Washington State Health Care Authority

REPORT TO THE LEGISLATURE

# Access to Behavioral Health Services for Children

Engrossed Second Substitute House Bill 2439; Section 3; Chapter 96, Laws of 2016; RCW 74.09.495;

Engrossed Second Substitute House Bill 1713; Section 3; Chapter 202, Laws of 2017;

Substitute Senate Bill 5779, Section 6; Chapter 226, Laws of 2017;

Engrossed Second Substitute House Bill 2779; Section 3; Chapter 175, Laws of 2018

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# Access to Behavioral Health Services for Children


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# Executive summary

Washington Apple Health (Medicaid) plays a critical role for many children with behavioral health needs. In Washington State, Apple Health eligible children may access behavioral health treatment through different programs depending on their eligibility and location. These programs include fee-for-service (FFS), managed care organizations (MCOs), integrated managed care (IMC), or behavioral health organizations (BHOs). With the exception of IMC, MCOs typically provide behavioral health services only to children with less acute behavioral health needs. In non-IMC regions, MCOs refer children with higher-acuity behavioral health treatment needs to their local BHO.

Access to behavioral health is a key state initiative. There have been several areas where strategic, cross-agency efforts have been developed at the behest of the agencies as well as through legislative workgroups. There are 3 remaining regions that will integrate with managed care on January 1, 2020, which will result in statewide integration. We continue to provide reimbursement for telehealth/telemedicine and are working to improve bi-directional availability of behavioral and physical health services. These initiatives may help improve disparities in access for children needing behavioral health services. Service modality alternatives, such as telemedicine, could improve access to behavioral health services. However, it is critical that these policy efforts consider and address the specific needs of rural communities and minority populations within statewide service delivery improvement efforts.

## Reporting requirements

The Revised Code of Washington (RCW) 74.09.495 directs HCA and DSHS to report annually on the status of access to behavioral health services for children birth through age 17. Reporting must include:

- The percentage of discharges for patients ages 6 through 17 who had a visit to the emergency room with a primary diagnosis of mental health or alcohol or other drug dependence during the measuring year and who had a 30-day follow-up visit with any provider with the same primary diagnosis;
- The percentage of health plan members with an identified mental health need who received mental health services during the reporting period;
- The percentage of children served by BHOs, including the types of services provided;
- The number of children's mental health providers available in the previous year, the languages spoken by those providers, and the overall percentage of children's mental health providers who were actively accepting new patients; and
- Data related to mental health and medical services for eating disorder treatment in children and youth, including the number of: (1) Eating disorder diagnoses; (2) patients treated in outpatient, residential, emergency, and inpatient care settings; and (3) contracted providers specializing in eating disorder treatment and the overall percentage of those providers who were actively accepting new patients during the reporting period.

## Barriers to accessing behavioral health services

The National Survey on of Children's Health looked at the percent of youth under the age 18 who needed mental health treatment but did not receive it. In 2017, the overall percentage of these youth in the United States was 22percent, and Washington State had a percentage of 24 percent.[1]

To promote access to behavioral health services, federal law mandates that Apple Health and CHIP programs comply with behavioral health parity requirements. Parity requirements help to ensure that financial requirements and treatment limitations (such as visit limits) applicable to mental health (MH) or substance use disorder (SUD) benefits are no more restrictive than those applied to other medical or surgical benefits. However, other barriers to accessing behavioral health services exist, such as:

- Lack of available treatment providers, specifically for children and youth experiencing co-occurring diagnoses;
- System gaps for children and youth experiencing eating disorders; and
- Client experience of stigma.

## Cross systems efforts

Washington has recognized the need for cross system coordination in order to provide meaningful access to behavioral health services for children, youth, and their families.

Continued efforts through the Children's Mental Health Workgroup (CMHWG) through SB 5903 recommended that roll-out of evidence-based coordinated specialty care programs statewide. Increase access for youth experiencing a first episode of psychosis in order to change life trajectory and divert from long-term disability. Legislation was passed to standup programs in all regions by October 2020, and to increase program presence based on population and incidence.

The workgroup has also dedicated attention to the expansion of the Partnership Access Line (PAL) to increase access and connection to services for children and teens. Systemic barriers such as access for individuals with private insurance and provider availability have been reported. The PAL line also needs a more secure funding source to serve Apple Health and non-Apple Health children. The Mental Health Referral Assist line is part of a two year pilot and has that is being highly utilized, demonstrating the usefulness of an assisted point of access.

There is also a subgroup dedicated to school-based initiatives, such as bolstering suicide prevention, addressing social and behavioral stress, funding behavioral health navigators, and helping schools align with the integration of mental health and substance use disorder treatment in order to address behavioral health needs.

In response to constituent and system partner feedback there has been an increasing need to develop resources and supports for children and youth experiencing co-occurring developmental

[1] Data source: 2017 National Survey of Children's Health, available at https://www.census.gov/data/datasets/2017/demo/nsch/nsch2017.html, accessed September 30th, 2019.

disability and mental health challenges. A workgroup was developed with the mission to improve health and safety outcomes to meet the needs of people with intellectual/ developmental disabilities (I/DD) by increasing capacity and improving access to appropriate and timely medical,

Dental, social support, housing, behavioral health and developmental disabilities services in the most integrated settings. Identify current systems gaps, needs, barriers and opportunities. Improve system coordination in and between agency systems. Will make recommendations to agency leadership about the expansion community based services, increasing access to providers trained to work with individuals with co-occurring IDD/Autism and mental health conditions.

In order to provide children and youth with access to comprehensive and developmentally appropriate care, various state systems need to be coordinated and responsive to children and youth that encounter multiple systems. The Health Care Authority convened a Cross Systems Cabinet to address barriers and gaps for these complex situations. It is an internally driven effort to align heads of state agencies to identify solutions and strategies for supporting complex, cross system children and youth. The group is identifying and defining the subpopulations being impacted by lack of access to the appropriate level of treatment or suitable placement. In calendar year 19 this group will work to identify community based supports and interventions needed to move toward meaningful and sustainable interventions. The group will work to identify programs/systems to leverage, implementation costs, ongoing costs, cost-offsets, and implementation timeframes.

## Access differs between populations

The need for behavioral health treatment is greater in some populations. Children and youth in foster care, and those involved in juvenile rehabilitation, often have a higher level of need for mental health and substance use disorder treatment, compared to other children receiving Apple Health services. Of those receiving general Apple Health services for youth (up to the age of 18) in SFY15 (the most recent year for which data is available), 17 percent demonstrated a behavioral health treatment need. The percentage of various subgroups that had behavioral health treatments needs are:

- In Children's Administration (CA) foster care: 50 percent
- With any Children's Administration (CA) involvement: 37 percent
- With Juvenile Rehabilitation (JR) involvement: 88 percent
- With Developmental Disabilities Administration (DDA) services: 30 percent
- With Economic Services Administration (ESA) Temporary Assistance for Needy Families (TANF) : 22 percent
- With ESA basic food: 18 percent[2]

[2] Pavelle, Lucenko, Soriano, Hughes, & Felver. (2018) "Behavioral Health Treatment Needs and Outcomes among Apple Health Children in Washington State." Washington State Department of Social and Health Services, Research and Data Analysis Division. Available at: https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/CHILDRENS_BH_DASHBOARD_2018FEB.pdf.pdf

There have been strategic efforts to connect youth receiving intensive foster care services and justice system-involved youth with behavioral health supports. Historically, when youth entered detention, Apple Health eligibility was suspended and unavailable until after discharge. Now Apple Health is accessible 30 days prior to discharge so that behavioral health programs, such as Wraparound with Intensive Services (WISe), can begin to engage youth, complete an initial assessment, and develop a bridge to aid the youth with their transition back into the community. To better serve youth receiving intensive foster care services, strategic planning around the coordination of Behavioral Rehabilitation Services (BRS) and Wraparound with Intensive Services (WISe) has occurred. This effort will result in joint services for youth involved in BRS foster care starting in fall 2019.

## Behavioral health integration

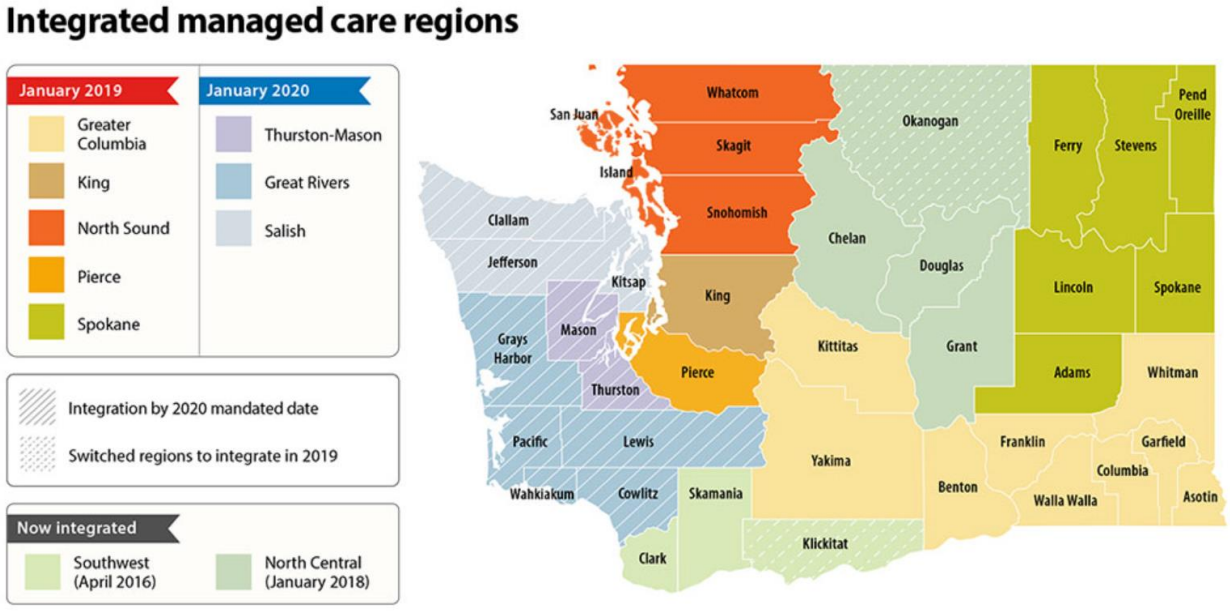
In Washington, Apple Health eligible children may access behavioral health treatment through fee-for-service (FFS), managed care organizations (MCOs), Integrated Managed Care (IMC), or behavioral health organizations (BHOs). Behavioral health integration began on April 1, 2016, with the creation of BHOs across the state and IMC in southwest Washington. In calendar year 2019, BHOs include Great Rivers, Salish, Thurston-Mason, and North Sound, which transitioned in July 2019.

