Washington State Health Care Authority

Report to the Legislature

Access to behavioral health services for children, youth, and young adults

Engrossed Second Substitute Senate Bill 5432; Section 4002(1); Chapter 325; Laws of 2019

RCW 74.09.495

December 1, 2023

Acknowledgements

The data collected for this report was provided by various individuals from multiple state departments, including Health Care Authority (HCA), Department of Social and Health Services' Research and Data Analysis Division (DSHS/RDA), and Washington State University's Social & Economic Sciences Research Center (WSU/SESRC). Many thanks to Amanda Lewis, Christine Mickelson, Diana Cockrell, Enos Mbajah, Felix Rodriguez, Grace Hong, Jasjit Grewal, Jessica Blose, Jesica Mikesell, Kari Samuel, Kathleen Donlin, Kent Miller, Kiki Fabian, Kris Royal, Lauren Kula, Liz Venuto, Lora Weed, Martha Aby, Patty King, Quentesa Garraway, Stacey Bushaw, and Sherry Wylie for contributing to this report.

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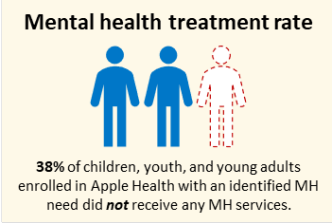
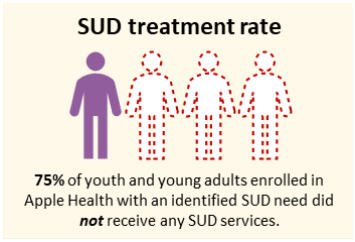
Executive summary

In accordance with RCW 74.09.495, Health Care Authority has reported on several metrics regarding access to behavioral health services for children, youth, and young adults (ages 0-25) enrolled in Apple Health (Medicaid) in 2022.



Mental Health Services: approximately 1 in 3 children, youth, and young adults enrolled in Apple Health who needed mental health services did not receive them, with young children and young adults less likely to receive needed services. Even after a visit to the emergency department for mental health needs, 40% of children, youth, and young adults did not receive follow-up care within seven days and 27% did not receive care within 30 days.

Substance Use Disorder Services: approximately 3 in 4 youth and young adults enrolled in Apple Health who needed substance use disorder services did not receive them. There was variation across age, gender, and racial/ethnic groups, but for all groups, the majority of the youth and young adults did not receive needed care. Even after an SUD-related emergency department visit, 79% of youth did not receive follow-up services within seven days of their visit, and 69% did not receive care within 30 days.



Provider Availability: Data regarding the availability of providers was limited; however, reports from various sources suggest that the availability of providers continues to be a key challenge in access to care. Data about the languages spoken by behavioral health providers serving children and youth was also limited. Still, the available data suggests that, in some settings, approximately 17% of providers speak a language other than English, with the most commonly spoken language being Spanish.

Eating Disorders: Data regarding eating disorder diagnoses found that 9,296 children, youth, and young adults (less than 1% of the total population) were diagnosed with an eating disorder. Data regarding eating disorders treatment and eating disorders providers was limited.

Looking forward: The Health Care Authority is currently involved in several efforts to address the barriers to access noted in this report and improve the system of care. While the information included in this report included only a subset of the Washington state population (children, youth, and young adults enrolled in Apple Health), the Children and Youth Behavioral Health Work Group's work to develop a strategic plan requires the collection of data statewide regarding all aspects of the behavioral health system of care, from promotion to prevention, treatment, and recovery, and for all children, youth, young adults, and families. This data will provide a roadmap for developing longer-term, system-wide strategies to ensure access to high-quality, equitable care and support.

Introduction

Background

Early and accurate recognition of behavioral health issues and appropriate and timely intervention enhance health outcomes while minimizing overall expenditures. However, within the current system of care, families face barriers to receiving a full range of services for children, youth, and young adults experiencing behavioral health problems. Disparities also exist in the diagnosis and initiation of treatment services for children of color, with studies demonstrating that children and youth of color are diagnosed and begin receiving early interventions at a later age.

To address these concerns, the legislature passed ESHB 2489 in 2016 to establish the Children & Youth Behavioral Health Workgroup to identify barriers to accessing behavioral health services for children, youth, and families and to advise the legislature on statewide behavioral health services for this population.

This bill also required the state Medicaid agency to report annually on the status of access to behavioral health services for children (birth through age 17) enrolled in Apple Health (Medicaid), as Apple Health covers approximately half of all children within Washington[1]. At a minimum, this report must include the following components, which must also be broken down by age, gender, and race/ethnicity:

a) 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 substance use disorder during the measuring year and who had a 30-day follow-up visit with any provider with the same primary diagnosis.
b) The percentage of children and youth with an identified behavioral health need who received behavioral health services during the reporting period.
c) The percentage of children and youth who received behavioral health services, including the services provided.
d) The number of children and youth behavioral health providers available in the previous year, the languages spoken by those providers, and the overall percentage of children's behavioral health providers actively accepting new patients.
e) Data related to mental health and medical services for eating disorder treatment in children and youth, including the number of eating disorder diagnoses; patients treated in outpatient, residential, emergency, and inpatient care settings; and contracted providers specializing in eating disorder treatment and the overall percentage of those providers who were actively accepting new patients during the reporting period.

[1] Calculation created from the Office of Financial Management's population data and the Apple Health Client eligibility dashboard.

Organization of results

In accordance with this statute, the Health Care Authority has provided the following report. Results are provided in four sections.

Section 1. Behavioral health services provided to children, youth, and young adults

- The percentage of all children, youth, and young adults who received behavioral health services and the services provided.

Section 2. Unmet need for behavioral health care for children, youth, and young adults

- The percentage of children, youth, and young adults with an identified behavioral health need who received behavioral health services during the reporting period.
- The percentage of children, youth, and young adults who received follow-up care after a visit to the emergency room for behavioral health needs.

Section 3. Behavioral health provider workforce serving children and youth

- The number of children and youth mental health providers available and the percentage of these providers who were actively accepting new patients.▪
- The languages spoken by those providers.▪

Section 4. Eating disorder diagnosis, treatment, and workforce for children, youth, and young adults

- The number of children, youth, and young adults diagnosed with an eating disorder.
- The percentage of children, youth, and young adults with an eating disorder who served in outpatient, residential, emergency, and inpatient care settings.▪
- The number of providers specializing in eating disorder treatment and the percentage of these providers actively accepting new patients.▪

Efforts to address access challenges: The results within this report highlight many difficulties regarding access to behavioral health services for children, youth, and young adults. The results describe current and recent efforts to address these challenges.

Understanding this data

Due to the differences in data collection and analysis over time, data in this report is not comparable to data reported in previous years.

While this report is required at minimum to include (and has historically included) data on children and youth from birth to age 18, this year's report expands this data to include children, youth, and young adults from birth *through age 25*. This update reflects a growing recognition within the behavioral health system of the ages of 18-25, or young adulthood, as a unique developmental phase. Emerging neurological research suggests that cognitive and executive functions approach their final 'adult' form by age 26, and this period of life also often involves critical transitions in access to various systems and supports (Silverstein et al., 2021).

For all metrics, race/ethnicity data is reported inclusively, which means that children and youth may be identified in multiple racial/ethnic categories. For more information, please see Appendix A: Data Collection & Definitions.

▪There are several limitations to the data provided in Sections 3 and 4 of this report; these limitations are described in full in those respective sections.

Results

Section 1. Behavioral health services provided to children, youth, and young adults

Background: In October 2021, the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP), and the Children's Hospital Association (CHA) jointly declared a national emergency in child and adolescent mental health. Although comprehensive information about the prevalence of mental health conditions for children and youth is limited, a review of national behavioral health data by the Centers for Disease Control and Prevention (CDC) suggested that as many as 1 in 5 children and youth may experience a mental health disorder every year (Bitsko et al., 2022), and data from the National Survey of Children's Health suggests that there have been significant increases in rates of mental health disorders for children and youth in recent years, especially following the onset of the COVID pandemic (Lebrun-Harris et al., 2022).

Children and youth of color, LQBTQIA+ children and youth, children living in rural areas, and children and youth with intellectual and/or developmental disabilities may be at increased risk of mental health concerns due to systemic racism, sexism, homophobia, and other types of oppression and marginalization (see the U.S. Surgeon General's 2021 Advisory on the Youth Mental Health Crisis), and nearly 70% of youth in the juvenile justice system have a diagnosable behavioral health disorder (Vincent et al., 2008).

Behavioral health challenges can vary across the developmental spectrum;. In contrast, attention to the mental health needs of young children has been limited, and the prevalence of mental health concerns in young children is likely comparable to school-age children (Vasileva et al., 2021). Intervention at this stage may be especially effective regarding health outcomes and cost (Oppenheim & Bartlett, 2022). On the other end of the spectrum, mental health and substance use disorder issues first appear or increase in severity and complexity for many individuals during young adulthood, and early intervention at this stage may reduce the current and lifetime burden of illness (Markoulakis et al., 2023).

