistance in Transition from Homelessness

As part of the Trueblood Settlement of Contempt Agreement, the state is funding targeted outreach, in-reach to jails, and engagement to connect identified individuals with behavioral health services using the FPATH model. In the Agreement, this program is called Intensive Case Management for High Utilizers.

Each month, RDA sends HCA an “eligibility list” of people with two or more competency evaluation court orders with different cause numbers and sign dates in the past 24 months, who are at higher risk for repeat court orders. HCA then applies filters to create a prioritized list of individuals based on housing status (prioritizing unstably housed and homeless), number of competency evaluation orders (four or more in the past 24 months), and county of residence (prioritizing rural counties). FPATH providers receive the prioritized eligibility list, while ASOs and forensic navigators get the full, unfiltered list.

FPATH teams are based in community behavioral health agencies and include case managers and certified peer specialists with lived experience who are grounded in their recovery. These specialists provide support to individuals on the FPATH eligibility list who may be experiencing homelessness or housing instability and have had multiple competency evaluation orders in the past 24 months. FPATH teams assertively seek to engage people and connect them with community supports including housing, transportation, health care, and behavioral health services. People ordered by a court to receive forensic navigator or outpatient competency restoration services may also use FPATH for case management services if they appear on the eligibility list created by RDA.

Current Status and Areas of Positive Impact

FPATH teams have been providing targeted outreach, in-reach, and engagement to people identified on the eligibility list since March 2020. Using a model like the federal PATH program, teams have been reaching out to eligible individuals with an emphasis on homeless or unstably housed individuals. FPATH aims to build relationships and rapport to connect people to long-term support with community resources and services. Many people who are FPATH-eligible are experiencing homelessness or housing instability, so FPATH teams always strive to engage people “where they are at.”

As noted earlier, teams prioritize outreach and engagement for people living in rural areas, those with four or more competency evaluation orders in the past 24 months regardless of housing status, and those experiencing homelessness. The intent behind prioritization is to assist in connecting those most at risk of additional court orders for competency evaluations to services in hopes of diverting them from further court involvement.

FPATH Program Participation Data

FPATH data in the current report come from the Homeless Management Information System and monthly Excel trackers submitted by FPATH providers for earlier periods, and from the Program Data Acquisition, Management, and Storage Solution for data collected from May 2024 onward.

The FPATH program began March 1, 2020, in Phase 1 regions, April 1, 2022, in the Phase 2 region, and April 30, 2024, in the Phase 3 regions.³ Between March 1, 2020, and June 30, 2025, 4,917 people were referred to the program across all regions. Of these, 3,197 met the HCA's prioritization criteria (i.e., unstably housed or homeless, four or more competency evaluation orders in the past 24 months, or residing in a rural county).

Of all people on the eligibility list, FPATH providers attempted to contact 1,920 (39 percent), and successfully contacted 1,804 (37 percent). As of June 30, 2025, a total of 1,030 people (21 percent of overall referrals) were enrolled in the FPATH program. Of these, the majority were male (71 percent) and between 30 and 49 years old (62 percent). More than half of enrolled people (54 percent) were homeless, while 21 percent were unstably housed, indicating that providers were focused on enrolling those in the priority population.

Predictive Model Development

Engrossed Substitute Senate Bill 6032 (Chapter 299, Laws of 2018) directed the DSHS to develop and implement a predictive modeling tool to identify persons with behavioral health needs who are at high risk of future involvement with the criminal legal system. In response to this directive, a predictive modeling tool was developed, as described in the legislative report submitted in 2018.⁴ In consultation with legislative staff, the target population for the predictive model was focused on court orders for competency evaluation, to align with the Trueblood objectives. Among the key lessons learned and included in the legislative report:

- "Prior experiences in the forensic mental health system are by far the most important information in predicting future competency evaluation court orders."
- "Rapid-cycle linkage of managed care enrollment with data from the recently implemented Forensic Data System offers the most timely opportunity for identifying enrolled Medicaid beneficiaries who are at high risk of a future competency evaluation referral."
- "We dropped arrest history, adjudication history, and behavioral health diagnosis variables from our final model due to data timeliness limitations in an operational context, with minimal loss of predictive accuracy in the validation sample."

Subsequent analysis of the validation sample developed for the legislative report (described further below) led RDA to make the following recommendations for operationalizing client lists to support

³ As determined by the Trueblood Contempt Settlement Agreement, programs are being implemented in phases. Phase 1 includes the Pierce (Pierce County), Southwest (Clark, Klickitat, and Skamania Counties), and Spokane Regions (Spokane, Adams, Ferry, Lincoln, Pend Oreille, Stevens Counties). Phase 2 includes the King Region (King County). Phase 3 includes Salish (Kitsap, Jefferson, Clallam Counties) and Thurston-Mason Regions (Thurston, Mason Counties).