IMC means the state purchases physical and behavioral health services together, instead of purchasing physical health services through Apple Health MCOs and purchasing behavioral health services separately through BHOs. In January 2019, integrated managed care has expanded to include King County, the Greater Columbia region, Pierce County, and the Spokane region. North Sound extended their transition plan to July of 2019 and is now also an IMC region. Entities involved in offering integrated managed care include the five Apple Health managed care plans — Amerigroup, Community Health Plan of Washington, Coordinated Care of Washington, and Molina Healthcare — and Beacon Health options as the behavioral health administrative services organization. (See Figure 1 below.)

In calendar year 2015, Substitute House Bill 1879 required integration of behavioral health services into a single MCO for children in foster care by January 2019. Coordinated Care of Washington (CCW) is the sole MCO for foster children and it is also one of the MCOs providing services in the North Central region. In this region, children in foster care began receiving both physical health and behavioral health services through Coordinated Care as of January 2018.



**Figure 1. Integrated Managed Care Regions**




**Managed care organizations by region**

| Managed care region | Amerigroup | Community Health Plan | Coordinated Care | Molina Healthcare | United Healthcare |
|---|---|---|---|---|---|
| **As of January 2019** | | | | | |
| Greater Columbia | ● | ● | ● | ● | |
| King | ● | ● | ● | ● | ● |
| North Central | ● | | ● | ● | |
| North Sound | ● | ● | ● | ● | ● |
| Pierce | ● | | ● | ● | ● |
| Spokane | ● | ● | | ● | |
| Southwest | ● | ● | | ● | |
| **Coming January 2020** | | | | | |
| Thurston-Mason | ● | | | ● | ● |
| Great Rivers | ● | | | ● | ● |
| Salish | ● | | | ● | ● |

*Note: Apple Health Foster Care is a statewide program, provided through Apple Health Core Connections (Coordinated Care of Washington).*

**Source:** "HCA announces managed care plans offering integrated care starting in 2019 and 2020," https://www.hca.wa.gov/about-hca/hca-announces-managed-care-plans-offering-integrated-care-starting-2019-and-2020, accessed on September 30, 2019. Note that this figure does not reflect the extended transition period for the North Sound region, which moved to integrated care in July 2019.

# Data results

## Limitations

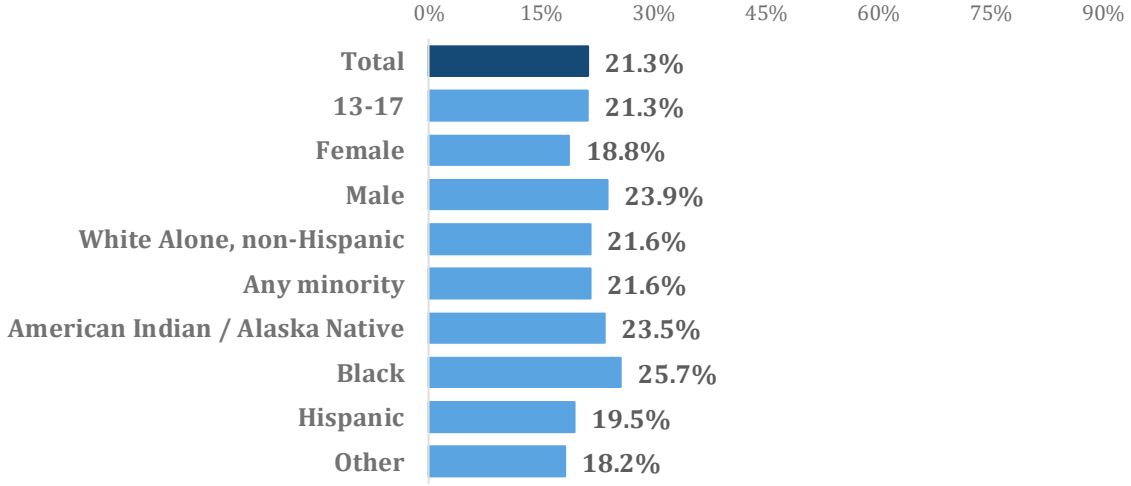
Due to the transition from BHOs to MCOs there have been changes to data collection. This shift means that we are unable to look longitudinally to make comparisons across the years, particularly for substance use HEDIS measures. There have also been gaps that have been observed in data trends. Work is being done to determine if these are true gaps or if there has been a change that impacted collection.

The 30-day follow-up after an emergency department visits for mental health disorders remains considerably higher at 84 percent (as illustrated in Figure 3 below). This percentage demonstrates improvement in the follow-up care within 30 days for individuals after an emergency visit for mental health reasons. Follow-up after emergency room visits for alcohol or drug use is significantly lower at 21 percent. This percentage decreased in 2018. Some of this change may be a result of data quality issues which may be a result of how the data is captured rather than changes in the field.

Some racial/ethnic groups, such as Asian/Native Hawaiian or Pacific Islander populations, had lower levels of follow-up (both 7-day and 30-day) for any behavioral health-related emergency department visit.

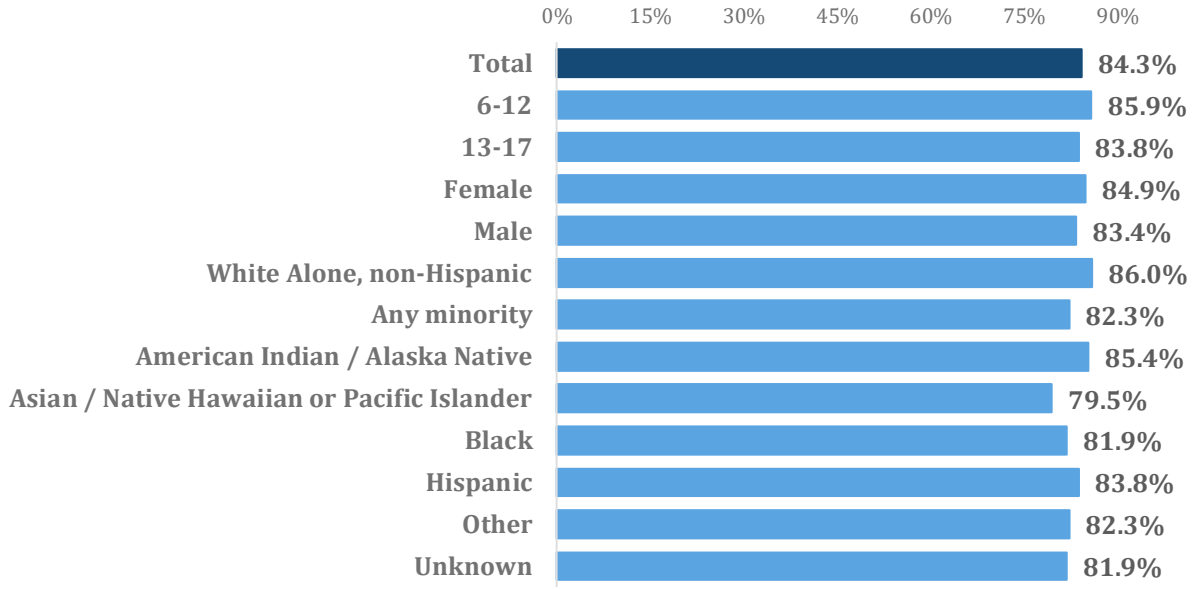
Appendix A contains the full datasets for calendar year (CY) 2018 follow-up after an emergency department visit.