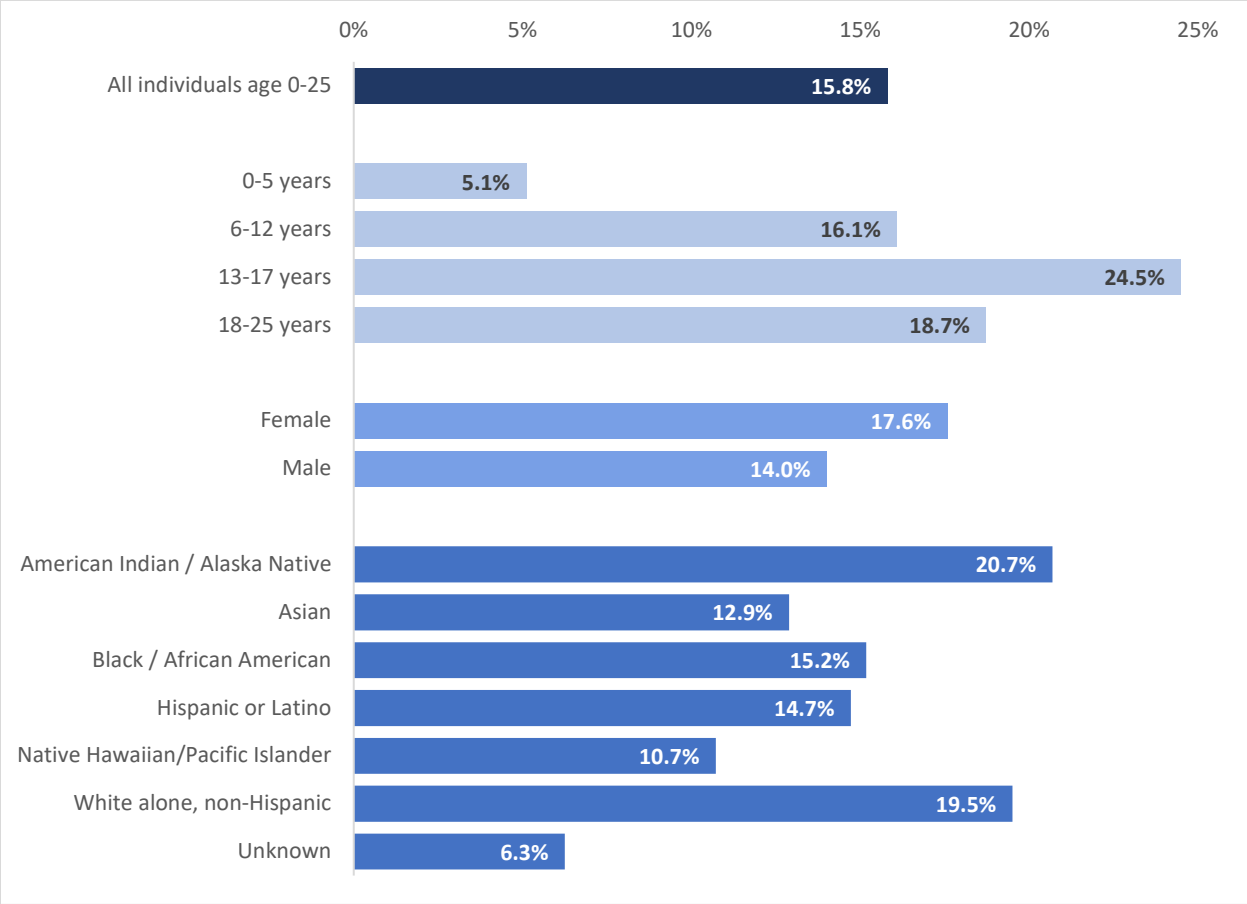
Washington is not exempt from this crisis of child and youth mental health; on March 26, 2021, Governor Jay Inslee issued an emergency proclamation regarding the Child and Youth Mental Health Crisis in Washington state, and in 2023, Mental Health America ranked Washington 40th in the nation for youth mental health. However, early diagnosis and appropriate services for children and their families can make a difference in the lives of children with mental disorders, especially when those services are family and youth-driven, community-based, and culturally and linguistically appropriate (see the Systems of Care values).

Key results: In 2022, approximately 16% of children, youth, and young adults (0 – 25 years) enrolled in Apple Health received mental health services, and about 1.5% of youth and young adults (13-25 years) received substance use disorder (SUD) services. There were also demographic differences in the percentage of children and youth who received mental health services across age, gender, and racial-ethnic groups.

Mental health services

In 2022, approximately 16% (n=189,220) of all children, youth, and young adults (0-25 years) enrolled in Apple Health received mental health services. A smaller proportion of young children (0-5 years) received mental health services, while a more significant proportion of youth (13-18 years) received services. There was also variation across gender and racial/ethnic groups in the proportion of those who received mental health services (see Figure 1).

Figure 1. Percent of all Apple Health enrolled children, youth, and young adults (0-25 years) who received any mental health treatment services in 2022, by age, gender, and race/ethnicity[2]



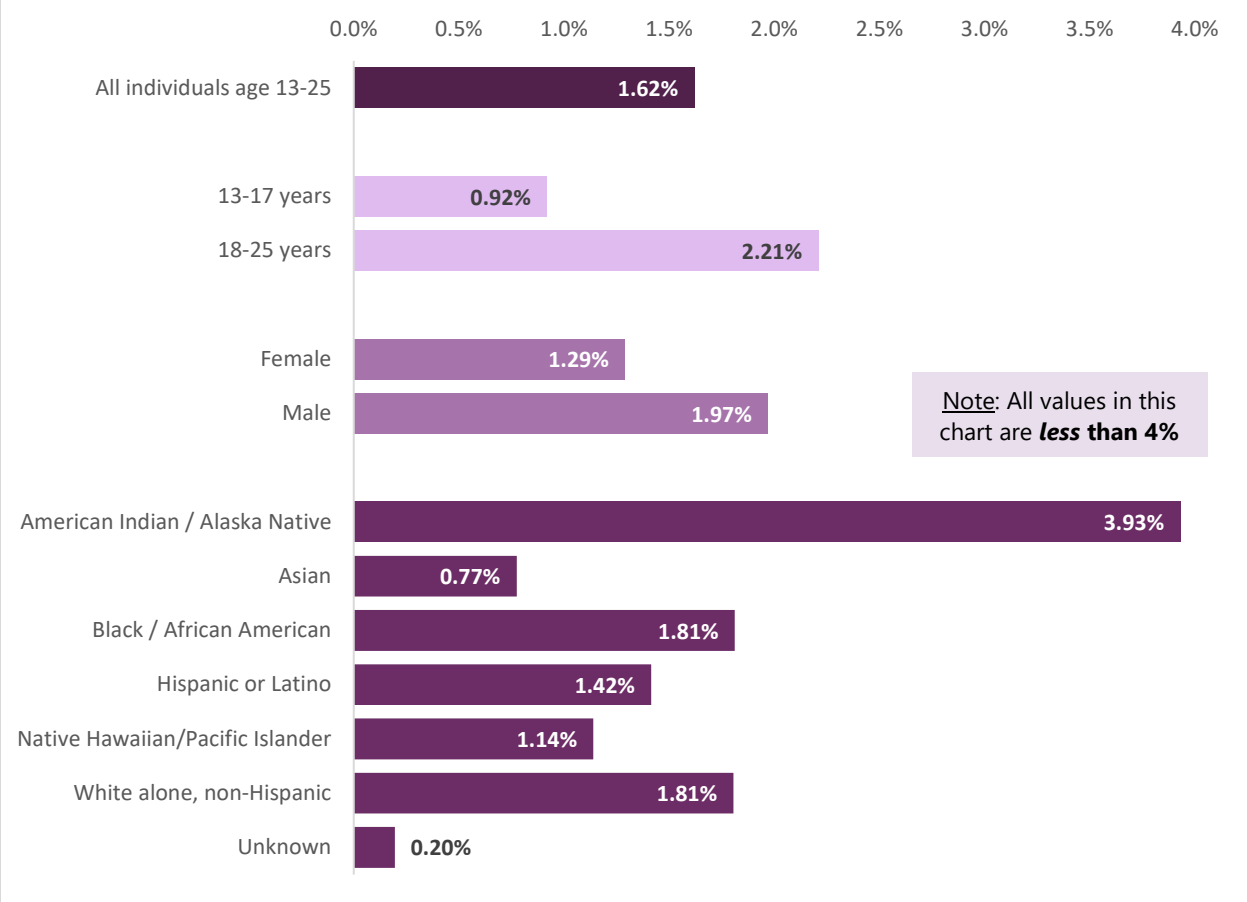
More information: More information about mental health services received by children, youth, and young adults, including complete demographic data and more information about the types of services received (outpatient, crisis, and/or inpatient services), is available in Appendix B: Additional Data Tables.

[2] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Substance use disorder services

In 2022, 1.6% (n= 8,778) of all youth and young adults (13-25 years) enrolled in Apple Health received substance use disorder (SUD) services. A higher percentage of young adults (18-25 years) received SUD services than youth (13-17 years), and a higher percentage of male youth and young adults received services than female youth and young adults. There was also variation in receipt of SUD services across racial-ethnic groups, with a more significant percentage of American Indian/Alaska Native youth and young adults receiving SUD treatment services than any other racial/ethnic group (see Figure 2).

Figure 2. Percent of all Apple Health enrolled youth and young adults (13-25 years) who received any substance use disorder treatment services in 2022, by age, gender, and race/ethnicity [3]



More information: More information about SUD services received by youth and young adults, including complete demographic data and more information about the types of services received (outpatient, crisis, and/or inpatient services), is available in Appendix B: Additional Data Tables.

[3] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Section 2. Unmet need for behavioral health care for children, youth, and young adults

Background: Nationally, about half of all children do not receive needed mental health services (Whitney & Peterson, 2019). While data on substance use disorder treatment for youth is more limited, a recent study suggests that 82% to 91% of youth do not receive needed SUD treatment (Clemens-Cope et al., 2021), and Youth & young adult SUD treatment listening sessions[4] held during the summer of 2023 with community members and system partners in Washington state found that access to care for youth SUD treatment in Washington state is extremely limited. In addition, children and youth of color are more likely to have unmet mental health needs (Casseus, 2023). The unmet needs can also be pronounced at the 'ends' of the developmental spectrum: young children (0-5 years) and young adults (18-25) are more likely to have unmet mental health needs than older children, youth, and older adults. (Ghandour et al., 2020; SAMHSA, 2021).

In the absence of a robust community behavioral health system, the emergency department (ED) can become the de facto provider of behavioral health services, particularly for those in crisis. Nationally, the number of mental health-related ED visits for children and youth is on the rise (Bommersbach et al., 2023), and emergency departments around Washington have reported record-high numbers of pediatric patients presenting in a mental health crisis (see Seattle Children's Hospital 2022 Community Health Assessment). When youth do present in the ER for behavioral health concerns, timely follow-up care is critical to ensuring their health and safety; attendance at a follow-up mental health appointment within one week of discharge is associated with half the risk for suicide (Fontanella et al., 2020). However, national data suggests that about 45% of children and youth do not receive follow-up care within one week (see Medicaid's State Health System Performance dashboard), and follow-up rates may be even lower for youth with substance-use disorders (Huginin et al., 2022).

Key results: Approximately a third of all children, youth, and young adults (0-25 years) with an identified mental health need did not receive any mental health services, with young children (0-5 years) and young adults (18-25 years) less likely to receive needed services; there were similar rates for follow-up care after a mental health-related ED visit. In addition, the majority of youth and young adults (13-25 years) with identified SUD treatment needs did not receive any SUD services, even after a SUD-related emergency department visit.

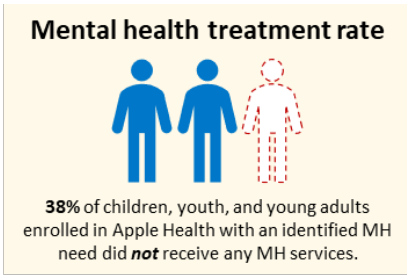
Understanding this data: This report defines identified needs through health record information[5]. Many children, youth, and young adults may need care that a health care provider has not documented. In addition, while this data highlights the percentage of those who received no services, even those who received services may *not* have received the appropriate intensity or quality of services.