⁴ Available at <https://www.dshs.wa.gov/ffa/rda/research-reports/predicting-referrals-competency-evaluation-required-engrossed-substitute-senate-bill-6032-chapter-299-laws-2018>.

the FPATH program:

- Target the FPATH program to people with two or more prior competency evaluation orders, with different cause numbers, with different sign dates, in the past 24 months.
- Use rapid-cycle linkage of FDS data, ACES social service data, ProviderOne Medicaid eligibility, managed care enrollment, and behavioral health data to identify the target population, measure risk factors, and create client lists to be updated monthly.
- Create distinct client lists for different user groups and populations to align with privacy requirements and care management responsibilities (e.g., separate lists for Medicaid MCOs, ASOs, state agency staff, and FPATH program staff).
- To support triage, outreach/engagement, and intervention planning, supplement client lists with client-level risk factors including homelessness, prior psychiatric hospitalization, and volume/result of prior evaluation/restoration court orders.

The advantages of the proposed approach included:

- Higher predictive accuracy in validation samples relative to the original model,
- More equitable risk scoring for people without prior enrollment in medical, food, or cash assistance programs,
- More timely data for operational use, and
- More accurate identity management (in a programmatic context where it is highly desirable to avoid “false positives”) by providing a far more focused set of cases where manual identity linkage is required.

These recommendations were presented to Plaintiff’s Counsel and the Court Monitor involved in Trueblood litigation in January 2020, with consensus support for proceeding in the proposed direction.

Validation Sample Analysis

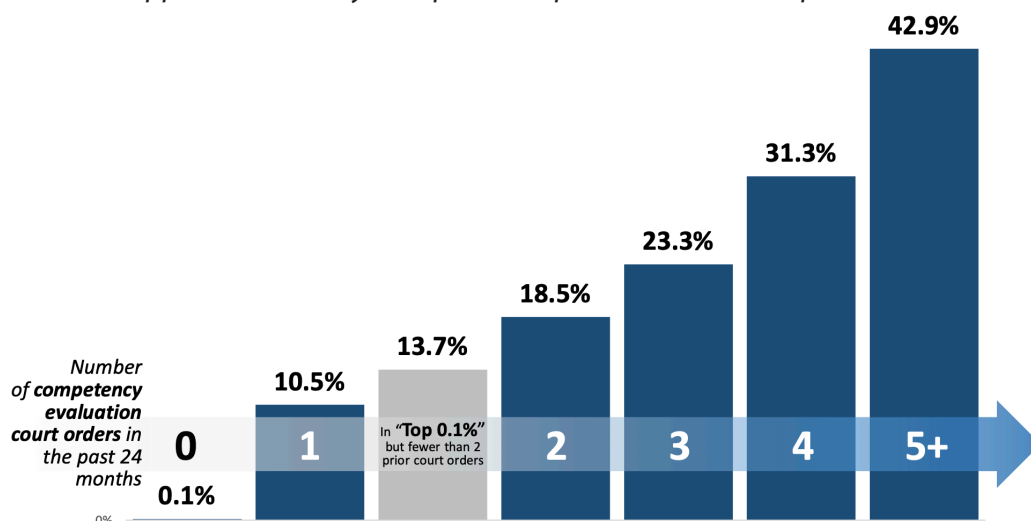
Figure 2 illustrates the efficacy of the implemented approach, relative to the results of the original predictive model, in the validation sample developed for the predictive modeling reflected in the 2018 legislative report. The implemented approach targets the population with 2+ referrals for eligibility for FPATH program services. As shown in the figure below, the population receiving a high-risk score via the original predictive model (defined as those in the top 0.1% of the risk pool) who did not meet the 2+ evaluation order criterion had a significantly lower rate of subsequent occurrence of the target outcome (a competency evaluation court order within the next 6 months), relative to persons meeting the 2+ evaluation order criterion.

In part, this is an illustration of the importance of competency order history in the original predictive model. Most clients who scored in the top 0.1% based on the original model had two or more competency evaluation court orders in the prior 24 months. But among those who did not meet this criterion, observed rates of the target outcome in the validation sample were relatively low. This observation, along with the significant operational considerations previously noted (timeliness of data, identity management implications, and equity for persons not connected to public assistance programs), formed the rationale for RDA’s proposed and subsequently implemented approach.