**Figure 2. Follow-Up after Emergency Department visit for alcohol and other drug dependence within 30 days in CY 2018**




**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Figure 3. Follow-up after emergency department visit for mental illness within 30 days of emergency department visit in CY 2018**




**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

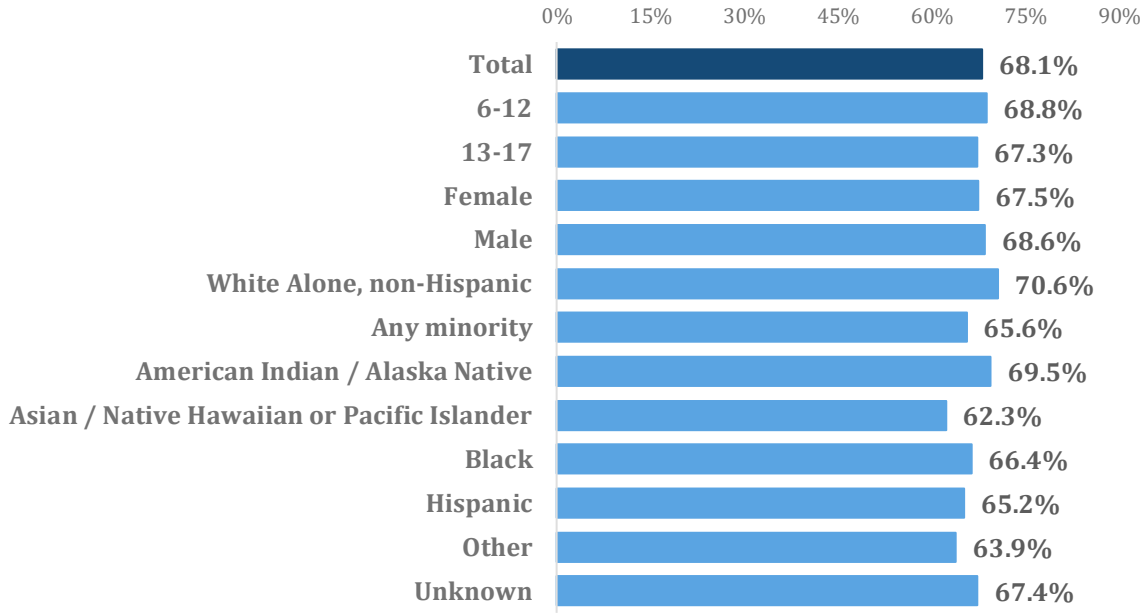
## Receipt of mental health service

In calendar year 2018, 68.1 percent of Apple Health children with an identified mental health need received mental health services during the reporting period. Some racial/ethnic groups continued to have lower levels of mental health treatment penetration, Appendix B provides additional demographic information.

There was greater penetration for mental health services (broadly defined). It noticeably improved from 2017 to 2018, particularly in the 12 to 17 age group. One interesting difference in 2018 is that services to both white only and any minority, with the exception of Native American, have seen a growth in penetration. The any minority demographics are currently at the penetration level that white only were last year. This cannot currently be described as a trend, but should be continuously monitored for disparities.

While there is unmet need in the population of children and youth served by Apple Health, these data suggest reasonable penetration of mental health (MH) services. In contrast, substance use disorder (SUD) treatment services do not show the same level of penetration.

**Figure 4. Mental health treatment penetration in 2018 — broadly defined**




**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, September 2019.

## Managed care organization services

During calendar year (CY) 2018, about 10.7 percent (96,227) of Apple Health and CHIP-eligible children (903,177) within BHO- and MCO-covered regions of the state received mental health services through MCOs. This rate increased, compared to the CY 2017 access rate of 6.1 percent. Also during CY 2018, 1.1 percent (3,904) of Apple Health and CHIP-eligible children ages 11-18 within BHO- and MCO-covered regions of the state (341,043) received substance use disorder services through MCOs. This rate remained about the same, comparted to the CY 2017 rate of 1.2 percent. See appendix C for additional information.

## Children's mental health providers

### Provider availability

Comprehensive availability data for children's mental health providers in the BHO, FFS, MCO, or IMC networks is not available. The state does not collect provider-level data with sufficient detail or consistency to reliably report on the number of mental health providers available to provide services, languages spoken by providers, and the number of providers accepting new clients.

There are seven MCOs offering health care services to Apple Health recipients. In regions that have not yet transitioned to Integrated Managed Care (IMC), the MCOs typically provide behavioral health services to children with less acute behavioral health needs. MCOs will refer children with higher-acuity behavioral health treatment needs to their local Behavioral Health Administrative Service Organization (BH-ASO).

MCOs report information to HCA about their contracted Apple Health providers to enable HCA to monitor provider network adequacy. This requirement provides some information on children's mental health provider availability. Appendix D identifies the number of behavioral health providers reportedly serving children during each quarter of calendar year 2018 by MCO and by county. Children's mental health providers are available in each county of the state, though availability varies by MCO network.

## Provider spoken languages

Comprehensive data about the spoken languages of children's mental health providers in the BHO, FFS, MCO, or IMC networks is not available. Appendix E includes information about language access within the Apple Health system.

## Providers accepting new patients

Comprehensive data about children's mental health providers in the BHO, FFS, MCO, or IMC networks accepting new patients is not available, because the state does not collect provider-level availability data with sufficient detail or consistency. To comply with reporting requirements in RCW 74.09.337, BHOs and MCOs must maintain accurate list of providers contracted to provide mental health services to children and youth. The list must contain current information regarding the providers' availability to provide services. However, those lists are not uniformly structured and do not all clearly identify which mental health providers serve children and youth and are accepting new patients.

MCOs report quarterly to the Health Care Authority regarding the number of enrolled providers and whether the providers are accepting new patients. Appendix F shows the proportion of children's mental health providers accepting new patients, by MCO. Based on three quarterly reports in 2018, every MCO has a majority of children's mental health providers accepting new patients. There is no data available for 2018, quarter 2. See appendix for more detail.

Reported provider care availability for accessing behavioral health services was relatively high for calendar year 2018. Of the total unduplicated contracted providers (indicating treatment services for children) across the seven Washington State MCOs, the total percentage of providers available to accept new clients ranged between 76 percent and 100 percent, with three of the MCOs at 90 percent or higher. While these outcomes are promising for the ability to access children's behavioral health services, barriers to accessing treatment for specific behavioral health conditions as well as timeliness scheduling accessing services should be considered. Access to providers with treatment experience in topic-specific conditions and access to prompt follow up care following emergency room services may remain a challenge, especially in more rural regions of the state.

There may be discrepancies between what has been reported to the Apple Health Program Operations and Integrity (MPOI) and what is reported on the MCO's provider search page. However, the provider search page reflects current availability and the MPOI reports reflect quarterly snapshots. It would be beneficial to crosswalk the provider's search page availability with the report in close proximity to ensure that the discrepancy is due to time rather than inaccurate reporting.



# Eating disorders

## Children and youth with eating disorder diagnoses

Current Apple Health claims data may include any of the following 12 eating disorder diagnoses:

1. Anorexia nervosa, binge eating/purging type;
2. Anorexia nervosa, restricting type;
3. Anorexia nervosa, unspecified;
4. Avoidant/restrictive food intake disorder;
5. Binge eating disorder;
6. Bulimia nervosa;
7. Eating disorder, unspecified;
8. Other eating disorders;
9. Other feeding disorders of infancy and early childhood;
10. Other specified eating disorder;
11. Pica of infancy and childhood; and
12. Rumination disorder of infancy.

Appendix G includes data on the number of Apple Health and CHIP-enrolled children with Apple Health claims that contained eating disorder diagnoses during calendar year 2018. Data are presented by demographic group and county location.

## Care settings for eating disorder treatment

There are currently three specialized care settings that identify as tailored for the treatment of eating disorders Washington State. These facilities operate specifically for the treatment of eating disorders and offer residential, partial hospitalization (PHP), and intensive outpatient (IOP) programming. These centers function as independent entities and patients are screened into services based on facility protocol, criteria, and insurance/payment ability. Nevertheless, the regional availability of such treatment care settings within Washington is an advantage for those patients who are able to access care. Following intensive care settings, outpatient care can be established, however, there is not currently a system for tracking providers who specialize in eating disorder treatment at this level within Washington State. At this time, some work is being done at the MCO level to collect this information.

Patients who do have the means to establish levels of intensive treatment are often prematurely discharged from the level of clinically recommended care due to limitations with insurance coverage. The complexity of providing effective eating disorder treatment services presents an opportunity for integrated care that effectively combines physical and behavioral health services.

Eating disorders notoriously require defined and consistent treatment for both behavioral health symptomology as well as physical health needs: the complication of adequately accounting for both subsets of needed care (i.e. when billing payers, whether to code a procedure/service due to the eating disorder or the medical condition that is directly associated with the eating disorder) introduces a realm of complication for comprehensive integrated care. Research studies indicate that discharge prior to full weight restoration and/or stability in symptom management leads to



higher rates of relapse,[3] further indicating a need for integrated care and targeted recovery for physical, behavioral, and psychological aspects upon discharge from eating disorder treatment services.[4]

At this time, HCA cannot report on the number of Apple Health patients who receive eating disorder treatment by care setting. To identify the care settings for eating disorder treatment, it is first necessary to identify whether an Apple Health client is receiving treatment specifically for an eating disorder. However, it is not possible to precisely identify treatment for eating disorders from health service claims data with available health service procedure codes.

### Contracted providers specializing in eating disorder treatment

Comprehensive data about children's mental health providers in the BHO, FFS, MCO, or IMC networks who specialize in eating disorders is not available primarily because no "eating disorder specialist" credential or license exists in Washington State. Because of this, available data does not capture provider-specific specialty information related to eating disorder treatment.

## Stigma associated with service access

Stigma remains a barrier for youth access to treatment for mental health and substance use disorder services. Presenting as cognitive perceptions held by individuals in regard to a condition or diagnosis, stigma has been documented to occur on individual, interpersonal, and societal levels (Bos, 2013).[5] For youth seeking to access behavioral health services, the presence of stigma may be a determining factor in choosing to not enter into treatment services or to seek the necessary level of care.