[4] More information about the Youth & young adult SUD treatment Listening Sessions is included in the Efforts to Improve Access to Behavioral Health Care section of the report.

[5] Specifically, the information in this report comes from 'claims data.' Claims data is a type of health care data that is created when providers and/or insurance companies submit information about services they have provided, in order to receive or substantiate payment. Claims data usually includes information about the service provided, as well as the health issue being addressed, in addition to other demographic data about the client and provider.

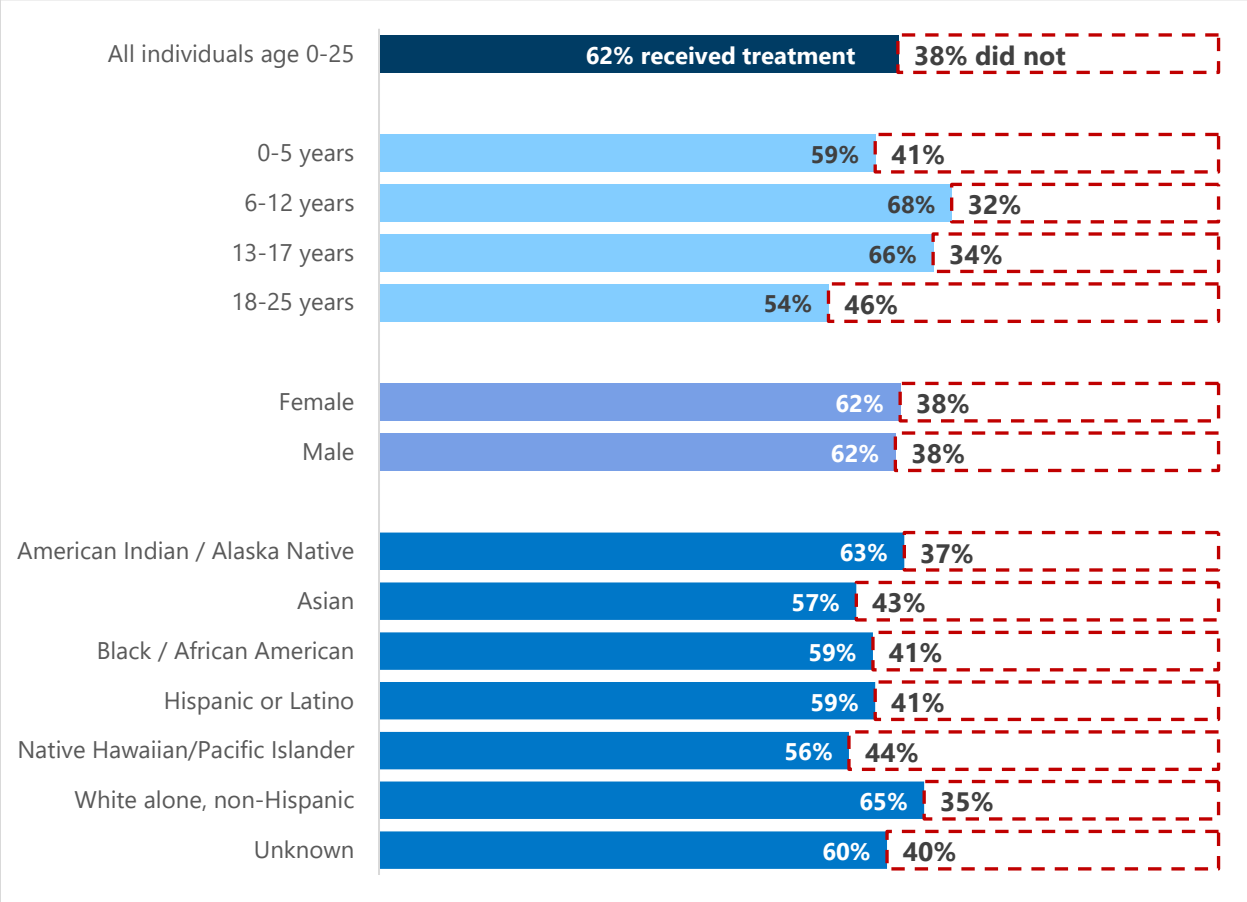
Unmet need for mental health care

During calendar years 2021 and 2022, 246,734 children, youth, and young adults (0-25 years) enrolled in Apple Health were identified as having a mental health treatment need, but 38% (n= 94,224) did not receive any mental health services in 2022. In other words, approximately 1 in 3 children, youth, and young adults with an identified mental health need did not receive needed care.



A smaller percentage of young children (0-5 years) and young adults (18-25 years) received needed mental health care than older children and youth (6-17 years). There was also some variation across racial/ethnic groups in the percentage of children, youth, and young adults who did not receive needed mental health care: non-Hispanic white and American Indian/Alaska Native children, youth, and young adults had the highest rates of receiving needed mental health care, while Native Hawaiian/Pacific Island and Asian children, youth, and young adults had the lowest rates (see Figure 3).

Figure 3. Mental health treatment rate in 2022 for children, youth, and young adults (0-25) enrolled in Apple Health, by age, gender, and race/ethnicity[6]

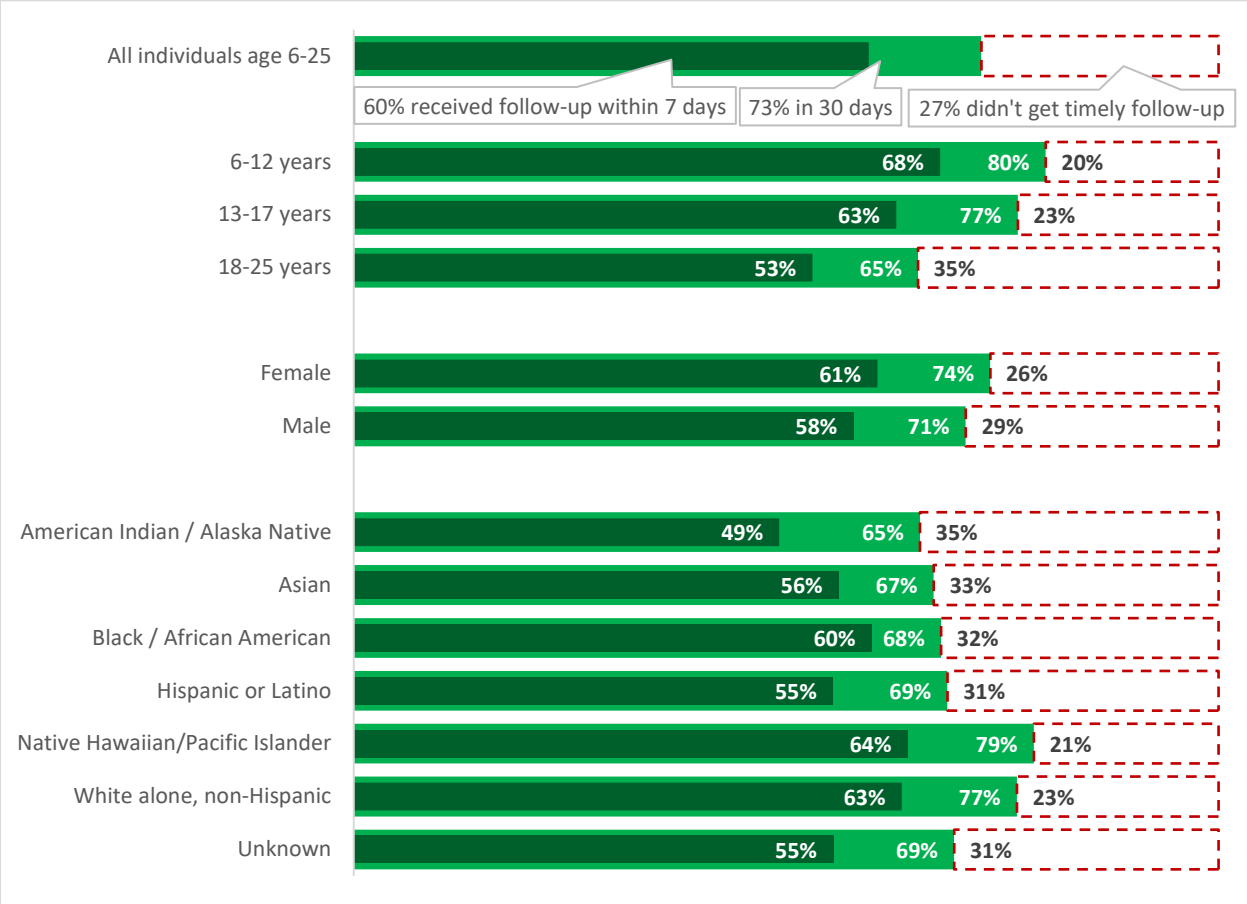


[6] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Unmet need for timely mental health care after an emergency department visit

As noted above, ensuring that children, youth, and young adults have access to needed mental health care after an emergency department (ED) visit is critical to their health and safety. In 2022, 3,407 children, youth, and young adults (6-25 years) enrolled in Apple Health were seen within an emergency department setting for mental health disorder symptoms. **40%** of these children, youth, and young adults did not receive follow-up care within one week, and **27%** did not receive care within 30 days. Similar to rates of unmet need for any mental health care, young adults (18-25 years) were less likely to receive follow-up care than older children and youth, and there was some variation across racial/ethnic groups (see Figure 4).

Figure 4. Mental Health ED follow-up in CY 2022 for Apple Health enrolled children, youth, and young adults by age, gender, and race/ethnicity[7]



More information: More information about the unmet need for mental health care among children, youth, and young adults, including complete demographic data, is available in Appendix B: Additional Data Tables.

[7] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Unmet need for substance use disorder (SUD) care

During 2021 and 2022, 26,466 youth and young adults (13-25 years) enrolled in Apple Health (Medicaid) were identified as having a substance use disorder (SUD) health treatment need, but 75% (n= 19,891) did not receive any SUD services. In other words, approximately 3 in 4 youth and young adults who were identified as having a SUD care need did not receive care. There was some variation across age, gender, and racial/ethnic groups in the percentage of youth and young adults who did not receive needed SUD care (see Figure 5), but for all groups, the majority did not receive needed care.