FIGURE 2

Assessing Predictive Accuracy: Proportion with a Competency Evaluation Court Order in the Following Six Months, by Number of Previous Court Orders

Supplemental analysis of proviso report validation sample data



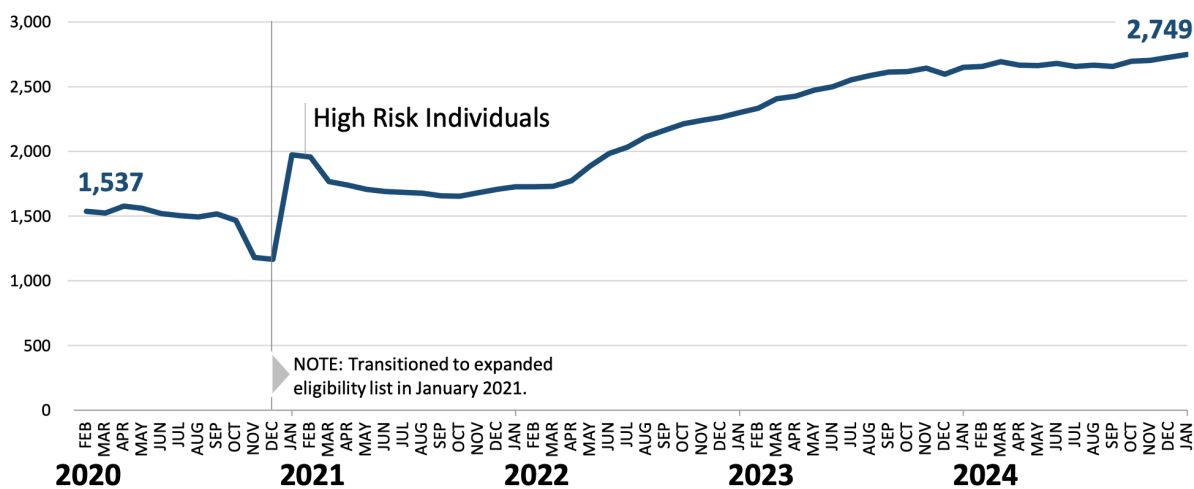
SOURCE: DSHS Research and Data Analysis Division.

The Number of Individuals Identified for the Eligibility List

Figure 3 shows the trend in the statewide aggregate eligibility list size. The list was originally restricted to people with recent participation in food, cash, or medical assistance. The increase in January 2021 reflects the removal of this restriction.

FIGURE 3

Statewide Monthly Trend in Individuals at High Risk

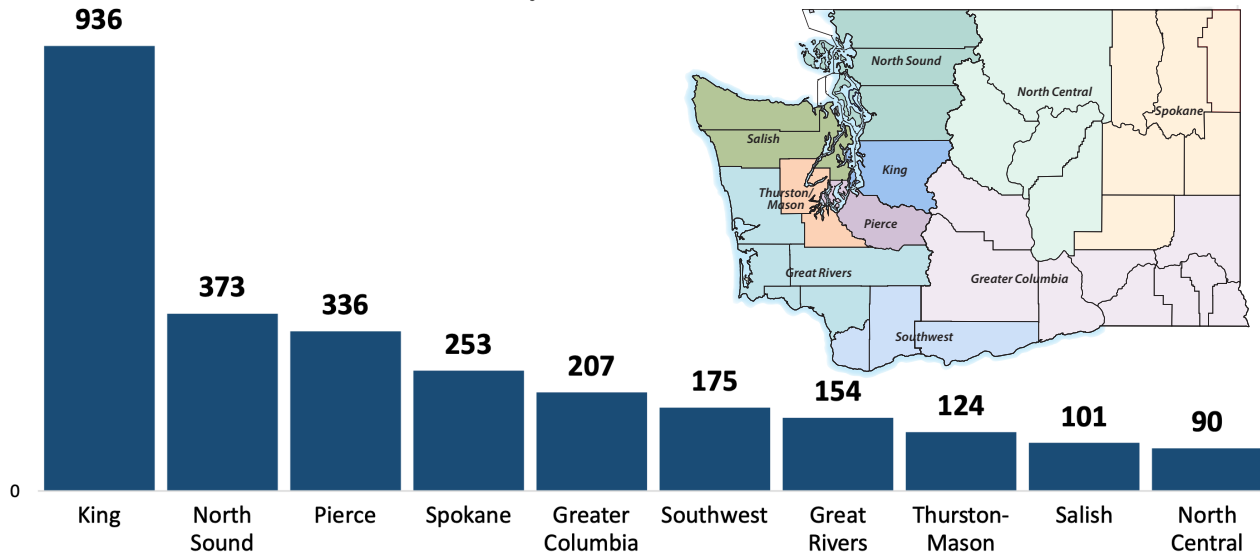


SOURCE: ProviderOne, Monthly FPATH eligibility lists.

Figure 4 provides the distribution of the January 2025 eligibility list by Apple Health region, excluding four persons for whom the region could not be assigned. King County represents 34 percent of the statewide target population.