Misconceptions surrounding mental illness and substance use disorders can manifest in several ways and forms, both overtly and passively.[5,6] Experiences of dehumanization, avoidance, depersonalization, discrediting, discounting, negative labeling, and social rejection have all been reported in investigative literature.[5, 7] Additional passive actions of discrimination and microaggressions can further negative experiences associated with stigmatization. In the context of

[3] Chakraborty K, Basu D. Management of anorexia and bulimia nervosa: An evidence-based review. *Indian J Psychiatry*. 2010 Apr-Jun; 52(2): 174–186. doi: 10.4103/0019-5545.64596.
[4] Bardone-Cone AM, Harney MB, Maldonado CR, Lawson MA, Robinson P, Smith R, Toshc A. Defining Recovery from an Eating Disorder: Conceptualization, Validation, and Examination of Psychosocial Functioning and Psychiatric Comorbidity. *Behav Res Ther*. 2010 Mar; 48(3): 194–202. doi: 10.1016/j.brat.2009.11.001.
[5] Bos AER, Pryor JB, Reeder GD, Stutterheim SE. Stigma: Advances in Theory and Research. *Basic & Applied Social Psychology*. Jan 2013, Vol 35. doi: 10.1080/01973533.2012.746147.
[6] Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine. Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change. Washington (DC): National Academies Press (US); 2016 Aug 3. 2, *Understanding Stigma of Mental and Substance Use Disorders*. Available from: https://www.ncbi.nlm.nih.gov/books/NBK384923/
[7] Smith LR, Earnshaw VA, Copenhaver MM, Cuningham CO. Substance use stigma: Reliability and validity of a theory-based scale for substance-using populations. *Drug Alcohol Depend*. 2016 May 1;162:34-43. doi: 10.1016/j.drugalcdep.2016.02.019.

youth access to behavioral health services, physical access to services may at times pose less of a barrier to seeking care than the challenges presented by the societal consequences associated with stigma. Factors such as blame, stereotypes of violence or unpredictability, limited knowledge regarding mental illness and substance use disorders, assumptions related to prior contact and experience with mental illness and substance use disorders, media portrayals, and variations in race, ethnicity, and culture may all impede comfortability and confidence in seeking access to behavioral health services that are otherwise available.

Stigmatization that youth diagnosed with mental illness or substance use disorders are more likely than their youth counterparts to become violent is also a prevalent assumption. A 2013 national survey revealed that 40 percent of Americans believed that youth suffering from depression were likely to be violent, an assumption that was likely linked to media coverage follow school shooting incidents and an overrepresentation of negative portrayals of depressed youth as violent and/or dangerous through media outlets.[8,9] More so, previous research has reported perceptions that individuals with substance use disorders are assumed to be more dangerous than individuals for schizophrenia or depression.[10] Substance use stigma, specifically, has been recognized as especially pervasive in addressing heath access barriers and improving heath inequities that exist among individuals suffering from substance use disorders.[7]

As a result of these recognized barriers, addressing misinformation surrounding the science of mental illnesses and substance use disorders is an area of opportunity for addressing stigma and improving youth access to behavioral health services. While public knowledge has increased regarding mental illnesses and substance use disorders as brain-based diseases since the 1950s, research shows that levels of stigma have not decreased, and unfortunately, remain quite high.[11] It is imperative to address the realities surrounding youth mental illness and substance use disorders, specifically that treatment is available and effective and that recovery is possible.

Despite the limitations in youth access to treatment as a result of stigmatization of mental illnesses and substance use disorders, research shows that the involvement of family involvement is particularly important in youth treatment and recovery for mental illnesses and substance use disorders.[9] This is a positive attribute that should be recognized and promoted for youth and their families when seeking treatment for behavioral health conditions. Family members are not only more likely to be a consistent support system for illness management and the first to recognize

[8] Pescosolido BA. The public stigma of mental illness: What do we think; what do we know; what can we prove? *Journal of Health and Social Behavior.* 2013;54(1):1–21.
[9] Soklaridis S, McCann M, Waller-Vintar J, Johnson A, Wiljer D. Where is the family voice? Examining the relational dimensions of the family- healthcare professional and its perceived impact on patient care outcomes in mental health and addictions. *PLoS One.* 2019 Apr 12;14(4):e0215071. doi: 10.1371/journal.pone.0215071.
[10] Schomerus G, Lucht M, Holzinger A, Matschinger H, Carta MG, Angermeyer MC. The stigma of alcohol dependence compared with other mental disorders: A review of population studies. *Alcohol and Alcoholism.* 2011;46(2):105–112.
[11] Pescosolido BA, Martin JK, Long JS, Medina TR, Phelan JC, Link BG. "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry.* 2010;167(11):1321–1330.

symptoms of potential relapse, surveyed youth have additionally indicated that having their family involved decreased feelings of isolation and shame and increased their sense of being understood and supported.

Experiences in behavioral health service access could further be improved by an effective relationship between families, health care providers, and the youth seeking treatment services (Soklaridis, 2019). Family systems research indicates that the family relationship with their healthcare provider is essential for effective access in behavioral health treatment services and recovery outcomes. Even after treatment services have been initiated, stigmatization of the behavioral health condition has been shown to limit the amount of information a youth is willing to share with their family, resulting in an isolating experience despite the fact that services have been accessed. Trustworthy relationships between the youth, family, and healthcare providers that create the space to address stigma and associated concerns have been shown to improve treatment communication and ultimately increase the chances of favorable outcomes.

## Opportunities

In order to determine the true barriers to access, it will be necessary to develop a strategy to improve the collection of data pertaining to substance use disorder. Methods for identifying family initiated treatment for substance use disorder are being developed. This is an opportunity to look at how treatment data is captured more broadly.

Stigma is a significant barrier to accessing both mental and behavioral health services. Several campaigns exist through prevention and as a result of the System of Care grant that are targeted at reducing stigma for mental health and to reduce the social pressures associated with using substances. Data demonstrates a need for specific strategies for addressing stigma associated with follow-up for emergency room encounters with substance misuse.

Further discussion is needed regarding the impact of health care payer policies on provision of services related to eating disorders and associated limitations in treatment, particularly related to length of stay in specialized care settings... Ensuring coverage of specialized care settings for eating disorder treatment is consistent with evidence-based determination of discharge criteria is both highly important, and is likely associated with higher rates of long-term successful treatment and lower rates of relapse. In addition, there are significant challenges to obtaining useful data: as eating disorders concern both mental health and physical health, providers may code their treatment in different ways depending on the provider type, service location, and system/payer factors. Identifying a robust methodology for successfully identifying relevant claims data to examine provision of eating disorder treatment services could provide useful information for data-driven decision making, but would also require substantial additional investment. .

# Conclusion

RCW 74.09.495 requires annual reporting to the Legislature on the measures discussed. There is room to improve data collection to better inform this report and various system efforts that can improve access to behavioral health services for children and youth.



- There are several cross-system efforts occurring simultaneously. These efforts should be coordinated.
- Leverage physical and behavioral health integration as an opportunity to improve the coordination and care surrounding eating disorders.
- The Legislature could direct the Department of Health to perform a sunrise review about creating an eating disorder specialist certification or licensure for current and future providers. This, too, would require additional resources.

Strategic, cross-agency efforts may help improve disparities in access to children's behavioral health treatment services. Several major initiatives are occurring simultaneously to address cross-system youth experiencing barriers to accessing trained professionals that can provide the appropriate level of care. Next year there should be opportunity to discuss the recommendations and how those recommendations will impact access to care for children and youth.

There are current initiatives taking place through the Children's Mental Health Workgroup that are working to improve access to behavioral health resources in schools as well as connection to regional resources. There is opportunity through integration to explore similar opportunities with primary care settings to improve screening, assessment, and referral to behavioral health services for both prevention and intervention opportunities.



# Appendix A: Follow-up after emergency department visit, calendar year (CY) 2018

**Table A.1. Follow-up after emergency department visit for alcohol and other drug dependence within 7 Days [HEDIS-FUA1], CY 2018**

| Demographic Category | Numerator | Denominator | Rate |
|---|---|---|---|
| Total | 75 | 656 | 11.4% |
| Age Category | | | |
| 13-17 | 75 | 656 | 11.4% |
| Gender | | | |
| Female | 39 | 329 | 11.9% |
| Male | 36 | 327 | 11.0% |
| Race/Ethnicity | | | |
| White Alone, non-Hispanic | 28 | 250 | 11.2% |
| Any minority | 47 | 389 | 12.1% |
| American Indian / Alaska Native | 11 | 85 | 12.9% |
| Asian / Native Hawaiian or Pacific Islander | *suppressed* | *suppressed* | 17.4% |
| Black | *suppressed* | *suppressed* | 12.9% |
| Hispanic | 24 | 210 | 11.4% |
| Other | 15 | 143 | 10.5% |
| Unknown | *suppressed* | *suppressed* | 0.0% |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Note:** Consistent with HCA Policy on Small Numbers, this table suppresses data for both the numerator and denominator in instances where either were less than 10, in order to avoid inadvertent re-identification of individuals.

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 7 Days (FUA, or Follow-Up: Alcohol).