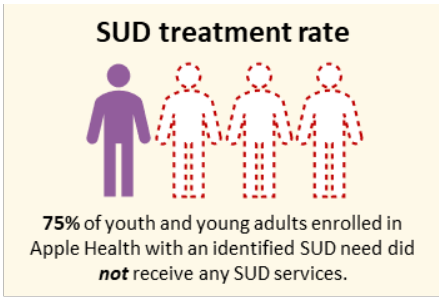
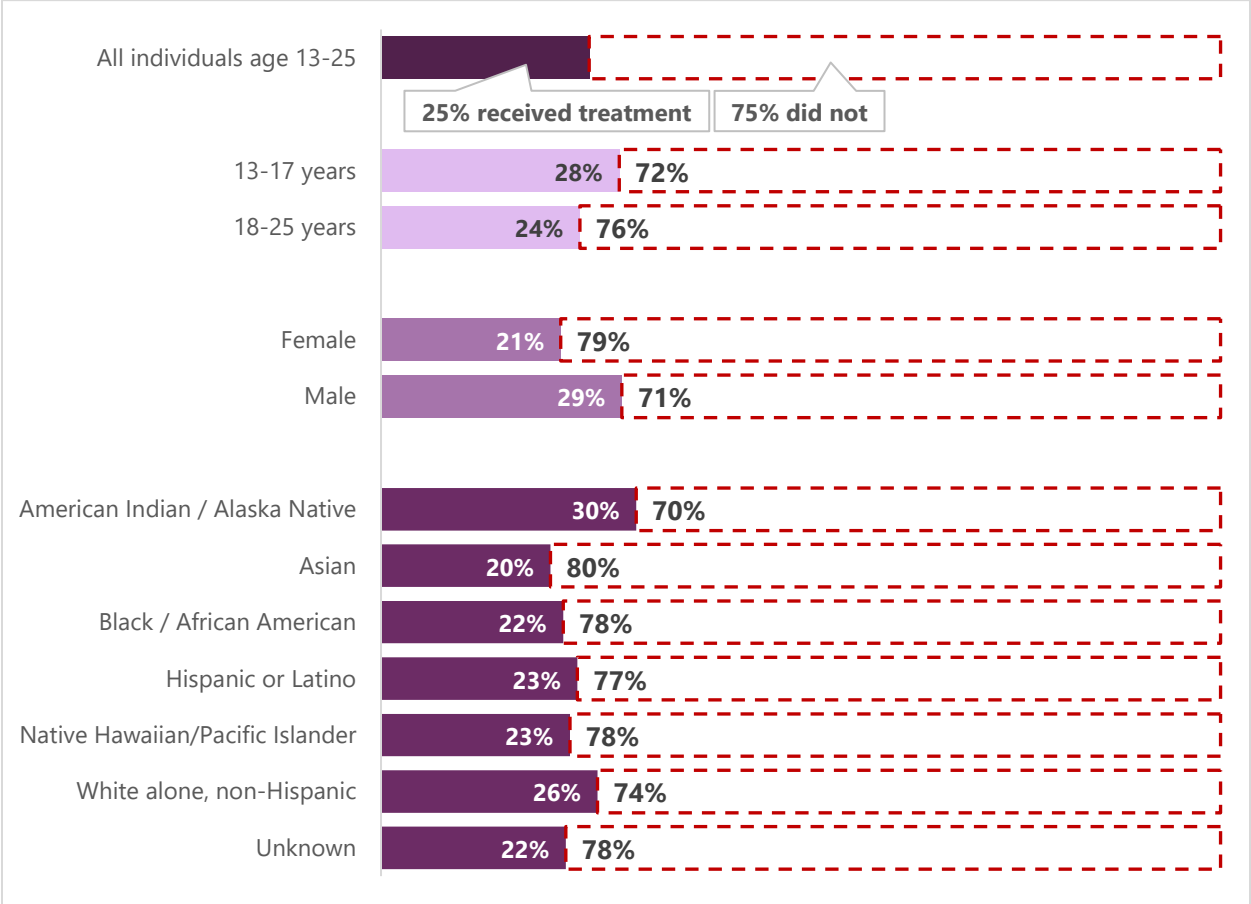


Figure 5. SUD treatment rates in CY 2022 for Apple Health enrolled youth and young adults by age, gender, and race/ethnicity[8]

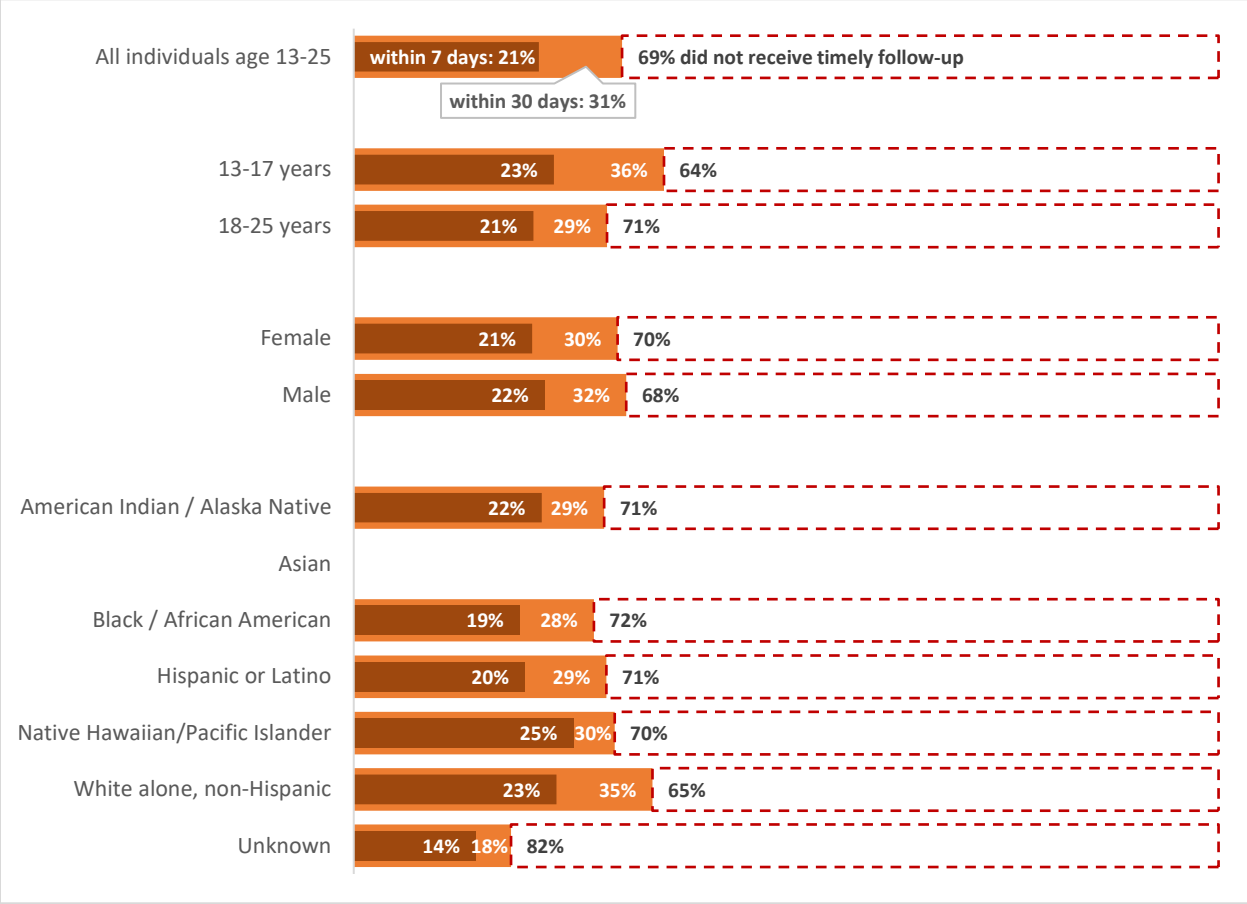


[8] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Unmet need for timely SUD care after an emergency department visit

In 2022, 2,481 youth and young adults (13-25 years) enrolled in Apple Health were seen within an emergency department setting due to SUD symptoms. **79%** of these youth and young adults did not receive follow-up services within one week of their ED visit, and **69%** did not receive care within 30 days. There was some variation across age, gender, and racial/ethnic groups in the percentage of youth and young adults who did not receive needed SUD care (see Figure 6), but similarly to the overall SUD treatment rate, the majority of the youth and young adults in all groups did not receive needed care.

Figure 6. Substance use disorder ED follow-up in CY 2022 for Apple Health enrolled youth and young adults by age, gender, and race/ethnicity[9]



*Data for Asian youth and young adults are not available for this metric due to suppression requirements for small numbers.

More information: More information about the unmet need for SUD care among youth and young adults, including complete demographic data, is available in Appendix B: Additional Data Tables.

[9] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Section 3. Behavioral health provider workforce serving children, youth, and young adults

Background: As noted previously, there are considerable gaps in access to care for children, youth, and young adult behavioral health, and the availability of the behavioral health workforce in Washington is one of the critical factors in this challenge. Data from the Health Resources and Services Administration (HRSA) shows that over a third of Washingtonians live in areas with a shortage of mental health providers. A survey by the Washington Council for Behavioral Health of licensed behavioral health agencies found that, in 2021, over half of all agencies had to close or limit outpatient services due to workforce shortages.

Finding providers who can serve children, youth, and young adults may be especially challenging: Washington state is categorized as facing a "severe shortage" of child and adolescent psychiatrists, and less than 1% of children in Washington attend school districts that meet the recommended ratio of students to school psychologists and counselors (see the National Center for Educational Statistics). A report from the Joint Legislative Audit and Review Committee (JLARC) found that the Mental Health Referral Service Line, a phone line staffed by Seattle Children's Hospital with a database of over 4,000 child- and youth- serving behavioral health providers, needed over three weeks on average to find an available provider for a family. Anecdotal reports from youth mental health providers in Washington indicate that providers are closing, not accepting new clients, or running with months-long waitlists (see Seattle Children's Hospital 2022 Community Health Assessment).

Shortages of providers with expertise in developmentally appropriate services exacerbate already existing inequities in accessing care. Recent reports[10] have found that the infant-early childhood mental health workforce is limited, which may contribute to the disparity in access to needed mental health services for young children, as noted earlier in this report. Listening sessions[11] held during the summer of 2023 with community members and system partners found that workforce challenges are a significant driver of limited SUD care, with low pay, lack of support and learning opportunities in early career pathways, and the licensing and credentialing process noted as barriers to a robust workforce.

Key results: Data regarding the availability of behavioral health providers who serve children, youth, and young adults was limited. The data about the languages spoken by behavioral health providers serving children and youth suggests that, in some settings, approximately 17% of providers talk about a language other than English, with Spanish being the most commonly spoken language. HCA continues to work with managed care organizations (MCOs) to monitor and understand what data they collect from behavioral health providers. This information may be used to update future network adequacy reporting standards and result in more complete data in the coming years.

[10] Cite reports

[11] More information about these Listening Sessions is available here.