FIGURE 4

FPATH Target Population by Apple Health Region
Supplemental analysis of proviso report validation sample data

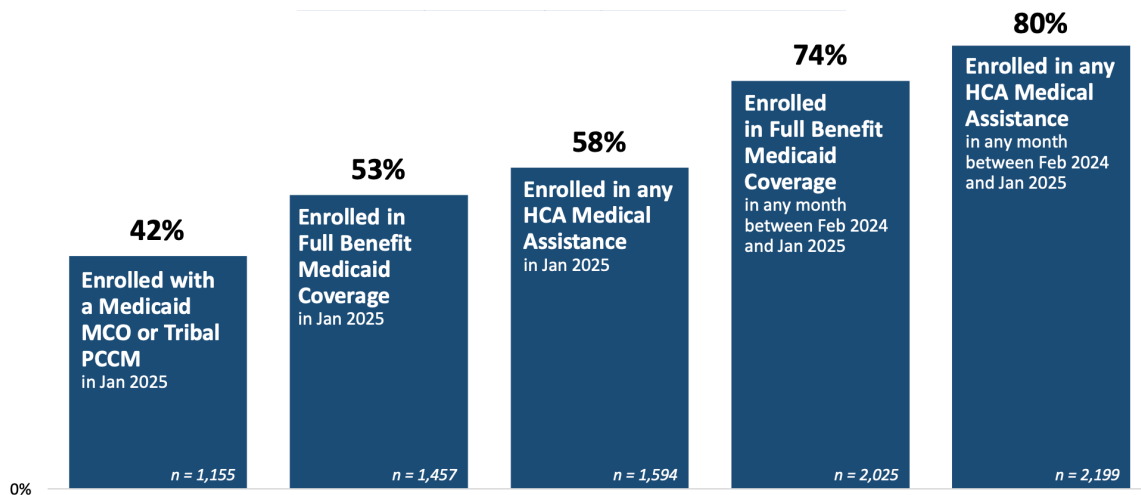


SOURCE: ProviderOne, Monthly FPATH eligibility lists.

Figure 5 provides information about the medical coverage status of the January 2025 eligibility list in that month (first three columns) or over the 12-month period ending in January 2025.

FIGURE 5

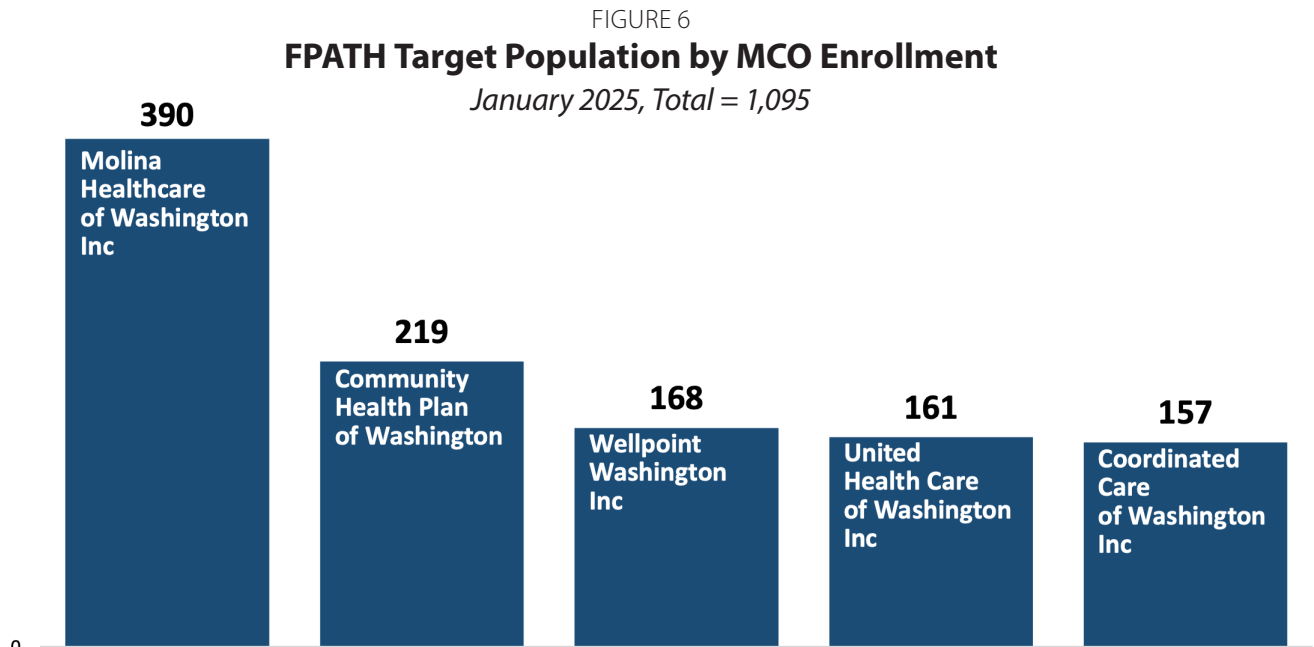
FPATH Target Population by Coverage Status
On January 2025 Eligibility List, Total = 2,749



SOURCE: ProviderOne, Monthly FPATH eligibility lists.