**Table A.2. Follow-up after emergency department visit for alcohol and other drug dependence within 30 days [HEDIS-FUA[1]], CY 2018**

| Demographic Category | Numerator | Denominator | Rate |
|---|---|---|---|
| Total | 140 | 656 | 21.3% |
| Age Category | | | |
| 13-17 | 140 | 656 | 21.3% |
| Gender | | | |
| Female | 62 | 329 | 18.8% |
| Male | 78 | 327 | 23.9% |
| Race/Ethnicity | | | |
| White Alone, non-Hispanic | 54 | 250 | 21.6% |
| Any minority | 84 | 389 | 21.6% |
| American Indian / Alaska Native | 20 | 85 | 23.5% |
| Asian / Native Hawaiian or Pacific Islander | *suppressed* | *suppressed* | 26.1% |
| Black | 18 | 70 | 25.7% |
| Hispanic | 41 | 210 | 19.5% |
| Other | 26 | 143 | 18.2% |
| Unknown | *suppressed* | *suppressed* | 11.8% |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Note:** Consistent with HCA Policy on Small Numbers, this table suppresses data for both the numerator and denominator in instances where either were less than 10, in order to avoid inadvertent re-identification of individuals.

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days (FUA, or Follow-Up: Alcohol).



**Table A.3. Follow-up after emergency department visit for mental illness within 7 days of emergency department visit [HEDIS-FUM[1]], CY 2018**

| Demographic category | Numerator | Denominator | Rate |
|---|---|---|---|
| Total | 2015 | 2705 | 74.5% |
| Age category | | | |
| 6-12 | 509 | 681 | 74.7% |
| 13-17 | 1506 | 2024 | 74.4% |
| Gender | | | |
| Female | 1252 | 1663 | 75.3% |
| Male | 763 | 1042 | 73.2% |
| Race/ethnicity | | | |
| White alone, non-Hispanic | 1125 | 1473 | 76.4% |
| Any minority | 824 | 1138 | 72.4% |
| American Indian / Alaska Native | 117 | 164 | 71.3% |
| Asian / Native Hawaiian or Pacific Islander | 87 | 122 | 71.3% |
| Black | 169 | 232 | 72.8% |
| Hispanic | 441 | 592 | 74.5% |
| Other | 277 | 373 | 74.3% |
| Unknown | 66 | 94 | 70.2% |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Note:**

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 7 Days (FUM, or Follow-Up: Mental).



**Table A.4. Follow-up after emergency department visit for mental illness within 30 days of emergency department visit [HEDIS-FUM[1]], CY 2018**

| Demographic category | Numerator | Denominator | Rate |
|---|---|---|---|
| Total | 2281 | 2705 | 84.3% |
| Age category | | | |
| 6-12 | 585 | 681 | 85.9% |
| 13-17 | 1696 | 2024 | 83.8% |
| Gender | | | |
| Female | 1412 | 1663 | 84.9% |
| Male | 869 | 1042 | 83.4% |
| Race/ethnicity | | | |
| White Alone, non-Hispanic | 1267 | 1473 | 86.0% |
| Any minority | 937 | 1138 | 82.3% |
| American Indian / Alaska Native | 140 | 164 | 85.4% |
| Asian / Native Hawaiian or Pacific Islander | 97 | 122 | 79.5% |
| Black | 190 | 232 | 81.9% |
| Hispanic | 496 | 592 | 83.8% |
| Other | 307 | 373 | 82.3% |
| Unknown | 77 | 94 | 81.9% |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Note:**

1. Healthcare Effectiveness Data and Information Set (HEDIS) measure: Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days (FUM, or Follow-Up: Mental).



# Appendix B: Receipt of mental health service, calendar year (CY) 2018

**Table B. Mental health treatment penetration–broadly defined [SUPPL-MH-B[1]], CY 2018**

| Demographic category | Numerator | Denominator | Rate |
|---|---|---|---|
| Total | 75654 | 111099 | 68.1% |
| Age category | | | |
| 6-12 | 39309 | 57123 | 68.8% |
| 13-17 | 36345 | 53976 | 67.3% |
| Gender | | | |
| Female | 35358 | 52379 | 67.5% |
| Male | 40296 | 58720 | 68.6% |
| Race/ethnicity | | | |
| White Alone, non-Hispanic | 37763 | 53524 | 70.6% |
| Any minority | 34212 | 52118 | 65.6% |
| American Indian / Alaska Native | 4155 | 5979 | 69.5% |
| Asian / Native Hawaiian or Pacific Islander | 2964 | 4758 | 62.3% |
| Black | 6044 | 9098 | 66.4% |
| Hispanic | 20349 | 31193 | 65.2% |
| Other | 12769 | 19988 | 63.9% |
| Unknown | 3679 | 5457 | 67.4% |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, August 2019.

**Note:**
Mental Health Service Penetration (Broad Version) is a Department of Social and Health Services measure. Denominator for percentages is number of persons with indications of mental health treatment need in the current or past CY. Numerator is number of persons receiving outpatient mental health services in the current CY. Outpatient mental health services include most modalities of outpatient mental health services delivered through DBHR (excludes, for example, case management), as well as Behavioral Rehabilitation Services from the Children's Administration, and outpatient mental health services delivered through the Health Care Authority or tribal authorities. Note that tabulation of mental health services received in this measure reflects a one-year window, whereas the mental health services component of indication of mental health needs reflects a two-year window.

# Appendix C: Rates of behavioral health service provision in calendar year (CY) 2018

**Table C1. Apple Health (Title 19) and Children's Health Insurance Program (CHIP) Youth (0-18) receiving Substance Use Disorder treatment (SUD Tx) or Community Mental Health (MH) treatment services, CY 2018**

| Region | Total eligible youth | Any SUD Tx or Community MH service | | Any SUD Tx service | | Any Community MH service | |
|---|---|---|---|---|---|---|---|
| | # | # | % | # | % | # | % |
| **Total Statewide** | **903,177** | **98,095** | **10.9%** | **3,907** | **0.4%** | **96,227** | **10.7%** |
| Great Rivers | 44,782 | 7,089 | 15.8% | 367 | 0.8% | 6,927 | 15.5% |
| Greater Columbia | 140,124 | 13,038 | 9.3% | 593 | 0.4% | 12,754 | 9.1% |
| King | 183,107 | 17,030 | 9.3% | 579 | 0.3% | 16,709 | 9.1% |
| North Central | 51,833 | 5,262 | 10.2% | 198 | 0.4% | 5,162 | 10.0% |
| North Sound | 135,023 | 14,883 | 11.0% | 614 | 0.5% | 14,560 | 10.8% |
| Pierce | 113,558 | 11,967 | 10.5% | 351 | 0.3% | 11,785 | 10.4% |
| Salish | 35,449 | 4,707 | 13.3% | 216 | 0.6% | 4,627 | 13.1% |
| Southwest | 68,668 | 7,695 | 11.2% | 312 | 0.5% | 7,558 | 11.0% |
| Spokane | 91,673 | 11,163 | 12.2% | 392 | 0.4% | 11,001 | 12.0% |
| Thurston-Mason | 38,791 | 5,250 | 13.5% | 285 | 0.7% | 5,133 | 13.2% |
| Unknown | 169 | 11 | 6.5% | *suppressed* | *suppressed* | 11 | 6.5% |

**Table C2a. Number of Apple Health Title 19 or CHIP-Eligible Youths ages 11-18 receiving any Substance Use Disorder treatment (SUD Tx) or Withdrawal Management (WM) services, CY 2018**

| Demographic Category | Eligible youth in each demographic category | | Among youth who received SUD Tx or WM services, percent in each category | | Of all eligible youth in this category, percent who received SUD Tx or WM services |
|---|---|---|---|---|---|
| | # | % | # | % | % |
| Total | 341,043 | 100% | 3,904 | 100% | 1.14% |
| Age Category | | | | | |
| 11-13 years | 139,409 | 40.88% | 401 | 10.27% | 0.29% |
| 14-18 years | 201,634 | 59.12% | 3,503 | 89.73% | 1.74% |
| Gender | | | | | |
| Female | 167,801 | 49.20% | 1,508 | 38.63% | 0.90% |
| Male | 173,242 | 50.80% | 2,396 | 61.37% | 1.38% |
| Race/Ethnicity | | | | | |
| White Alone, non-Hispanic | 140,146 | 41.67% | 1,603 | 41.06% | 1.13% |
| Any minority | 189,768 | 55.64% | 2,296 | 58.81% | 1.21% |
| Unknown | 9,149 | 2.68% | *suppressed* | *suppressed* | *suppressed* |
| Race/Ethnicity detail | | | | | |
| African American / Black | 37,285 | 10.93% | 495 | 12.68% | 1.33% |
| American Indian / Alaska Native | 23,737 | 6.96% | 520 | 13.32% | 2.19% |
| Asian | 24,967 | 7.32% | 164 | 4.20% | 0.66% |
| Asian/Pacific Islander | 409 | 0.12% | 11 | 0.28% | 2.69% |
| Hispanic | 111,963 | 32.83% | 1,373 | 35.17% | 1.23% |
| Native Hawaiian or Pacific Islander | 17,447 | 5.12% | 150 | 3.84% | 0.86% |