Availability of behavioral health providers serving children & youth

Understanding this data: Federal law (42 CFR § 438) requires state Medicaid programs to monitor managed care plans' provider directories and network adequacy standards. Apple Health managed care organizations (MCOs) are contractually required to provide a *Network Provider Submission* to HCA each quarter; this submission includes information regarding the number of and availability of child- and youth-serving (under age 18) individual mental health providers and substance use disorder (SUD) facilities in their networks.

However, the variation in the number and availability of providers reported through these submissions by the different MCOs and in other quarters suggests inconsistencies in data collection, validation, and reporting. Provider network data quality is a challenge nationally; a recent study using Medicaid-managed care data from four states found that a small number of providers delivered most of the care to Medicaid members, and behavioral health providers had the highest percentage of 'ghost providers,' providers who saw no Medicaid members (Ludomirsky et al., 2022). In addition, provider availability can be a challenging concept to measure in real-time; provider availability can change from day to day, so even when required quarterly, reported data may not align with actual availability.

HCA does not currently collect the same type of information from providers who are contracted to provide services to children and youth enrolled in Apple Health without a managed care plan, also known as fee-for-service[12]. Federal law (42 CFR § 447) states that state Medicaid programs must monitor fee-for-service (FFS) access. However, FFS networks are not subject to the same federal network adequacy standards as managed care programs. **The information provided below only includes mental health and substance use disorder providers contracted through managed care**.

Mental health providers

In 2022, data from managed care organizations (MCOs) regarding the number and availability of contracted individual child- and youth-serving (under age 18) mental health providers demonstrated substantial variability, which suggests inaccuracies and/or inconsistencies in how this data was collected and validated. Due to these concerns, HCA is not including this data in this report. HCA is actively engaged in efforts regarding data quality improvement for this metric, including through a Process Improvement Workgroup that began in the summer of 2023.

The workgroup meets regularly to identify and work to address areas for improvement. While the workgroup had not implemented any significant changes at the time of this report, workgroup members mapped out areas for internal process improvement and collected detailed responses from each MCO about their processes to collect, validate, and report youth mental health provider network data; MCO responses revealed differences in their approaches, which aligns with the fact that inconsistencies continue

[12] While 95% of all children and youth enrolled in Apple Health are enrolled in managed care, almost half of all children enrolled in Apple Health without managed care are American Indian/Alaska Native and over a third are Latine/Hispanic (see the Apple Health Client Eligibility Dashboard); understanding access to care for the fee-for-service population is a critical component of HCA's commitment to health equity.

to be seen in the reported data. Future work will involve continued conversations with MCOs to clarify reporting requirements and strategies to align processes across MCOs. The workgroup will also explore possibilities for collecting similar data regarding the behavioral health fee-for-service provider network. Lastly, in May 2023, the Centers for Medicaid and Medicare Services (CMS) published proposed rules that would revise Medicaid network adequacy standards, which, if enacted, may result in additional changes to Apple Health provider network data.

Substance use disorder (SUD) providers

In 2022, managed care organizations (MCOs) reported that they contracted with varying numbers of youth-serving substance use disorder (SUD) agencies/facilities across quarters (see Table 1). Most MCOs reported contracting with around 120-200 different youth-serving SUD agencies/facilities each quarter, with some variation across MCOs and quarters.

Table 1. Range of number of contracted youth- serving SUD agencies/facilities across quarters by Managed Care Plan (MCO), in 2022

Managed Care Organization	Number of agencies/facilities
Amerigroup Washington	126 - 136
Coordinated Care of Washington	199 - 205
Coordinated Care of Washington – Integrated Foster Care	199 - 205
Community Health Plan of Washington	194 - 196
Molina Healthcare of Washington	120 - 161
UnitedHealthcare Community Plan	173 - 191

MCOs reported extremely high rates of new client acceptance for these facilities, with almost all MCOs reporting that 100% of youth-serving facilities were accepting new clients every quarter (see Table 2). As noted in the previous section, given the many sources reporting difficulty in finding youth-serving SUD providers, the accuracy of this data is unclear.

Table 2. Range of percentage of contracted youth- serving SUD agencies/facilities who were accepting new clients across quarters by Managed Care Plan (MCO), in 2022[13]

Managed Care Organization	Percentage of agencies/facilities
Amerigroup Washington	100%
Coordinated Care of Washington	100%
Coordinated Care of Washington – Integrated Foster Care	100%
Community Health Plan of Washington	100%
Molina Healthcare of Washington	99 - 100%
UnitedHealthcare Community Plan	100%

More information: More details about the availability of SUD facilities serving youth are available in Appendix B: Additional Data Tables.

[13] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

Language(s) spoken by behavioral health providers serving children and youth

Background: A shortage of providers who can deliver culturally and linguistically appropriate services is a concern to improving access to care, especially given the rising percentage of Washingtonians who speak a language other than English; the most recent census data shows that approximately 20% of children in Washington speak a language other than English (not necessarily to the exclusion of English), with about 10% speaking Spanish. Individuals who speak English less than very well are more likely to experience delays in treatment, inadequate care, and misdiagnosis (Ohtani et al., 2015). While recent data suggests that most mental health facilities provide services in languages other than English, about half of those facilities use interpreters rather than bi- or multi-lingual clinical staff (Loho & Rosenheck, 2021). Although interpretation services can support families in accessing care[14], the linguistic match between providers and clients further improves access to and also increases the effectiveness of behavioral health services (Marquine & Jimenez, 2021; Griner & Smith, 2006).

Understanding this data: Historically, some information about the languages spoken by behavioral health providers has been collected through the Behavioral Health Provider Survey (BHPS), sent to all behavioral health agencies licensed through Washington's Department of Health. The 2022 survey had a response rate of only 35%, which means that most behavioral health agencies are ***not*** represented in the data below. Behavioral health agencies reported on the languages spoken by all staff. So, while the results provided below are specific to agencies serving children and youth, they are not necessarily representative of the individual providers serving them. In addition, because this survey is only sent to behavioral health agencies, this section does not include information about the languages spoken by behavioral health providers outside of licensed behavioral health agencies (i.e., in private practice, primary care settings, etc.).[15]

Beginning in January 2023, managed care organizations (MCOs) must report on the languages behavioral health providers speak as part of their Network Provider Submission[16]. While this data had not reached maturity by the time of this report, it may be included in future years.

In 2022, behavioral health agencies serving children and youth (under age 18) reported that approximately 17% of their clinical staff were bilingual or multi-lingual and could provide services in a non-English language.

17% of providers were reported to be bi- or multi-lingual.

[14] Per 42 C.F.R. § 438.10(c)(4)), Apple Health (Medicaid) providers are required to make available interpreter services and translated written materials for clients with a primary language other than English. Learn more on HCA's Interpreter Services webpage.

[15] An HCA analysis found that, in 2019, almost twice as many children received behavioral health services within primary care settings (7%) than in behavioral health agency settings (4%), with some variation across regions, age, and racial/ethnic groups. Understanding culturally and linguistically appropriate mental health services in all service settings is a critical component of HCA's commitment to integrated care and equity.

[16] Per managed care contracts, on a quarterly basis, managed care organizations must provide documentation of their provider network, including critical provider types, all contracted specialty providers, and additional information, as required by the Combined Provider Submission report template (see Section 6.1.2).

Spanish was the most common second language spoken by clinical staff at these agencies, representing 10% of staff. Other commonly spoken languages among staff were Chinese (1.4%), Korean (0.6%), Vietnamese (0.6%), American Sign Language (0.4%), and Tagalog (0.4%).

More information: Additional information about the number and percent of staff who spoke languages other than English is available in the full report: Languages spoken at behavioral health agencies serving children and youth in Washington state (2021/2022).

Section 4. Eating disorder diagnosis, treatment, and providers

Background: With a mortality rate higher than any mental illness other than substance use disorders, eating disorders are a significant public health problem (Derenne & Lock, 2016), and the average age of onset for eating disorders is 12- to 13-years-old, with eating disorder specialists reporting an increase in the diagnosis of children, some as young as five or six (Mental Health America). Adolescence and young adulthood are critical periods for the initial development of eating disorders since the majority of eating disorder cases occur by age 25 years. While information on the prevalence of eating disorders is limited, data from the National Comorbidity Survey Adolescent Supplement (NCS-A) suggests that the prevalence among U.S. adolescents aged 13 to 18 years is roughly 3% (Merikangas et al., 2010). Although previously mischaracterized as diseases of non-Hispanic white, affluent adolescent girls, eating disorder behaviors are increasingly recognized across all racial and ethnic groups, in lower socioeconomic classes, preadolescent children, males, and LGBTQIA+ youth. However, diagnosis and care may be delayed for certain groups due to the misperceptions still held by some health care providers (Hornberger et al., 2021).

The treatment of eating disorders is multidisciplinary, often long-term, and may require expensive, high-level care, such as inpatient stabilization or partial hospitalization programs. In addition, many outpatient providers may not have the expertise to provide quality treatment (Hornberger et al., 2021). However, there is strong evidence to suggest the efficacy of a family-focused, developmentally appropriate, and multidisciplinary approach to care for children and youth with eating disorders (Mairs & Nichols, 2016). When treatment is provided, youth have greater success in recovery from eating disorders than their adult counterparts, with overall recovery rates of approximately 70% (Hornberger et al., 2021).

Key results: During 2022, 9,296 children, youth, and young adults (0-25 years) enrolled in Apple Health (Medicaid) were diagnosed with an eating disorder. A higher proportion of female children, youth, and young adults than males had an eating disorder diagnosis, and a more significant percentage of youth (13-17 years) had eating disorder diagnoses than other age groups.

Other information about eating disorder treatment settings and specialized providers was limited. However, HCA is currently partnering with the Research and Data Analysis (RDA) team at the Department of Social and Health Services (DSHS) to conduct a descriptive study of youth enrolled in Apple Health with eating disorders, which may provide additional information on this topic in future years.

