

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

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Access to Behavioral Health Services For Children

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Executive Summary

Apple Health (Medicaid) plays a critical role for many children with behavioral health needs. In Washington State, Medicaid-eligible children may access behavioral health treatment through fee-for-service (FFS), managed care organizations (MCOs), Fully-Integrated Managed Care (FIMC), or Behavioral Health Organizations (BHOs). With the exception of FIMC, MCOs typically provide behavioral health services to only children with less acute behavioral health needs. Children with higher acuity behavioral health treatment needs are usually referred to the local BHO.

Access barriers to children's behavioral health services have been widely noted and often disproportionately impact certain populations. To assess access barriers, we analyzed performance measures linked to access to care for children (0-17 years old). The information in this report addresses the following measures:

1. Follow-up after emergency department visit for mental illness or alcohol and other drug dependence within 30 days;
2. Children with an identified mental health need who received mental health services during the reporting period;
3. Children served by behavioral health organizations, including the types of services provided;
4. Children's mental health providers available in the previous year;
5. Languages spoken by mental health providers; and
6. Children's mental health providers who were actively accepting new patients.

Only 23.4 percent of Medicaid-covered children received follow-up care within 30 days after emergency department visits for alcohol and other substance use disorders. The 30-day follow-up after an emergency department visits for mental health disorders was considerably higher at 78.1 percent. Some racial/ethnic groups, such as Black and 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.

In 2016, 62.7 percent of Medicaid-covered children with an identified mental health need received mental health services during the reporting period. Some racial/ethnic groups had lower levels of mental health treatment penetration, including Asian/Native Hawaiian or Pacific Islander (54.4 percent) and Hispanic (57 percent) populations.

Strategic, cross-agency efforts may help improve disparities in access. Service modality alternatives, such as tele-health, could improve access to behavioral health services. However, it is critical these policy efforts consider and address the specific needs of rural communities and minority populations as part of the statewide service delivery improvement.



Background

The Revised Code of Washington (RCW) 74.09.495, states:

“To better assure and understand issues related to network adequacy and access to services, the authority and the department shall report to the appropriate committees of the legislature by December 1, 2017, and annually thereafter, on the status of access to behavioral health services for children birth through age seventeen using data collected pursuant to RCW 70.320.050. At a minimum, the report must include the following components broken down by age, gender, and race and ethnicity: (1) The percentage of discharges for patients ages six through seventeen 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 follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within thirty days of discharge; (2) The percentage of health plan members with an identified mental health need who received mental health services during the reporting period; and (3) The percentage of children served by behavioral health organizations, including the types of services provided. The report must also include 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.”

Apple Health (Medicaid) plays a critical role for many children with behavioral health needs. It provides comprehensive coverage for children and makes treatment affordable by limiting or eliminating out-of-pocket costs. According to National Health Interview Survey (NHIS) data, children enrolled in Medicaid or State Children’s Health Insurance Program (CHIP) were more likely to see a mental health professional (14 percent) or doctor (9.4 percent) for an emotional or behavioral problem than their privately insured counterparts (8.3 percent versus 5.1percent, respectively) in 2014.¹

Federal law requires Medicaid and CHIP programs to comply with behavioral health parity requirements to ensure that 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. Despite this, access to behavioral health services often has barriers such as lack of available treatment providers, transportation challenges, and client experience of stigma.

¹ Medicaid Access in Brief: Children’s Use of Behavioral Health Services. June 2016. MACPAC. Advising Congress on Medicaid and CHIP Policy. Issue Brief. Access to Behavioral Health Services for Children December 1, 2017



Certain minority ethnic and racial populations may experience additional obstacles when accessing behavioral health care. Factors such as language barriers, religious/cultural traditions, and distrust of the medical establishment may prevent client access to behavioral health care. Distrust of physicians has been found to be higher among blacks and Hispanics than among whites in the United States for various reasons, from historical adverse treatment to individual experiences within the health care system.² Studies indicate it is difficult to isolate the effect of low English proficiency from cultural values because all of these factors are interconnected.³