**Table C2b. Number of Apple Health Title 19 or CHIP-Eligible Youths ages 11-18 receiving Substance Use Disorder (SUD) Outpatient treatment services (Outpatient SUD Tx), Residential treatment services (Residential SUD Tx), and Withdrawal Management (WM) services, CY 2018**

| Demographic Category | Among youth who received SUD Tx or WM services, percent in each category | | Received Outpatient SUD Tx | | Received Residential SUD Tx | | Received WM services | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Total (by SUD service type) | 3,904 | 100% | 3,639 | 100% | 545 | 100% | 62 | 100% |
| Age Category | | | | | | | | |
| 11-13 years | 401 | 10.27% | 375 | 10.31% | 32 | 5.87% | *suppressed* | |
| 14-18 years | 3503 | 89.73% | 3264 | 89.69% | 513 | 94.13% | 60 | 96.77% |
| Gender | | | | | | | | |
| Female | 1,508 | 38.63% | 1,398 | 38.42% | 229 | 42.02% | 30 | 48.39% |
| Male | 2,396 | 61.37% | 2,241 | 61.58% | 316 | 57.98% | 32 | 51.61% |
| Race/Ethnicity | | | | | | | | |
| White Alone, non-Hispanic | 1,603 | 41.06% | 1,476 | 40.56% | 277 | 49.17% | 36 | 41.94% |
| Any minority | 2,296 | 58.81% | 2,159 | 59.33% | 268 | 50.83% | 26 | 58.06% |
| Unknown | *suppressed* | | *suppressed* | | 0 | 0% | 0 | 0% |
| Race/Ethnicity detail | | | | | | | | |
| African American / Black | 495 | 12.68% | 470 | 12.92% | 51 | 9.36% | *suppressed* | |
| American Indian / Alaska Native | 520 | 13.32% | 474 | 13.03% | 88 | 16.15% | 12 | 19.35% |
| Asian | 164 | 4.20% | 148 | 4.07% | 31 | 5.69% | *suppressed* | |
| Asian/Pacific Islander | 11 | 0.28% | 10 | 0.27% | 0 | 0% | *suppressed* | |
| Hispanic | 1,373 | 35.17% | 1,304 | 35.83% | 157 | 28.81% | 15 | 24.19% |
| Native Hawaiian or Pacific Islander | 150 | 3.84% | 137 | 3.76% | 21 | 3.85% | *suppressed* | |



**Table C3a. Number of Apple Health Title 19 or CHIP-eligible youths ages 0-18 receiving any community mental health (MH) services, CY 2018**

Any community MH services included Outpatient, Crisis, and Community Hospital or Evaluation & Treatment Services

| Demographic Category | Eligible youth in each demographic category | | Among youth who received any community MH services, percent in each category | | Of all eligible youth in this category, percent who received community MH services |
|---|---|---|---|---|---|
| | # | % | # | % | % |
| Total | 903,117 | 100% | 96,227 | 100% | 10.65% |
| Age Category | | | | | |
| 0-4 years | 258,608 | 28.63% | 6,827 | 7.09% | 2.64% |
| 5-11 years | 352,250 | 39.00% | 40,176 | 41.75% | 11.41% |
| 12-13 years | 90,685 | 10.04% | 16,040 | 16.67% | 17.69% |
| 14-18 years | 201,634 | 22.32% | 33,184 | 34.49% | 16.46% |
| Gender | | | | | |
| Female | 441,385 | 48.87% | 47,308 | 49.16% | 10.72% |
| Male | 461,792 | 51.13% | 48,919 | 50.84% | 10.59% |
| Race/Ethnicity | | | | | |
| White Alone, non-Hispanic | 369,936 | 40.96% | 45,675 | 47.47% | 12.35% |
| Any minority | 480,115 | 53.16% | 49,543 | 51.49% | 10.32% |
| Unknown | 53,086 | 5.88% | 1,009 | 1.05% | 1.90% |
| Race/Ethnicity detail | | | | | |
| African American / Black | 100,825 | 11.16% | 11,309 | 11.75% | 11.21% |
| American Indian / Alaska Native | 57,356 | 6.35% | 9,509 | 9.97% | 16.72% |
| Asian | 59,706 | 6.61% | 4,898 | 5.09% | 8.20% |
| Asian/Pacific Islander | 597 | 0.07% | 104 | 0.11% | 17.42% |
| Hispanic | 281,520 | 31.17% | 29,013 | 30.15% | 10.31% |
| Native Hawaiian or Pacific Islander | 46,801 | 5.18% | 3,390 | 3.52% | 7.24% |



**Table C3b. Number of Apple Health Title 19 or CHIP-eligible youths ages 0-18 receiving community mental health (MH) outpatient treatment services (OP MH TX), crisis services (Crisis MH), and community hospital or evaluation & treatment (MH CH/E&T) services, CY 2018**

| Demographic Category | Among youth who received any MH services, percent in each category | | Received OP MH Tx services | | Received Crisis MH services | | Received MH CH/E&T services | |
|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % |
| Total | 96,227 | 100% | 95,133 | 100% | 7,323 | 100% | 1,918 | 100% |
| Age Category | | | | | | | | |
| 0-4 years | 6,827 | 7.09% | 6,820 | 7.17% | 53 | 0.72% | *suppressed* | |
| 5-11 year | 40,176 | 41.75% | 39,992 | 42.04% | 1,737 | 23.72% | 260 | 13.56% |
| 12-13 years | 16,040 | 16.67% | 15,801 | 16.61% | 1,536 | 20.98% | 403 | 21.01% |
| 14-18 years | 33,184 | 34.49% | 32,520 | 34.18% | 3,997 | 54.58% | 1,253 | 65.33% |
| Gender | | | | | | | | |
| Female | 47,308 | 49.16% | 46,736 | 49.13% | 3,855 | 52.64% | 1,214 | 63.30% |
| Male | 48,919 | 50.84% | 48,397 | 50.87% | 3,468 | 47.36% | 704 | 36.70% |
| Race/Ethnicity | | | | | | | | |
| White Alone, non-Hispanic | 45,675 | 47.47% | 45,167 | 47.48% | 3,556 | 51.32% | 927 | 48.33% |
| Any minority | 49,543 | 51.49% | 48,962 | 51.47% | 3,758 | 48.56% | 991 | 51.67% |
| Unknown | 1,009 | 1.05% | 1,004 | 1.06% | *suppressed* | | 0 | 0% |
| Race/Ethnicity detail | | | | | | | | |
| African American / Black | 11,309 | 11.75% | 11,188 | 11.76% | 919 | 12.55% | 316 | 16.48% |
| American Indian / Alaska Native | 9,509 | 9.97% | 9,458 | 9.94% | 842 | 11.50% | 256 | 13.35% |
| Asian | 4,898 | 5.09% | 4,850 | 5.10% | 336 | 4.59% | 130 | 6.78% |
| Asian/Pacific Islander | 104 | 0.11% | 104 | 0.11% | 11 | 0.15% | *suppressed* | |
| Hispanic | 29,013 | 30.15% | 28,655 | 30.12% | 1,966 | 26.85% | 447 | 23.31% |
| Native Hawaiian or Pacific Islander | 3,390 | 3.52% | 3,361 | 3.53% | 216 | 2.95% | 76 | 3.96% |



**Table C4. Types of behavioral health services provided, CY 2018**

| Category | Treatment modality |
|---|---|
| Substance Use Disorder (SUD) | Case Management |
| Substance Use Disorder (SUD) | Intensive Inpatient Residential Services |
| Substance Use Disorder (SUD) | Long-Term Care Residential Services |
| Substance Use Disorder (SUD) | Medication Assisted Treatment |
| Substance Use Disorder (SUD) | Outpatient Treatment |
| Substance Use Disorder (SUD) | Recovery House Residential Services |
| Substance Use Disorder (SUD) | SUD Residential (unknown location) |
| Substance Use Disorder (SUD) | Withdrawal Management |
| Mental Health (MH) | Care Coordination Services |
| Mental Health (MH) | Child And Family Team Meeting |
| Mental Health (MH) | Community Hospital |
| Mental Health (MH) | Crisis Services |
| Mental Health (MH) | Day Support |
| Mental Health (MH) | Engagement And Outreach |
| Mental Health (MH) | Evaluation & Treatment |
| Mental Health (MH) | Family Treatment |
| Mental Health (MH) | Group Treatment Services |
| Mental Health (MH) | High Intensity Treatment |
| Mental Health (MH) | Individual Treatment Services |
| Mental Health (MH) | Intake Evaluation |
| Mental Health (MH) | Involuntary Treatment Investigation MH |
| Mental Health (MH) | Jail Services/Community Transition |
| Mental Health (MH) | MH Inpatient (unknown location) |
| Mental Health (MH) | Medication Management |
| Mental Health (MH) | Medication Monitoring |
| Mental Health (MH) | Mental Health Services Provided In A Residential Setting |
| Mental Health (MH) | Outpatient Treatment |
| Mental Health (MH) | Peer Support |
| Mental Health (MH) | Psychological Assessment |
| Mental Health (MH) | Rehabilitation Case Management |
| Mental Health (MH) | Respite Care Services |
| Mental Health (MH) | Special Population Evaluation |
| Mental Health (MH) | Stabilization Services |
| Mental Health (MH) | Supported Employment |
| Mental Health (MH) | Therapeutic Psychoeducation |

**Source:** DSHS Research and Data Analysis Division, Client Outcomes Database, July 2019.

# Appendix D: MCO-contracted mental health providers serving children by MCO and county, calendar year (CY) 2018

The three tables in this appendix summarize data on contracted behavioral health provider availability reported by the Managed Care Organizations (MCOs) in calendar year 2018, for quarters 1, 3, and 4. Data is not available for quarter 2 of 2018, as data submissions were not required by HCA due to the readiness activities in progress to prepare for the transition to Integrated Managed Care (IMC) in multiple regions across the state.

**Notes:** Apple Health Managed Care Organization's contracts require current and accurate provider directories shared with the public and provided in quarterly updated data sets to HCA. Mental health providers are defined by professional licensure and specialties.

In the tables below, MCO Plan names are shortened as follows: "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "CCW" means Coordinated Care of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan.