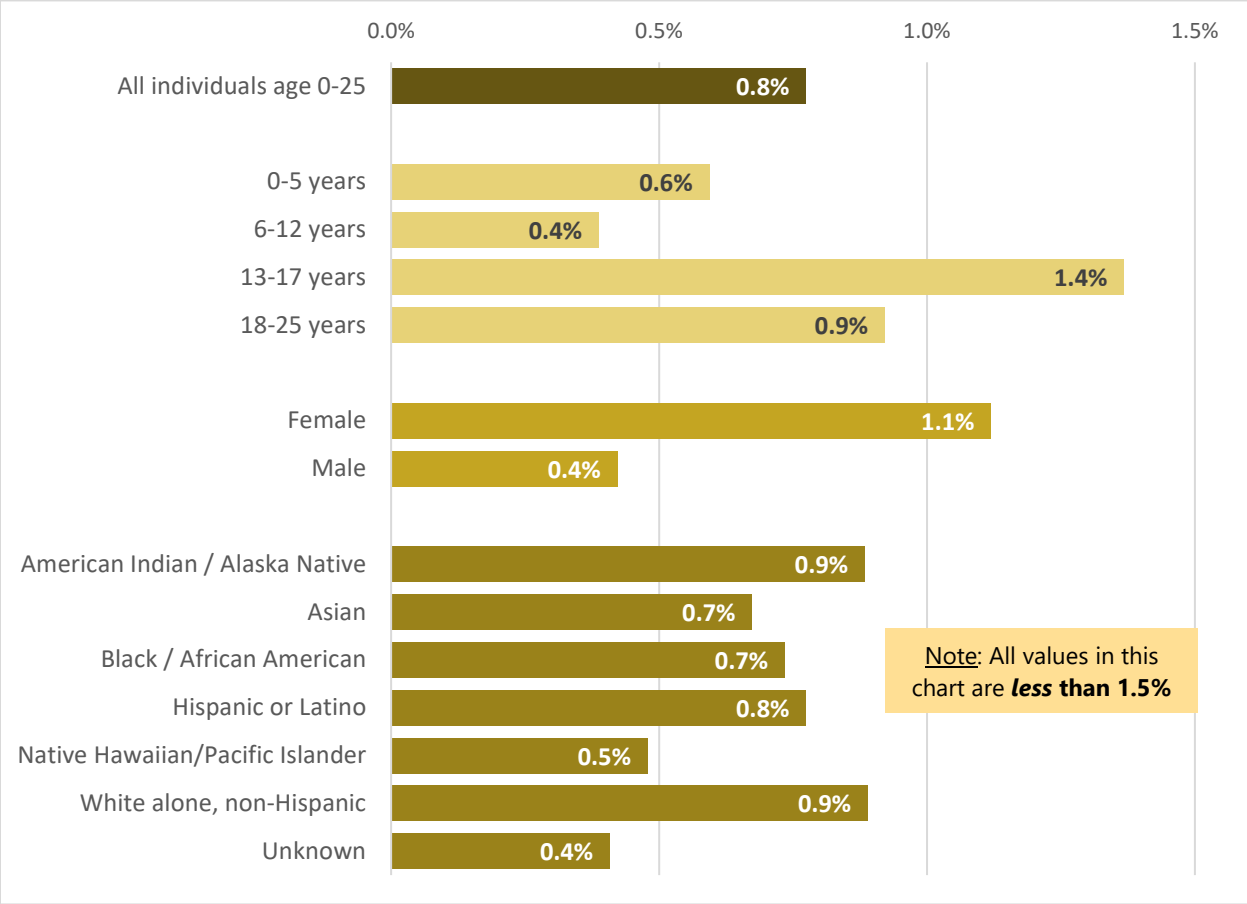
Eating disorder diagnoses

During 2022, 9,296 children, youth, and young adults (0-25 years) enrolled in Apple Health were diagnosed with an eating disorder[17], representing less than 1% of all Apple Health children, youth, and young adults.

[17] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

A higher proportion of female children, youth, and young adults than male children, youth, and young adults had an eating disorder diagnosis, and a more significant percentage of youth (13-17 years) had eating disorder diagnoses than other age groups. Even though the percentage of youth (13-17 years) with an eating disorder was higher than other age groups at 1.5%, it was still lower than the estimated national prevalence cited above (3%). In addition, there was some variation across racial/ethnic groups in the percentage of children, youth, and young adults who were diagnosed with an eating disorder (see Figure 7).

Figure 7. Eating disorder diagnoses in CY 2022 for Apple Health enrolled children, youth, and young adults by age, gender, and race/ethnicity[18]



Further information regarding eating disorder diagnoses by age, gender, and race is available in Appendix B: Additional Data Tables.

Eating disorder treatment services

Children, youth, and young adults with eating disorder diagnoses may receive a mixture of emergency, inpatient, and outpatient services and may receive these services in both behavioral health and physical health settings; the complexity of the mixture of care makes analysis of this data challenging. At this time, HCA cannot report on the number of Apple Health children, youth, and young adults who receive eating

[18] For more information about how this data is collected and defined, see Appendix A: Data Sources & Definitions.

disorder treatment by care setting. However, HCA is currently partnering with the Research and Data Analysis (RDA) team at the Department of Social and Health Services (DSHS) to conduct a descriptive research study regarding Apple Health (Medicaid) youth with eating disorders. The study will include an overview of the demographic characteristics of these youth, as well as their utilization of different services, and it is planned to be published by early December 2023.

Providers specializing in eating disorder treatment

Various behavioral and physical health care provider types, including behavioral health specialists, inpatient hospitals, and primary care providers, provide eating disorder treatment. Nationally, no specific taxonomy or provider type captures a specialty in eating disorder treatment. Until recently, HCA did not collect additional systemic data across all provider types to capture this. However, beginning in April 2023, managed care organizations (MCOs) must report in their Network Provider Submission[19] whether licensed behavioral health agencies within their networks specialize in treating eating disorders. While this data had not reached maturity by the time of this report, its inclusion in future years may help this report meet its legislative requirements.

[19] Per managed care contracts, on a quarterly basis, managed care organizations must provide documentation of their provider network, including critical provider types, all contracted specialty providers, and additional information, as required by the Combined Provider Submission report template (see Section 6.1.2).

Efforts to Improve Access to Behavioral Health Care

As noted throughout the report, there are striking gaps in access to behavioral health care for children, youth, and young adults enrolled in Apple Health, with disparities, particularly around substance use disorder (SUD), care for youth and young adults, and mental health care for young children and young adults; gaps in access remained even following crises when children, youth, and young adults sought care in emergency departments. The Health Care Authority has been involved in several efforts to address these gaps and improve access. Many of these initiatives are guided by involvement and leadership from the community and center on the importance of diversity, equity, and inclusion in their approach and outcomes to address disparities in access.

Behavioral health care for children, youth, and young adults in crisis

As noted in the report, thousands of children and youth enrolled in Apple Health visited the emergency department (ED) for behavioral health needs in 2022. Still, many of those youth did not receive critical follow-up care. Research has shown that youth mobile crisis teams effectively reduce the number of behavioral health-related ED visits among youth (Fendrich et al., 2019).

In 2023, Washington state legislature passed E2SHB 1134, amending E2SHB 1477, which established call center hubs for those calling 988 and formed a Crisis Response Improvement Strategy Committee (CRIS) to assess the current crisis system and make recommendations moving forward. E2SHB 1134 added a lived experience subcommittee seat to the CRIS steering committee and requires HCA to establish endorsement standards for mobile rapid response crisis teams. Crisis teams, including youth crisis teams, can volunteer to become endorsed and, if so, are eligible to get an enhanced case rate. Additionally, if response time requirements in the bill are met, additional performance payments are available.

In 2023, HCA tripled the number of youth teams in the state from 4 to 13, which tripled the county coverage from 5 to 17 counties. HCA is rolling out national best practices in crisis care for youth, called Mobile Response and Stabilization Services (MRSS), which bring the crisis continuum to the family by providing both the crisis intervention phase and the separate but connected in-home stabilization phase, wherever the youth is. By implementing this model, teams can identify youth in need early, divert families from emergency departments and law enforcement, connect families to providers through warm handoffs, and keep kids safe in their homes, schools, and communities.

It is worth noting that MRSS best practices recommend offering in-person support to youth in crisis, including face-to-face risk assessments and safety planning with the family since youth in crisis impacts the caregiver's ability to respond to and de-escalate that crisis. Although the newly established 988 line is currently marketed to youth and families (including through schools and social media), regional crisis lines (RCLs) remain operational. They are the best resource to access MRSS. Until 988 can identify minor callers and their parents/caregivers, calls for MRSS should be made to the regional crisis lines. In addition, since a responsible adult often accompanies youth, MRSS best practice fidelity should be prioritized over the response times requirements outlined in E2SHB 1134, noted above.

For more information about MRSS, watch this recorded presentation.

Substance use disorder services for youth and young adults

As noted in the report, the majority of youth and young adults with an identified SUD need did not receive any services, even after an SUD-related emergency department visit, and listening sessions with the community and stakeholders have affirmed a lack of systematic access to needed care. Several critical efforts are helping to create a more robust support system for these individuals.

Youth & young adult SUD treatment listening sessions

In response to recent youth substance use disorder (SUD) residential closures, three informational listening sessions were held in June, July, and August of 2023 to hear about the impacts of the closures on providers and other related needs. Session participants included behavioral health providers, managed care organizations (MCOs), behavioral health administrative services organizations (BH-ASOs), and other state and system partners. Many system gaps and disparities were brought forth through these sessions, organized by the timeline for addressing them.

Immediate: *needs that should be addressed within 0-3 months*

- Knowledge of services and supports in real-time.
- Statewide and regional access to SUD and mental health co-occurring treatment across the continuum of care.
- Networking opportunities amongst providers.

Intermediate: *needs that should be addressed within 3-24 months*

- Assessing access and referral pathways.
- Identifying barriers in the licensing and credentialing process.
- Continued efforts to build upon the workforce.

Long-term: *needs that should be addressed within two or more years*

- A full continuum of SUD services and supports available across the state.
- Higher reimbursement rates for SUD services.
    - Dedicated efforts to expand the workforce, such as through increased pay for SUD providers and mental health clinicians who address co-occurring mental health and SUD needs.

The findings from these listening sessions align with the results of a 2022 co-design project with youth, young adults (YYA), and community partners to identify barriers and challenges to accessing SUD treatment for young people and their families. All these contributing factors must be components of strategic efforts to expand and strengthen the delivery of healthcare services for young people and families in the state of Washington. More detailed information from each session can be found **here.**

Statewide Washington Collegiate Recovery Support Initiative

Washington State University and HCA have partnered to develop a statewide Washington Collegiate Recovery Support Initiative (SWCRSI). The goal of SWCRSI is to offer the chance for college students in recovery from substance use to experience the opportunities that higher education shows in the college environment. These programs provide support and positive community connections to prevent a return to substance use and support and promote successful academic performance. Grant funding is provided to help institutes of higher education throughout the state of Washington to prepare, implement, and develop self-sustaining collegiate recovery supports and services. Current programs are located at:

- Green River College
- Gonzaga University
- Washington State University
- Skagit Valley College
- Renton Technical College
- Eastern Washington University
- Central Washington University

For more information, please visit the Collegiate Recovery webpage.