Figure 5 shows there is significant Medicaid coverage churn in this population, likely driven by high rates of incarceration and homelessness. For example, among people on the January 2025 list, 53 percent had full benefit Medicaid coverage in that month, while 74 percent had full benefit Medicaid coverage at some time over the 12-month period spanning February 2024 through January 2025.

Figure 6 shows the distribution of the MCO-enrolled January 2025 eligibility list by organization. At 36 percent, Molina Healthcare of Washington had the largest share of Medicaid beneficiaries on the January 2025 eligibility list.



SOURCE: ProviderOne, Monthly FPATH eligibility lists.

Analysis of Impacts on Access to Services and Recidivism

The budget proviso asks the Department to provide “a summary of the administrative data to identify whether implementation of the tool is resulting in increased access and service levels and lower recidivism rates for high-risk clients at the state and regional level.” An evaluation design has been developed and shared with the Trueblood Plaintiff’s counsel and court monitor as part of the State’s Trueblood Settlement Agreement activities. Initial evaluation findings were not available for inclusion in this report.

MCO and ASO Activities

HCA requires both the Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (ASOs) to engage in care coordination for people at high-risk for cycling through the forensic mental health system. To support those efforts, HCA has provided lists of FPATH-eligible participants to MCOs, ASOs, and the FPATH providers, including demographic information for people in the highest need of outreach and assistance.

Managed Care Organizations

HCA contracts with five MCOs across the State of Washington. MCO contracts include language requiring them to develop and implement plans for improving access to timely and appropriate treatment for individuals with behavioral health needs and current or prior criminal justice involvement.⁵ The MCOs continued to make use of these lists and have bolstered their programs targeted to those who are criminal court involved.

Wellpoint Washington

Wellpoint Washington, or WLP is the new name for Amerigroup Washington, Inc., a health insurance company that provides managed care for state and federal health programs, including Apple Health (Medicaid) and Medicare Advantage plans. Wellpoint's goals are to ensure safe community reintegration, reduce recidivism, and promote overall well-being for people who are involved in the criminal legal system. Their approach to enhancing care coordination for members at high risk of criminal legal involvement involves a multi-faceted strategy that utilizes assessments and targeted support to address individual needs. WLP prioritizes integrated strategies that bridge health and social support services while leveraging data analytics to identify high-risk individuals and tailor interventions. WLP strategies include:

Key Tools and Processes:

- Licensed behavioral health professionals: High-risk cases are triaged by licensed BH professionals, ensuring specialized focus.
- Trueblood High Utilizer Report: Ensures comprehensive outreach irrespective of member location.
- Forensic program collaboration: Members are contacted through collaboration with forensic programs to enhance care coordination.

Reentry coordination, comprehensive education, and resource linkage:

- Reentry work and collaboration: Coordinating with jail staff and community resources for housing, employment, education, and healthcare.
- Mental health and substance use disorder Support: Providing access to in-network mental health agencies and substance use treatment programs.
- Case management and goal setting: Pre- and Post-discharge telephonic case management with regular check-ins and personalized whole health assessments.

⁵See Appendix 1 for excerpts from the Apple Health Integrated Managed Care contract related to clients involved in the criminal justice system. Found at <https://www.hca.wa.gov/assets/billers-and-providers/imc-medicaid.pdf>

Additional Member Resources:

- Transportation, internet, and technology support: Eligible members receive gift cards for GED tests and internet services, and laptops for employment and education.
- Meditation app subscription: Annual subscriptions to support mental well-being.
- Safelink and GED support: Encouragement of educational advancement and communication connectivity.
- Peer support: Covering costs for eligible members to become peer support counselors, fostering community connection and support.

Community Health Plan of Washington

In 2025, Community Health Plan of Washington enhanced re-entry services to align with 1115 waiver requirements. This included adding community health workers to an existing team of case managers to support the needs of this population. This multidisciplinary Carceral Transitions team works collaboratively with correctional facilities, community organizations, and healthcare providers to ensure coordinated care for members. Staff continue to provide care coordination post-release, supporting a seamless reintegration into the community.