**Data source:** HCA Network Adequacy Reporting by Apple Health MCOs.

**Table D.1. MCO mental health providers that are accepting new clients, by MCO network and county during the first quarter of CY 2018 (2018-Q1)**

| 2018-Q1 | MCO Plan | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Adams | 92.2% | 92.2% | 92.7% | 92.2% | 92.2% |
| Asotin | 98.4% | 98.4% | 98.4% | 99.8% | 98.4% |
| Benton | 99.8% | 100.0% | 100.0% | 99.8% | 99.8% |
| Chelan | 96.4% | 97.5% | 100.0% | 100.0% | 100.0% |
| Clallam | 78.7% | 75.1% | 78.7% | 99.6% | 100.0% |
| Clark | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Columbia | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cowlitz | 99.9% | 99.9% | 99.9% | 100.0% | 99.9% |
| Douglas | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Ferry | 92.9% | 89.9% | 65.9% | 95.1% | 95.9% |
| Franklin | 100.0% | 100.0% | 100.0% | 99.2% | 100.0% |
| Garfield | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Grant | 84.4% | 99.5% | 99.5% | 99.5% | 84.6% |
| Grays Harbor | 94.8% | 99.5% | 93.8% | 94.8% | 94.1% |
| Island | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

| 2018-Q1 | MCO Plan | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Jefferson | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| King | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Kitsap | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Kittitas | 100.0% | 100.0% | 84.9% | 100.0% | 100.0% |
| Klickitat | 97.3% | 97.2% | 55.2% | 97.3% | 97.0% |
| Lewis | 99.7% | 95.2% | 89.6% | 95.4% | 98.9% |
| Lincoln | 85.8% | 84.0% | 84.0% | 85.8% | 85.8% |
| Mason | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Okanogan | 100.0% | 94.9% | 80.6% | 100.0% | 100.0% |
| Pacific | 87.7% | 100.0% | 89.1% | 100.0% | 100.0% |
| Pend Oreille | 86.7% | 82.3% | 82.3% | 86.7% | 86.7% |
| Pierce | 100.0% | 99.9% | 99.9% | 99.9% | 100.0% |
| San Juan | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Skagit | 96.2% | 99.5% | 97.4% | 98.2% | 96.2% |
| Skamania | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Snohomish | 99.5% | 100.0% | 99.5% | 99.9% | 99.5% |
| Spokane | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Stevens | 95.7% | 96.7% | 92.4% | 95.8% | 99.1% |
| Thurston | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Walla Walla | 100.0% | 100.0% | 97.3% | 97.3% | 94.8% |
| Wahkiakum | 100.0% | 100.0% | 100.0% | 99.6% | 100.0% |
| Whatcom | 99.3% | 99.3% | 99.7% | 100.0% | 100.0% |
| Whitman | 96.8% | 91.4% | 96.6% | 97.0% | 97.8% |
| Yakima | 99.8% | 99.6% | 99.6% | 99.8% | 99.8% |



**Table D.2. MCO mental health providers that are accepting new clients, by MCO network and county during the third quarter of CY 2018 (2018-Q3)**

| 2018-Q3 | MCO PLAN | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Adams | 99.0% | 99.0% | 99.0% | 92.2% | 98.5% |
| Asotin | 98.4% | 98.4% | 98.4% | 99.8% | 98.4% |
| Benton | 99.8% | 100.0% | 100.0% | 100.0% | 99.8% |
| Chelan | 100.0% | 97.5% | 100.0% | 100.0% | 100.0% |
| Clallam | 78.7% | 78.7% | 78.7% | 84.8% | 100.0% |
| Clark | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Columbia | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cowlitz | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Douglas | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Ferry | 87.0% | 89.9% | 65.9% | 95.1% | 92.9% |
| Franklin | 100.0% | 100.0% | 100.0% | 99.2% | 99.2% |
| Garfield | 100.0% | 100.0% | 49.9% | 100.0% | 100.0% |
| Grant | 99.3% | 99.5% | 99.5% | 99.5% | 84.6% |
| Grays Harbor | 94.8% | 99.5% | 93.8% | 94.8% | 94.1% |
| Island | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Jefferson | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| King | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Kitsap | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Kittitas | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Klickitat | 97.3% | 97.2% | 55.2% | 97.4% | 97.0% |
| Lewis | 99.2% | 95.2% | 89.6% | 95.4% | 98.9% |
| Lincoln | 90.6% | 89.2% | 91.0% | 85.8% | 91.0% |
| Mason | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Okanogan | 100.0% | 94.9% | 94.4% | 100.0% | 100.0% |
| Pacific | 87.7% | 100.0% | 93.1% | 100.0% | 100.0% |
| Pend Oreille | 86.7% | 82.3% | 82.3% | 86.7% | 86.7% |
| Pierce | 100.0% | 99.9% | 99.9% | 99.9% | 100.0% |
| San Juan | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Skagit | 96.2% | 99.5% | 96.2% | 96.2% | 96.2% |
| Skamania | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Snohomish | 99.5% | 100.0% | 99.5% | 99.5% | 99.5% |
| Spokane | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Stevens | 93.3% | 96.8% | 93.4% | 95.8% | 99.1% |
| Thurston | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

| 2018-Q3 | MCO PLAN | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Walla Walla | 100.0% | 100.0% | 97.3% | 97.3% | 80.7% |
| Wahkiakum | 99.6% | 100.0% | 100.0% | 99.6% | 99.6% |
| Whatcom | 99.3% | 99.3% | 100.0% | 100.0% | 100.0% |
| Whitman | 97.0% | 91.6% | 97.8% | 97.0% | 98.0% |
| Yakima | 99.8% | 99.6% | 99.6% | 99.8% | 99.8% |



**Table D.3. MCO mental health providers that are accepting new clients, by MCO network and county during the fourth quarter of CY 2018 (2018-Q4)**

| 2018-Q4 | MCO PLAN | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Adams | 98.9% | 99.0% | 98.9% | 90.8% | 98.3% |
| Asotin | 98.5% | 98.5% | 98.5% | 99.6% | 98.5% |
| Benton | 99.5% | 99.7% | 99.7% | 99.7% | 99.5% |
| Chelan | 100.0% | 97.3% | 100.0% | 100.0% | 100.0% |
| Clallam | 81.5% | 81.5% | 81.5% | 86.9% | 100.0% |
| Clark | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Columbia | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Cowlitz | 99.8% | 99.8% | 99.8% | 99.8% | 99.8% |
| Douglas | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Ferry | 89.4% | 92.2% | 89.4% | 96.8% | 94.5% |
| Franklin | 100.0% | 100.0% | 100.0% | 100.0% | 98.9% |
| Garfield | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Grant | 99.3% | 99.6% | 99.6% | 99.6% | 87.3% |
| Grays Harbor | 96.3% | 99.7% | 95.3% | 96.3% | 95.6% |
| Island | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Jefferson | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| King | 99.9% | 99.9% | 99.9% | 99.9% | 99.9% |
| Kitsap | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Kittitas | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Klickitat | 97.5% | 97.5% | 60.1% | 97.7% | 97.2% |
| Lewis | 99.1% | 95.3% | 100.0% | 95.5% | 98.9% |
| Lincoln | 88.9% | 88.9% | 89.2% | 82.2% | 89.2% |
| Mason | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Okanogan | 100.0% | 94.7% | 97.1% | 100.0% | 100.0% |
| Pacific | 87.8% | 100.0% | 93.8% | 97.9% | 100.0% |
| Pend Oreille | 89.9% | 85.0% | 85.0% | 89.9% | 85.0% |
| Pierce | 100.0% | 99.9% | 100.0% | 99.9% | 100.0% |
| San Juan | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Skagit | 96.7% | 99.9% | 97.5% | 96.7% | 96.7% |
| Skamania | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Snohomish | 99.6% | 100.0% | 99.6% | 99.6% | 99.6% |
| Spokane | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Stevens | 94.4% | 97.4% | 94.4% | 96.3% | 99.2% |
| Thurston | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |



| 2018-Q4 | MCO PLAN | | | | |
|---|---|---|---|---|---|
| COUNTY | Amerigroup | CHPW | CCW | Molina | United |
| Walla Walla | 100.0% | 100.0% | 97.7% | 97.7% | 81.1% |
| Wahkiakum | 99.7% | 100.0% | 100.0% | 99.7% | 99.7% |
| Whatcom | 99.5% | 99.5% | 99.7% | 100.0% | 100.0% |
| Whitman | 96.6% | 91.2% | 97.4% | 96.5% | 94.2% |
| Yakima | 99.8% | 99.7% | 99.7% | 99.8% | 99.8% |



# Appendix E: Language access through interpreter services for Apple Health clients

Apple Health clients, whose primary language is not English, may receive Apple Health interpreter services. Washington was the first state in the nation to establish a healthcare interpreter certification program,[12] which has standards that apply to interpreter services that include Apple Health interpreter services as well. The certification program provides assurance that providers are sufficiently skilled at conveying the necessary medical terminology appropriately in a language other than English.[13]

In accordance with 42 C.F.R. § 438.10(c)(4), Apple Health providers — whether contracted through a BHO, MCO, FFS, or IMC network — must make available interpreter services and translated written materials for clients with a primary language other than English. Apple Health providers must provide free language access services to any client who experiences trouble speaking or understanding English, is deaf, or hard of hearing. Washington State agencies use *Interpreter and Translation Services* contracts. These contracts require contractors to ensure the competency of their employed or contracted interpreters and translators.

Apple Health contracts also require participation in the promotion of the *National Standards for Culturally and Linguistically Appropriate Services*. U.S. Department of Health & Human Services defines these fifteen standards as "steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services."[14]

Some safeguards exist to identify instances when these language resources are not accessible. HCA's *Investigations and Reasonable Accommodation Unit* investigates reports of civil rights violations, which may include client experiences related to engaging language access services. In addition, the BHO network offers a free, confidential ombudsman service to address barriers to clients.