Medication for Opiate Use Disorder (MOUD) for youth

Medication for Opiate Use Disorder (MOUD) services are a critical component of the entire continuum of SUD services for youth and young adults. Still, recent stakeholder engagement efforts have confirmed that similarly to the low rate of access to any needed SUD care for youth, access to MOUD in Washington state is exceptionally low statewide for individuals under 18.

HCA is undertaking several efforts to increase youth access to MOUD services. HCA staff offer technical assistance to providers regarding MOUD treatment for youth and develop educational materials for patients and providers on topics such as the age of consent and FDA labeling of MOUD products for youth. HCA's State Opioid Response (SOR) grant[20] funding also supports the Adolescent MOUD Learning Collaborative, a statewide learning series facilitated by the Alcohol, Drug, and Addiction Institute (ADAI), for providers treating or interested in treating adolescents and young adults with opioid use disorder.

HCA staff are working to establish workgroups with Opioid Treatment Programs, which are the only outpatient treatment settings where individuals can receive all three types of medication for the treatment of an Opioid Use Disorder; the goal of these workgroups is that all Opioid Treatment Programs in Washington state offer MOUD services to youth by the end of calendar year 2024. In addition, HCA has been working with the residential treatment facilities that provide SUD services to youth to ensure they accept youth clients who currently receive or need MOUD services, per state and federal law. Lastly, HCA lifted an age restriction in the most recent iteration of the SOR grant, allowing individuals younger than 18 to qualify as a priority population for MOUD services provided through this grant. For more information, please visit the SOR webpage and the MOUD webpage.

Mental health services for young adults

As noted in the report, young adults (18-25 years) have higher rates of unmet mental health needs than older children and youth (6-17 years). HCA currently has several projects and initiatives to support young adults in getting access to needed mental health care in home and community settings and to provide developmentally appropriate wrap-around supports, such as supported employment, that enhance mental well-being in the transition to adulthood.

[20] Grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Healthy Transitions Project

HCA's Healthy Transitions grant[21] supports behavioral health agencies to develop and enhance their expertise in effective services for older youth and young adults (YYA) ages 16-25 with mental health conditions. This investment created non-stigmatizing, trauma-informed opportunities in the community and developmentally appropriate outreach and engagement activities in the following domains: employment, education, living situation, personal effectiveness, well-being, legal, and community-life functioning. These developmentally focused activities helped connect youth and young adults who might otherwise not have accessed behavioral health services. Through the project,

- 434 transition-age youth have enrolled in behavioral health services.
- 915 transition-age youth were contacted through outreach and engagement activities.
- 123 referrals were made as a result of outreach and engagement activities.

For more information, please review the Healthy Transitions Project fact sheet.

New Journeys Coordinated Specialty Care

While the onset of first-episode psychosis typically presents in youth and young adulthood, early intervention with evidence-based treatment decreases the duration of untreated psychosis, improving outcomes over a lifetime, resulting in reduced healthcare costs and improved quality of life for individuals and their families. **New Journeys Coordinated Specialty Care** is a treatment curated to meet the needs of youth and young adults in Washington experiencing a first episode of psychosis, with treatment services of a higher intensity than those offered in regular outpatient settings. New Journeys provides evidence-based health and recovery support interventions for youth and young adults when first diagnosed with psychosis.

New Journeys services are delivered by multi-disciplinary mental health professionals who work as a team and provide treatment, rehabilitation, and support services for individuals to achieve their goals. The service array is provided on an outpatient basis with options for home and community settings based on the individual's needs and what they identify as helping them achieve a more meaningful life. Service components include individual and/or group psychotherapy, supported employment and education, family psychoeducation and support, psychiatry, and peer support. As of September 2023, sixteen New Journey teams across nine regional service areas are active or in development, and more than 600 individuals have been served by New Journeys teams since 2015. For more information, visit the New Journeys webpage.

Mental health services for young children

As noted in the report, young children (0-5 years) have higher rates of unmet mental health needs than older children and youth (6-17 years). Following legislation passed in 2021 [2SHB 1325], HCA has begun implementing policies designed to support developmentally appropriate mental health assessments for these children, as the mental health assessment is a critical step in accessing care. These policies, collectively called Mental Health Assessments for Young Children, included changes to reimbursement that will allow providers to serve infants and young children better and funding for professional development opportunities that will build the workforce's capacity to provide these specialized services. Through the work of the Infant-Early Childhood Mental Health Workforce Collaborative, over 450 mental health

[21] Grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

professionals have received training in the DC:0-5™, a diagnostic system for mental health conditions in children younger than six, with additional trainings ongoing.

A survey of 20 behavioral health providers found moderate uptake of MHAYC policies and that when implemented, MHAYC policies billing for services more accessible, increased provider competence in serving young children, and improved access to developmentally appropriate services. However, it also revealed challenges to implementation. To learn more about these challenges and how to address them, HCA staff conducted focus groups with over 100 behavioral health providers across the state as part of an Infant-Early Childhood Mental Health Statewide Tour. A report on the findings from these focus groups is anticipated for later this year. For more information, please visit the Infant-Early Childhood Mental Health webpage.

Behavioral health systems of care for children, youth, young adults, and families

As noted in the report, there are several areas with notable gaps in access to behavioral care for children, youth, and young adults enrolled in Apple Health across both mental health and substance use disorder (SUD) services, impacting children and youth of all ages, genders, and racial/ethnic identities. HCA and its partners are currently involved in several efforts to create a system of care that can more fully meet the needs of children, youth, young adults, and their families.

Kids Mental Health WA (Regional Behavioral Health Navigators)

The Kids Mental Health WA (also known as Regional Youth Behavioral Health Navigators) is an initiative designed to support each region in the state in:

- Standing up community-wide teams that convene to support the children, youth, and families.
- Building an access portal for individuals concerned about a child or youth to reach out and request support.
- Convening multi-system disciplinary teams, pulling partners from the community-wide team who have potential assets that can support the child and family in accessing what they are seeking, and/or develop a plan of stability. At the same time, the resource options get worked out.

The regional teams prioritize requests for support for young people needing intensive services. Health Care Authority (HCA) is partnering with Behavioral Health Administrative Service Organizations (BH-ASOs), Kid's Mental Health Pierce County, and the Department of Developmental Administration (DDA) to set up three regions per year from SFY2023 - 2025. Technical assistance, collaborative learning spaces, and pathways for real-time input on regional strengths and needs are also provided for teams as they stand up. For more information, please visit the Kids Mental Health Washington webpage.

Center for Parent Excellence (COPE)

The Center of Parent Excellence, or COPE, is operated by A Common Voice and staffed by parent support specialists hired for their lived experience as a parent/caregiver. It is funded through the Mental Health Block Grant and is available to all families in WA state as an insurance blind service. Services offered through COPE include:

- One-on-one support for parents/caregivers accessing and navigating behavioral health services on behalf of their child.
- Support groups are provided twice a month for parents regionally.
- Monthly affinity groups designed for employed family peers employed in Washington State's behavioral health system.
- Assistance to wrap around with intensive services WISe Child and Family Teams.

During the state fiscal year 2023, 137 families received individual support, 268 families attended parent groups, and nine families attended parent consultations provided by COPE. For more information, please visit the COPE webpage.

Family Youth System Partner Round Tables (FYSPRTs)

Family Youth System Partner Round Tables (FYSPRTs) are a platform for families, youth, and system partners to collaborate, listen, and incorporate the community's voice into behavioral health decision-making at the regional and state level. The FYSPRTs are a critical part of the Child, Youth and Family Behavioral Health Governance Structure, which consists of families, youth, and inter-agency members at the community, state, and legislative levels who inform and provide oversight for policy making and program planning for behavioral health services for children, youth, and families. The goal is to ensure family, youth, and system partners' involvement in policy development and decision-making. Washington has one statewide FYSPRT, ten regional FYSPRTs, and multiple local FYSPRTs.

FYSPRTs are essential for addressing regional recurring gaps, barriers, and needs and sharing experiences and knowledge to improve outcomes for youth and families in Washington. For example, in the past few years, the FYSPRTs have presented recurring gaps and needs related to children's behavioral health respite services and non-emergency medical transportation to legislative groups that are part of the Governance Structure to address these needs statewide. For more information about FYSPRTs, please visit HCA's FYSPRT webpage.

School-based Services and Medicaid Opportunities charter workgroup

School Districts (SDs) and Educational Service Districts (ESDs) struggle to ensure their students receive needed health care services to benefit from their education. Due to provider shortages within the community, especially providers offering behavioral health services, many students in crisis are often placed on long wait lists or may never receive the services they need.

Some schools have tried to fill this gap by providing health care services to students within the school setting. Many of these services may be Medicaid reimbursable. Still, schools may not participate in all of HCA's available Medicaid programs due to a lack of awareness, staffing issues, or administrative burdens, such as billing, documentation, and contracting. In response, HCA has developed a cross-divisional chartered workgroup to develop recommendations to improve student access to needed physical and behavioral health care services in the school setting by ensuring compliance with the new CMS guidance and exploring new opportunities to decrease administrative burden while increasing Medicaid reimbursement. Please refer to the Medicaid School-Based Behavioral Health Services and Billing Toolkit for more information.

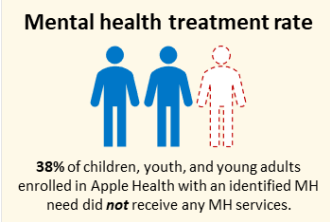
Managed care performance improvement project and performance oversight

The report notes that managed care organizations (MCOs) support children's and youths' access to behavioral health care. HCA has prioritized increasing behavioral health access for children and youth in Washington state and has been working with the (MCOs) through Performance Improvement Projects (PIP) to decrease the care gap, especially for children and youth from Black, Indigenous, and People of Color (BIPOC) communities. The multi-MCO collaborative PIP is partnering with primary care providers to identify BIPOC children and youth who may have unmet needs and coordinate ongoing resources and care. In addition, the MCO collaborative is engaging behavioral health providers in a survey to continue to learn more about care barriers and access issues to formulate future interventions. The results of the PIP will be described in the 2024 Managed Care External Quality Review report.

HCA has also been increasing collaboration with and across MCOs and oversight of MCOs to ensure strong coordination of access to behavioral health services. MCOs actively partner with each other and HCA to support improved cohesiveness across the Apple Health system in messaging and expectations for the provider network to help continuity of care for clients better. HCA requires MCOs to provide information on outreach and engagement activities for care coordination, service initiation, and appointment follow-up through the quarterly Children's Mental Health Report. For more information, please get in touch with the HCA Managed Care Programs mailbox.