Carceral Transitions case managers conduct targeted outreach and are assigned to all incarcerated members identified on the Trueblood High Utilizers report. They share relevant information with correctional facilities to promote continuity of care during incarceration.

Complex discharge case managers assist members facing barriers to safe discharge, including those listed on the Trueblood report. They facilitate referrals and collaborate with facilities and community partners to ensure members are discharged to appropriate levels of care.

Coordinated Care of Washington

Coordinated Care of Washington continues to conduct outreach to Trueblood-identified members through the Trueblood High Utilizer Report. Their Re-Entry team also remains active in engaging individuals currently in carceral facilities or recently released, offering resources, care coordination, and care management. As of July 1, 2025, Coordinated Care has implemented pre- and post-release reentry targeted case management in accordance with the HCA Reentry Targeted Case Management guidelines.⁶ Coordinated Care case managers coordinate with the corrections facilities, courts, and other reentry service providers to outreach to members identified on the FPATH report. Coordinated Care has created specific workflows to assist with care coordination and collaboration with corrections facilities; these have been updated to reduce barriers associated with the process.

Once the client is reached and agrees to case management, Coordinated Care provides services such as:

- Finding doctors, dentists, behavioral health providers, telehealth, and treatment services that are culturally and linguistically appropriate.

⁶See [Reentry Initiative FAQs](#) for facts about the Reentry Targeted Case Management program

- Scheduling appointments and court-ordered assessments such as those required for Least Restrictive Alternative placements, conditions of probation, or Trueblood cases.
- Scheduling transportation to appointments.
- Applying for community resources such as employment, housing, food, disability benefits, cell phone services, and other benefits and resources.
- Connecting to culturally appropriate care and resources, including Indian Health Care Providers and tribal-specific resources for American Indian/Alaska Native populations.
- Making sure eligibility is active after release.
- Covering emergency medication fills without prior authorization for members being released from correctional facilities, including prescriptions filled on the day of release to allow for continuity of care.

UnitedHealthcare

Trueblood data are used to improve the coordination of care services to members. Data primarily received from the Trueblood FPATH report is provided to the Senior Clinical Program Manager for Criminal Justice who conducts a thorough review of each member. Following a review, members are then assigned according to whichever internal clinical or behavioral health team best suits their needs. If the member is transitioning from a carceral facility, then members are assigned to a community health worker on the jail transitions team for outreach and enrollment. During outreach, and subsequent enrollment, each member is provided with an assessment of needs to include medical, medication management, mental, dental as well as social determinants of health such as transportation, disability, housing, employment, and other support services.

While UnitedHealthcare still maintains a geographically dispersed team, which allows face to face meetings with members, expansion into other regions has allowed them to maneuver into provision of telehealth and virtual offerings of services. Members still receive outreach in custody and in the community daily. Members who are assessed and meet additional criteria may be assigned to various clinical or behavioral health programs.

UnitedHealthcare still collaborates with behavioral health advocates to provide an assessment, care coordination, and/or referral to a treatment center or telephonic modality for Medication Assisted Treatment. This population, while often having high needs, are difficult to reach, and reluctant to engage.

In 2024, UnitedHealthcare was approached by DSHS to pilot a Trueblood program out of South Correctional Entity (SCORE) Jail. UnitedHealthcare facilitated communication efforts between DSHS program managers and all MCOs and eventually there was forward movement with program implementation. A data share agreement was signed and executed between UnitedHealthcare and DSHS at the end of 2024 and the program began sending UnitedHealthcare Trueblood referrals during Q1 of 2025. As UnitedHealthcare already had an onsite community health worker, they were able to connect with members in person and provide them with services. Unfortunately, DSHS informed UnitedHealthcare that they lost their funding for this pilot, and the program ended effective June 30, 2025. During the pilot program's tenure, they connected to the Genoa Pharmacy program which saw an increase in members receiving prescriptions month-over-month.

Molina

Molina has strengthened its collaboration with Juvenile Rehabilitation by expanding coordination efforts and regularly participating in future planning and admission meetings with Juvenile Rehabilitation staff. This ongoing partnership ensures smoother transitions and better support for criminal legal-involved youth.

Molina prioritizes in-person engagement with jail leadership to enhance care coordination and foster stronger relationships. In 2025 alone, the team has conducted 58 in-person meetings across facilities.

In response to growing needs, Molina has also increased staffing capacity to support more frequent in-person visits to carceral facilities, ensuring improved continuity of care and timely access to services.

Molina's leadership has been recognized as subject-matter experts, serving as guest speakers at multiple conferences, including the Washington State "State of Reform" health policy event.