[12] The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond. 2007. Chen, et al. J Gen Intern Med, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609>, accessed August 28, 2018.
[13] Title VI of the Civil Rights Act. LEP Guidance of HHS Competence of Interpreters (VI. A.), <https://www.gpo.gov/fdsys/pkg/FR-2003-08-08/html/03-20179.htm>, accessed August 28, 2018.
[14] Culturally and Linguistically Appropriate Services, <https://www.thinkculturalhealth.hhs.gov/clas>, accessed August 28, 2018.

# Appendix F: Number and availability of MCO-contracted mental health providers serving children, calendar year (CY) 2018

The table in this appendix summarizes data on contracted behavioral health provider availability across the state, as reported by the Managed Care Organizations (MCOs) in calendar year 2018, for quarters 1, 3, and 4. Data is not available for quarter 2 of 2018, as data submissions were not required by HCA due to the readiness activities in progress to prepare for the transition to Integrated Managed Care (IMC) in multiple regions across the state. In addition, quarter 3 data for Molina Healthcare of Washington were suppressed due to data quality issues.

**Table F1. Number of children's behavioral health providers, and number and percentage of children's behavioral health providers who were actively accepting new patients, by MCO and by 2018 CY quarter**

| Calendar Year 2018 | Amerigroup | CHPW | CCW | Molina | United |
|---|---|---|---|---|---|
| Quarter 1 | | | | | |
| total contracted | 2299 | 2376 | 1997 | 4010 | 1832 |
| number available | 1903 | 2273 | 1841 | 3635 | 1832 |
| percent available | 82.8% | 95.7% | 92.2% | 90.6% | 100% |
| Quarter 2 | | | | | |
| total contracted | | | not available | | |
| number available | | | | | |
| percent available | | | | | |
| Quarter 3 | | | | | |
| total contracted | 2653 | 2428 | 2071 | | 2058 |
| number available | 2029 | 2318 | 1908 | suppressed | 2058 |
| percent available | 76.5% | 95.5% | 92.1% | | 100% |
| Quarter 4 | | | | | |
| total contracted | 2665 | 2683 | 2858 | 4333 | 2036 |
| number available | 2043 | 2559 | 2591 | 3777 | 2036 |
| percent available | 76.7% | 95.4% | 90.7% | 87.2% | 100% |

**Source:** HCA Network Adequacy Reporting by Apple Health MCOs

**Definitions:** In the table above, MCO Plan names are shortened as follows: "Amerigroup" means Amerigroup Washington. "CHPW" means Community Health Plan of Washington. "CCW" means Coordinated Care of Washington. "Molina" means Molina Healthcare of Washington. "United" means United Health Care Community Plan.

"Total contracted" indicates the total unduplicated number of individual providers contracted by each MCO and that indicated they treat children. In instances where individual providers work at multiple behavioral health provider agencies or at multiple locations, provider NPI was used to remove duplicates from the reported data.



"Number available" indicates to total unduplicated number of individual providers that indicated they are accepting new clients.

"Percent available" indicates the percent of individual providers that are accepting new clients (numerator is "Number available" and denominator is "Total contracted").

**Notes:** Apple Health Managed Care Organization's contracts require current and accurate provider directories shared with the public and provided in quarterly updated data sets to HCA. Mental health providers are defined by professional licensure and specialties.



# Appendix G: Children and youth enrolled in Apple Health or CHIP with eating disorder diagnoses, calendar year (CY) 2018

**Table G.1. Number and percent of children and youth (age 0–20) enrolled in Apple Health or CHIP with eating disorder diagnoses by age and gender, CY 2018**

| Demographic category | Apple Health/CHIP eligible youth[1] with eating disorder[2] | Apple Health/CHIP eligible youth[1] | Rate |
|---|---|---|---|
| **TOTAL** | **4,427** | **977,913** | **0.45%** |
| | | | |
| **AGE CATEGORY** | | | |
| 0–5 | 1,447 | 299,909 | 0.48% |
| 6–11 | 839 | 303,522 | 0.28% |
| 12–17 | 1,463 | 265,031 | 0.55% |
| 17–20 | 678 | 109,451 | 0.62% |
| **GENDER** | | | |
| Female | 2,694 | 481,004 | 0.56% |
| Male | 1,733 | 496,909 | 0.35% |
| **RACE/ETHNICITY** | | | |
| White Alone, Non-Hispanic | 1,955 | 381,661 | 0.51% |
| Any Minority | 2,268 | 517,182 | 0.44% |
| American Indian / Alaska Native | 331 | 62,924 | 0.53% |
| Asian / Native Hawaiian or Pacific Islander | 341 | 99,755 | 0.34% |
| Black | 469 | 109,463 | 0.43% |
| Hispanic | 1377 | 301,931 | 0.46% |
| Unknown | 204 | 79,070 | 0.26% |

**Source:** RDA Integrated Client Databases. Prepared from summary data provided by DSHS Research and Data Analysis Division, August 2019.

**Notes:**

1. All children and youth (age 0–20) as of June 2017 who had at least one month of full-benefit Apple Health (Title 19 medical coverage) or enrolled in CHIP during CY 2018.
2. The cases of eating disorder include clients with one of the following diagnoses in CY2016-2017: Anorexia nervosa, unspecified; Anorexia nervosa, restricting type; Anorexia nervosa, binge eating/purging type; Bulimia nervosa; Other eating disorders; Binge eating disorder; Avoidant/restrictive food intake disorder; Other specified eating disorder; Eating disorder, unspecified; Rumination disorder of infancy; Other feeding disorders of infancy and early childhood; and Pica of infancy and childhood.

**Table G.2. Number and percent of children and youth (age 0–20) enrolled in Apple Health or CHIP with eating disorder diagnoses by county, CY 2018**

| Count | Apple Health/CHIP eligible youth[1] with eating disorder diagnosis[2] | Apple Health/CHI eligible youth[1] | Rate |
|---|---|---|---|
| **All Counties** | **4,427** | **977,913** | **0.45%** |
| Adams | 31 | 6,510 | 0.48% |
| Asotin | 17 | 3,572 | 0.48% |
| Benton | 124 | 35,273 | 0.35% |
| Chelan | 80 | 14,294 | 0.56% |
| Clallam | 31 | 9,810 | 0.32% |
| Clark | 265 | 69,283 | 0.38% |
| Columbia | suppressed | suppressed | -- |
| Cowlitz | 89 | 18,680 | 0.48% |
| Douglas | 55 | 8,385 | 0.66% |
| Ferry | suppressed | suppressed | -- |
| Franklin | 102 | 24,719 | 0.41% |
| Garfield | suppressed | suppressed | -- |
| Grant | 107 | 24,430 | 0.44% |
| Grays Harbor | 51 | 12,391 | 0.41% |
| Island | 31 | 7,538 | 0.41% |
| Jefferson | 13 | 2,936 | 0.44% |
| King | 965 | 198,667 | 0.49% |
| Kitsap | 138 | 25,659 | 0.54% |
| Kittitas | 34 | 4,786 | 0.71% |
| Klickitat | 13 | 3,335 | 0.39% |
| Lewis | 42 | 13,816 | 0.30% |
| Lincoln | suppressed | suppressed | -- |
| Mason | 56 | 9,605 | 0.58% |
| Okanogan | 36 | 8,813 | 0.41% |
| Pacific | 19 | 3,082 | 0.62% |
| Pend Oreille | suppressed | suppressed | -- |
| Pierce | 468 | 122,943 | 0.38% |
| San Juan | suppressed | suppressed | -- |
| Skagit | 73 | 19,836 | 0.37% |
| Skamania | suppressed | suppressed | -- |
| Snohomish | 411 | 89,651 | 0.46% |
| Spokane | 453 | 80,142 | 0.57% |
| Stevens | 26 | 7,887 | 0.33% |



| Count | Apple Health/CHIP eligible youth[1] with eating disorder diagnosis[2] | Apple Health/CHI eligible youth[1] | Rate |
|---|---|---|---|
| Thurston | 181 | 32,598 | 0.56% |
| Wahkiakum | suppressed | suppressed | -- |
| Walla Walla | 25 | 9,317 | 0.27% |
| Whatcom | 162 | 27,378 | 0.59% |
| Whitman | 15 | 3,848 | 0.39% |
| Yakima | 281 | 68,945 | 0.41% |
| *Unknown* | *suppressed* | *suppressed* | -- |

**Source:** RDA Integrated Client Databases. Prepared from summary data provided by DSHS Research and Data Analysis Division, August 2018.

**Notes:** We suppressed both the numerator (i.e., Apple Health/CHIP Eligible Youth with Eating Disorder) and denominator (Apple Health/CHIP Eligible Youth) if either were less than 10.

1. All children and youth (age 0–20) as of June 2018 who had at least one month of full-benefit Apple Health (Title 19 medical coverage) or enrolled in CHIP during CY 2018.
2. The cases of eating disorder include clients with one of the following diagnoses in CY2017-2018: Anorexia nervosa, unspecified; Anorexia nervosa, restricting type; Anorexia nervosa, binge eating/purging type; Bulimia nervosa; Other eating disorders; Binge eating disorder; Avoidant/restrictive food intake Other specified eating disorder; Eating disorder, unspecified; Rumination disorder of infancy; Other feeding disorders of infancy and early childhood; and Pica of infancy and childhood.