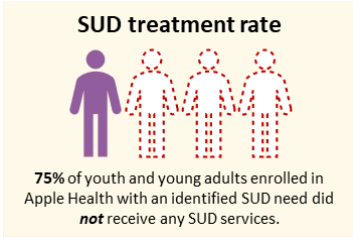
Conclusion

In accordance with RCW 74.09.495, Health Care Authority has reported on several metrics regarding access to behavioral health services for children, youth, and young adults (ages 0-25) enrolled in Apple Health (Medicaid) in 2022.



Mental Health Services: approximately 1 in 3 children, youth, and young adults enrolled in Apple Health who needed mental health services did not receive them, with young children and young adults less likely to receive needed services. Even after a visit to the emergency department for mental health needs, 40% of children, youth, and young adults did not receive follow-up care within seven days and 27% did not receive care within 30 days.

Substance Use Disorder Services: approximately 3 in 4 youth and young adults enrolled in Apple Health who needed substance use disorder services did not receive them. There was variation across age, gender, and racial/ethnic groups, but for all groups, the majority of the youth and young adults did not receive needed care. Even after an SUD-related emergency department visit, 79% of youth did not receive follow-up services within seven days of their visit, and 69% did not receive care within 30 days.



Provider Availability: Data regarding the availability of providers was limited; however, reports from various sources suggest that the availability of providers continues to be a key challenge in access to care. Data about the languages spoken by behavioral health providers serving children and youth was also limited. Still, the available data suggests that, in some settings, approximately 17% of providers speak a language other than English, the most commonly spoken language being Spanish.

Eating Disorders: Data regarding eating disorder diagnoses found that 9,296 children, youth, and young adults (less than 1% of the total population) were diagnosed with an eating disorder. Data regarding eating disorders treatment and eating disorders providers was limited.

Looking forward: The Health Care Authority is currently involved in several efforts to address the barriers to access noted in this report and improve the system of care. While the information included in this report included only a subset of the Washington state population (children, youth, and young adults enrolled in Apple Health), the Children and Youth Behavioral Health Work Group's work to develop a strategic plan requires the collection of data statewide regarding all aspects of the behavioral health system of care, from promotion to prevention, treatment, and recovery, and for all children, youth, young adults, and families. This data will provide a roadmap for developing longer-term, system-wide strategies to ensure access to high-quality, equitable care and support.

Appendix A – Data Collection & Definitions

Appendix A provides information about the data collection and analysis process, including definitions of metrics used in this report.

Section 1: Behavioral health services provided to children and youth

Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all children and youth (0-25 years) enrolled in Apple Health for at least one month during the reporting period (calendar year 2022). See the note on Apple Health eligibility groups at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of mental health services: These include crisis, inpatient, medication management, peer support, family treatment, case management, and psychoeducation.

Definition of SUD Services: SUD services provided to this population include detoxification, residential treatment, case management, medication-assisted treatment, and outpatient treatment.

Section 2: Unmet need for behavioral health care for children and youth

Data source: Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all children and youth (0-25 years) enrolled in Apple Health for at least 11 months during 2022. See the note on Apple Health eligibility groups at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of unmet need for mental health care: This item is tracked using the HEDIS measure SUPPL-MH-B Mental Health treatment penetration, broadly defined. Mental health treatment rate is the number of children and youth who received mental health services in calendar year 2022 out of the number identified as having a mental health need in calendar years 2021-2022. Children and youth identified as having a mental health need had a diagnosis of mental illness, receipt of psychotropic medication, and/or a mental health service in 2021 or 2022. Children and youth who received mental health services during the measurement year received at least one treatment service or were identified as receiving the management of a mental health condition within a primary care setting during 2022.

Definition of unmet need for substance use disorder care: This item is tracked using the RDA-defined measure - SUPPL-SUD: Substance Use Disorder Treatment Rate. Substance use disorder treatment rate is the number of youths who received SUD services out of the number who were identified as having an SUD need. Youth identified as having an SUD need includes youth with at least one substance-related diagnosis, procedure, prescription, treatment, or arrest in CY 2021 or CY 2022. Youths that received SUD service during the measurement year received substance use disorder services, outpatient mental health disorder services, or both in CY 2022. Substance use disorder services include inpatient services, outpatient services, opiate substitution, and case management.

Definition of unmet need for timely follow-up care after an emergency department visit: The definitions for these metrics come from four HEDIS (Healthcare Effectiveness Data and Information Set) measures that track coordination of care after a child or youth is seen in the ED for a SUD or mental health disorder symptom presentation. More information about the definition of these measures is available at the links from the National Committee for Quality Assurance (NCQA) below:

- Follow-up after emergency department visit for alcohol and other drug dependence - within seven days and 30 days of emergency department visit (HEDIS-FUA-7D and HEDIS-FUA-30D).
- Follow up after emergency department visit for mental illness - within seven days and 30 days of emergency department visit (HEDIS-FUM-7D and HEDIS-FUM-30D).

Section 3: Behavioral health provider workforce serving children and youth

Available Providers

Data source: Data was provided by Managed Care Organizations to the HCA on a prospective, quarterly basis. MCOs receive this data from providers. Providing this data is a component of contractually required network adequacy analyses.

Population: Individual mental health providers and substance disorder treatment agencies/facilities contracted with each managed care organization during each quarter were included in this analysis. Providers with the same National Provider Identifier (NPI) were identified as duplicates and were removed. Providers contracted to serve children and youth enrolled in Apple Health without a managed care plan (also known as fee-for-service) are not included in the population for this report.

Definition of mental health provider: mental health providers include individually licensed practitioners of the following types: Physician, Osteopathic Physician, Nurse Practitioner, Social Worker advanced license, Marriage and Family Therapist, Mental Health Counselor, and Psychologist. Agency-affiliated counselors and peers are not considered "mental health providers" for this analysis.

Definition of child- and youth-serving mental health provider: Within the network adequacy data, MCOs report whether each provider/facility serves youth, either Yes or No.

Definition of youth-serving substance use disorder facility: Within the network adequacy data, MCOs report whether each facility provides any of the following services, reporting either Yes or No: Youth Outpatient, Youth Intensive Outpatient, Youth Residential, and Youth Recovery House.

Definition of accepting new clients: Within the network adequacy data, MCOs report whether each provider and facility anticipates accepting new clients in the coming quarter, reporting either Yes or No.

Languages Spoken by Providers

Data source: These data are from the Behavioral Health Provider Survey (BHPS), an online survey conducted from December 2021 through April 2022. The online survey was conducted from December 2021 through April 2022. The target population for the survey consists of Department of Health licensed, community-based mental health (MH) and substance use disorder (SUD) treatment agencies providing publicly funded services in Washington state.

Population: The sample originally included 754 agencies, with each location considered a distinct entity. However, agencies with multiple sites were allowed to consolidate them into one survey. Accounting for survey consolidation and agency closures, the adjusted population size is 662 agencies. Responses were

received from 231 agencies, resulting in a response rate of 34.9%. One hundred twenty-six agencies indicated they provide BH services to children and youth, representing 54.5% of the agencies responding to the survey. These 126 agencies were the population of focus for this report.

Definition of bi- and multi-lingual providers: Respondents were asked, "How many of your behavioral health clinical staff are bilingual or multilingual and can provide BH services in a non-English language?" That question was followed up with, "How many of your behavioral health clinical staff speak a language other than English?" The survey listed 46 different languages plus an 'Other' category.

Section 4: Eating disorder diagnosis, treatment, and providers

Data source: Data source: Data were retrieved from the Department of Social and Health Services (DSHS) Integrated Client Databases (ICDB), which contain administrative data from several state data systems, including the ProviderOne Medicaid data system and the Behavioral Health Data System (BHDS).

Population: all youth (0-25 years) who were enrolled in Apple Health for at least one month during the reporting period (calendar year 2022). See the note on Apple Health eligibility groups at the end of this appendix for more detailed information about how enrollment in Apple Health is defined.

Definition of eating disorder: The following ICD-9 and ICD-10 codes were used to define a diagnosis of an eating disorder.

ICD 9	
Code	**Long Code Description**
307.1	Anorexia nervosa
307.5	Other & Unspecified disorders of eating
307.50	Eating disorder, unspecified
307.51	Bulimia nervosa
307.52	Pica
307.53	Rumination disorder
307.54	Psychogenic vomiting
307.59	Other disorders of eating

ICD 10	
Code	**Long Code Description**
F50.00	Anorexia nervosa, unspecified
F50.01	Anorexia nervosa, restricting type.
F50.02	Anorexia nervosa, binge eating/purging type
F50.2	Bulimia nervosa
F50.8	Other eating disorders
F50.81	Binge eating disorder
F50.82	Avoidant/restrictive food intake disorder
F50.89	Other specified eating disorders
F50.9	Eating disorder, unspecified
F98.21	Rumination disorder of infancy
F98.29	Other feeding disorders of infancy and early childhood
F98.3	Pica of infancy and childhood

Note on Apple Health eligibility groups.

For reports in past years, only children and youth in Apple Health eligibility groups that received full Medicaid (Title XIX), or SCHIP (Title XXI) benefits were included in this population. However, this year's report expanded the population to include additional eligibility groups that receive comparable benefits, such as the state-funded children's health program, which covers undocumented children and youth ineligible for federally funded Medicaid/CHIP benefits. Table 1 below outlines which Apple Health eligibility groups are included in the Apple Health population referenced in this report.

Table 1. Apple Health eligibility groups inclusion

Description	Included
Categorically Needy Blind/Disabled	Yes
Medically Needy Blind/Disabled	Yes
Categorically Needy Aged	Yes
Medically Needy Aged	Yes
Categorically Needy Workers with Disabilities (HWD) (Ticket to Work)	Yes
Categorically Needy Pregnant Women	Yes
Categorically Needy Family Medical	Yes
Affordable Care Act Expansion Adults	Yes
Categorically Needy Children	Yes
CHIP	Yes
Medically Needy - Other Disabled (Family/Pregnancy)	Yes
Alien Emergency Medical (AEM)	No
CHP - State Only < 18	Yes
Medicare Savings Program / QMB Only	No
Take Charge	No
Categorically Needy Breast & Cervical Cancer (BCCT)	Yes
Involuntary Treatment Act	No
Family Planning Services Only; Federally Qualified	No
Detox services	No
Psychiatric Inpatient Indigent Program	No
Categorically Needy Children Other - Foster Care ages 18 < 26	Yes
Pregnant Women; Not Federally Qualified	No
Family Planning Services Only; Not Federally Qualified	No
MCS-A/B/D/ADATSA; Not Federally Qualified	No
Medicare Savings Program / QDWI, QI, SLMB Only	No

Appendix B – Additional Data Tables

View additional detailed data tables.