Additionally, Molina has developed two innovative initiatives to improve healthcare access for incarcerated and recently released individuals:

1. Mobile Health Clinic Deployment – A mobile clinic was stationed at the courthouse and jail campus in Spokane, providing on-site medical care to recently released individuals.
2. Library and Jail Partnership – In collaboration with the Stevens County Library District and Stevens County Jail, Molina launched a unique program to distribute telehealth-enabled laptop kits. These kits are available for recently incarcerated individuals to check out through the library system, offering them a vital connection to healthcare services and other essential resources.

Behavioral Health Administrative Service Organizations

The HCA contracts with eight Behavioral Health Administrative Service Organizations in ten regions across the State of Washington. The ASOs provide crisis services and are frequently the first point of contact for clients who are at risk of criminal legal involvement.

This year, the ASOs report increased collaboration and care coordination related to criminal legal-involved individuals. While these are not all specific to the target population for FPATH, the programs have resulted in strong partnerships between the ASOs and the court systems across the state.

Carelon

Carelon Behavioral Health (serving North Central, Southwest, and Pierce regions) reports that they are committed to partnering with the HCA to support individuals at the cross-section of behavioral health and the criminal legal system. Carelon receives monthly updated Trueblood rosters from the HCA for all three regions. These rosters are sorted for MCO eligibility and current incarcerated status. Individuals receive Care Coordination and Case Management services from the following entities. In Pierce County, Trueblood Diversion case management services are offered through Greater Lakes. In SWWA, Case Management services are available to Trueblood Diversion members through Columbia River Mental Health through the FHARPS program. NCWA does not have a dedicated Trueblood Diversion oversight team, so unfunded Trueblood Diversion members receive outreach services from the Carelon clinical team who attempt to enroll them in case management for additional support. Carelon is working closely with Catholic Charities on providing additional support to Trueblood Diversion members in NCWA.

Some of their efforts to engage with this population are:

- The Criminal Justice Treatment Account provides substance use disorder treatment and recovery support services for individuals facing charges by a prosecutor or enrolled in drug court.
- Assisted Outpatient Treatment (AOT) uses a court order to provide behavioral health treatment for clients meeting specific criteria.
- Enhanced Mobile Crisis Response and Enhanced Crisis Triage/Stabilization serves to increase the effectiveness of those programs in local areas.
- The Recovery Navigator Program offers peer-lead recovery support, field-based case management, and care coordination.
- Our Jail Transition Services programs provide mental health assessment and care coordination for individuals transitioning out of jails.
- The Peer Pathfinder Program assists individuals through the entry process to identify necessary services and resources and provide a successful transition to long-term behavioral health and community supports.
- Carelon teams facilitate multidisciplinary team meetings across programs and in cooperation with local clinical and social service agencies.
- Carelon receives a monthly roster of unfunded individuals utilizing Forensic Assertive Community Treatment, or FACT, services through Greater Lakes Mental Health for individuals in Pierce County. This roster is utilized for care coordination and oversight of individuals participating in the FACT Community teams under Carelon ASO.

Spokane ASO

Spokane Region ASO reports that the Peer Pathfinder - Jail Transitions Program provides peer support services to assist individuals as they prepare for re-entry after incarceration. This program assists individuals through the discharge process to identify necessary services and resources and provide a warm hand-off to long-term behavioral health supports.

Salish

As a new Trueblood region, Salish ASO continues to see the development of Trueblood programs including FPATH and FHARPS as well as the expansion of OCRP because of data indicating the need in the Salish Region. Salish continues to work with and support agencies to serve individuals involved in the criminal legal system, including through Criminal Justice Treatment Account and Recovery Navigator Program (RNP) programs. Mobile Crisis Outreach Teams in the region routinely coordinate with law enforcement agencies regarding the provision of crisis services to criminal legal involved individuals.

Specifically, Salish ASO works to improve care coordination for individuals who are at high risk of criminal justice involvement by:

- Facilitating a quarterly law enforcement engagement meeting, that has included up to 27 jurisdictions across our region to address behavioral health needs.
- Supporting behavioral health and program focused trainings to law enforcement groups across the region's three counties.
- Facilitating community conversations related to crisis service engagement for this population.
- Facilitating a quarterly navigator meeting that includes co-response embedded in law enforcement and fire to continue conversations about community-based needs. These forums have included jail programs, diversion programs, and outreach programs.

King County

King County uses the data provided through the FPATH list and matches it with other utilization data to generate a monthly list of individuals in need of care coordination. This meeting, facilitated by the King County Diversion and Reentry Services Trueblood Team, occurs once a month and includes participants from Trueblood diversion programs, administrators for Program for Active Community Treatment, providers for FPATH and FHARPS, MCOs, and other community behavioral health programs as needed.

These collaborative meetings allow MCOs to clarify roles in coordinating services and ensure that necessary referrals are in place, particularly for clients transitioning into or out of hospitals and other managed care facilities. Additionally, the FPATH list is used in other care coordination meetings to identify clients eligible for FPATH and FHARPS services, ensuring timely and appropriate referrals.

Partnership between MCOs and ASOs

The MCOs collaborate with the ASOs across the state to ensure better coordination for clients. For example, Wellpoint actively participates in local Trueblood coordination efforts, e.g. attending the King and Spokane County coordination meetings and coordinating frequently with the Grays Harbor Trueblood Coordinator.

UnitedHealthcare continues to maintain a close relationship with ASOs within each region and King County Behavioral Health Recovery Division to ensure a clear referral path for individuals who may be transitioning to or away from Integrated Managed Care coverage. UHC is participating in bi-weekly operations meetings, attending the bi-weekly clinical rounds, and attending the monthly Joint Operations Committee meeting with KCICN.

UnitedHealthcare presently attends the monthly scheduled King County Trueblood Care Coordination meetings where members are comprehensively discussed and participants provide solutions and a care team approach to aid referrals to specialists, social agencies, and connect to medical and behavioral health services. Attending this meeting allows for an opportunity to collaborate with King County community providers on UHC's members and understand the services that they are receiving in the community that our organization may not presently be aware of. Topics during these meetings include member hospitalizations, care coordination, housing needs, and referral sources.

King County reports that participants include outpatient behavioral health care providers (including Trueblood diversion programs and FPATH/FHARPS contracted providers), administrators for PACT and other outpatient services, and forensic navigators. These collaborative meetings are used by MCOs to determine roles for coordinating services and to ensure necessary referrals are in place, especially for clients making transitions into or out of managed care.

Spokane County Region oversees a quarterly Jail Transitions and Coordination meeting, which was created in 2022 to encourage and support transitions from incarcerated settings. Similar efforts are supported by ASOs across the state.

Clients served with Diversion Funds

The Trueblood Misdemeanor Diversion funds have been leveraged by both ASOs and MCOs to provide services and to connect clients with various community resources.

In SFY 2025, MCOs primarily used these funds to provide crisis services, freestanding evaluation and treatment, mental health residential and inpatient treatment, and outpatient mental health treatment. The majority of ASOs used TMD funds for crisis services, freestanding evaluation and treatment, and rehab case management for hundreds of clients. Other uses of the funds included:

- ITA commitment services,
- ITA judicial administrative, 90- and 180-day commitment hearings,
- Program for Active Community Treatment, and
- Supported employment.

Discussion

In 2025, MCOs and ASOs continued to strengthen their programs to provide individual case management and care coordination for people involved in the criminal legal system. They routinely used lists of individuals who are at high risk of a subsequent competency evaluation order to guide outreach efforts and inform cross-sector case management meetings. Both MCOs and ASOs have also introduced new strategies to support individuals at risk of, or currently involved in, the criminal legal system across the state. These efforts have improved policies, communication, and service coordination, advancing the shared goal of reducing incarceration and recidivism.

APPENDIX 1

MCO and ASO Requirements Related to Criminal Justice

Examples of specific requirements⁷ from the Apple Health Integrated Managed Care contract:

- 14.1.11 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in Behavioral Health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.
- 14.7.1.15 The Contractor will provide Care Coordination to Enrollees who are named on the HCA Referral List, also known as the “high utilizer list,” in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Enrollees with Behavioral Health needs and current or prior criminal justice involvement to receive Care Coordination. The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund report template. Reports must be submitted to HCA through MC-Track by January 31, for the reporting period from July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.
- 14.22.1 For the purposes of this subsection, “correctional facility” includes city and county jails, Department of Corrections facilities, youth correctional facilities, and Juvenile Rehabilitation facilities.
- 14.22.1.1 The Contractor shall coordinate care for enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities and reentry partners to enable the Contractor and these facilities to share health information about the Enrollees. Transitional Care Coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee’s release, including honoring another MCO’s Prior Authorization for admission to SUD residential facility.

ASO contract requirements excerpt⁸:

- 15.1.2 The Contractor will provide Care Coordination to Individuals who are named on the HCA Referral List, also known as the “high utilizer list,” in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Individuals with Behavioral Health needs and current or prior criminal justice involvement receive Care Coordination
- 15.1.3 The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund Report template. Reports must be submitted to HCA by January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.

⁷ Found at <https://www.hca.wa.gov/assets/billers-and-providers/imc-medicaid.pdf>

⁸ Found at [Behavioral health-administrative services organization contract \(wa.gov\)](https://www.hca.wa.gov/assets/billers-and-providers/behavioral-health-administrative-services-organization-contract-wa.gov)