Gaps between behavioral health treatment need and service access have been widely discussed nationally. A review of the *National Survey on Drug Use and Health* found certain racial and ethnic populations may be less likely to seek and/or receive treatment for suicidal ideation. In particular, Native Americans were among the populations with lowest treatment utilization, but also among the highest for rates of suicide attempts⁴. There is also a notable lack of racial and cultural diversity among mental health providers, even as demographic trends indicate an increase in both minority populations and their requirements for mental health treatment.⁵

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 Medicaid.⁶

Nationally, children who live in rural locations may have difficulty accessing behavioral health services. Geographic isolation, often combined with increased workforce shortages in rural areas, may create additional challenges for rural children to access behavioral health services.⁷

In Washington State, Medicaid-eligible children may access behavioral health treatment through fee-for-service (FFS), managed care organizations (MCOs), Fully-Integrated Managed Care (FIMC), or Behavioral Health Organizations (BHOs). Behavioral health integration began on April 1, 2016, with the creation of BHOs across the state and FIMC in southwest Washington. As of 2017, BHOs include Great Rivers, Greater Columbia, King County, North Central, North Sound, Optum-Pierce, Salish, Spokane County Regional, and Thurston-Mason.

² Racial/Ethnic Differences in Physician Distrust in the United States. 2007. Armstrong, et al. *Am J Public Health*. 97(7).

³ Cross-cultural barriers to mental health services in the United States. 2011. Leong FTL, Kalibatseva Z. *Cerebrum: Dana Forum Brain Science*.

⁴ Ethnic and racial differences in mental health service utilization for suicidal ideation and behavior in a nationally representative sample of adolescents. 2016. Nestor, B.A., et al. *Journal of Affective Disorders*. 202:197-202.

⁵ Health Disparities & Mental/Behavioral Health Workforce. American Psychological Association, <http://www.apa.org/about/gr/issues/workforce/disparity.aspx>.

⁶ Children's Services in Washington State. 2016. DSHS Research and Data Analysis Division, http://www.governor.wa.gov/sites/default/files/documents/BlueRibbonRDA_2016_0510_FINAL_v2.pdf.

⁷ Access to Mental Health Services for Children in Rural Areas. 2017. Center for Disease Control. Policy Brief. Access to Behavioral Health Services for Children
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FIMC means the state purchases physical and behavioral health services together, instead of purchasing physical health services through Medicaid MCOs and purchasing behavioral health services separately through BHOs. Fully-Integrated Managed Care is currently limited to southwest Washington and may be accessed only in Skamania and Clark counties. The FIMC coordinating organizations include Community Health Plans of Washington, Molina Healthcare, and Beacon Health Options. Beacon Health Options serves as the Behavioral Health Administrative Services Organization (BH-ASO). In 2018, the North Central region (Chelan, Douglas, and Grant counties) will also adopt the FIMC model.

In 2015, Substitute House Bill 1879 required integration of behavioral health services into a single managed care organization for children in foster care by October 2018. Coordinated Care of Washington (CCW) is the sole managed care organization for foster children and it is also one of the managed care organizations providing services in the new, fully-integrated managed care region, North Central. In effect, these foster children will receive both physical health and behavioral health services through Coordinated Care beginning January 2018.

Data Results

The information in this report addresses the following measures⁸:

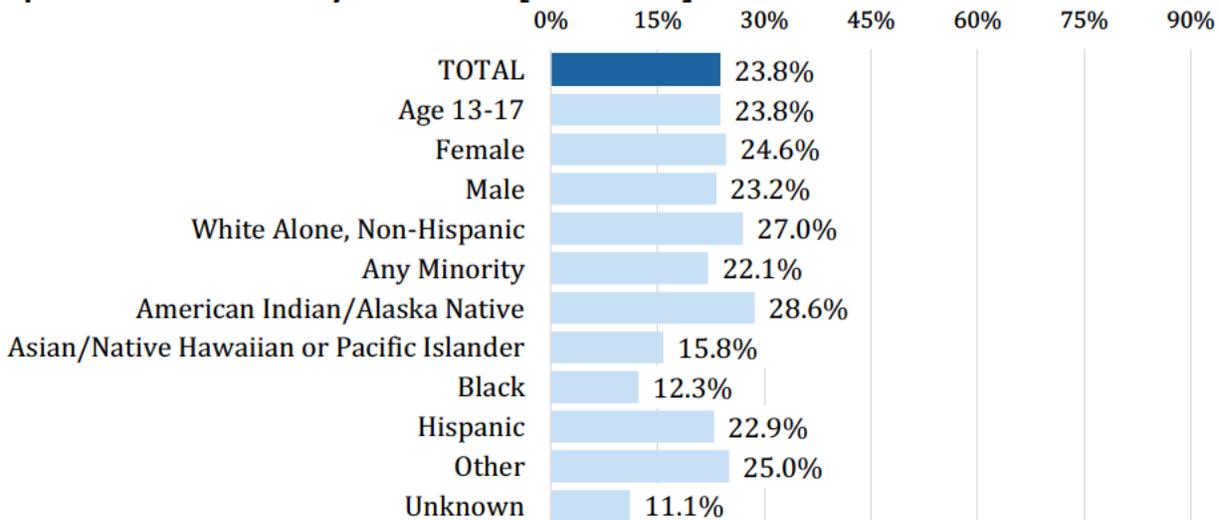
1. Follow-up after emergency department visit for mental illness or alcohol and other drug dependence within 30 days;
2. Children with an identified mental health need who received mental health services during the reporting period;
3. Children served by behavioral health organizations, including the types of services provided;
4. Children's mental health providers available in the previous year;
5. Languages spoken by mental health provider providers; and
6. Children's mental health providers who were actively accepting new patients.

Follow-Up After Emergency Department Visit

As illustrated in Figure 1, 23.8% of Medicaid children received follow-up after emergency department visits for alcohol and other substance use within 30 days. The 30-day follow-up emergency department visit for mental health disorders was considerably higher at 78.1%. Figures 1 and 2 illustrate these data along with demographic profiles, as requested within the legislation.

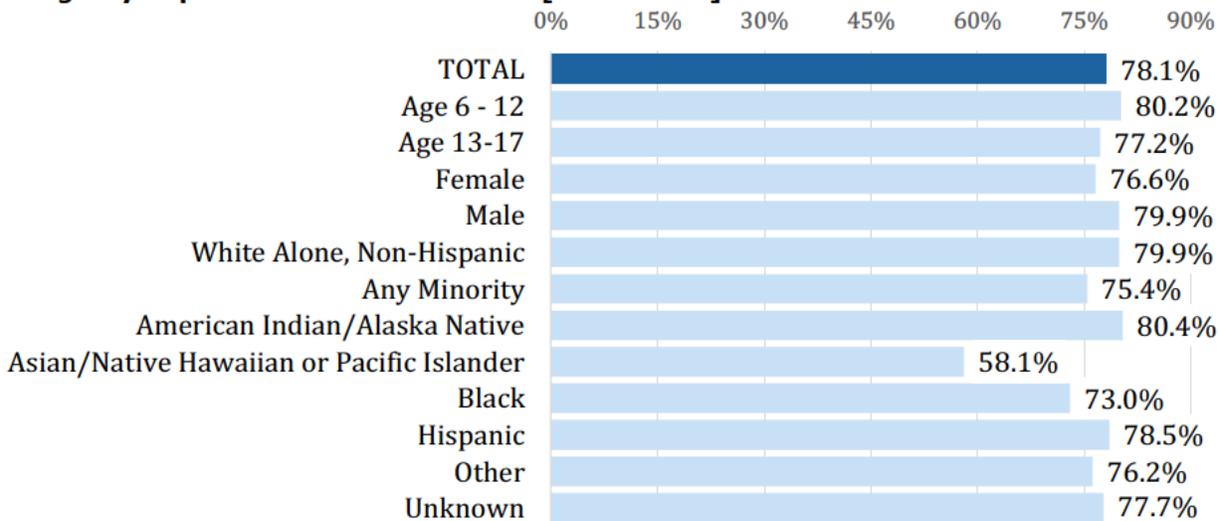
⁸ Please note formal measure name may include obsolete terminology not aligned with current Diagnostic and Statistical Manual of Mental Disorders language.
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FIGURE 1. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days in CY 2016 [HEDIS-FUA]



SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, September 2017.

FIGURE 2. Follow-up after Emergency Department Visit for Mental Illness within 30 Days of Emergency Department Visit in CY 2016⁹ [HEDIS-FUM]



SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, September 2017.

Some racial/ethnic groups, such as Black and 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 follow-up after an emergency department visit.

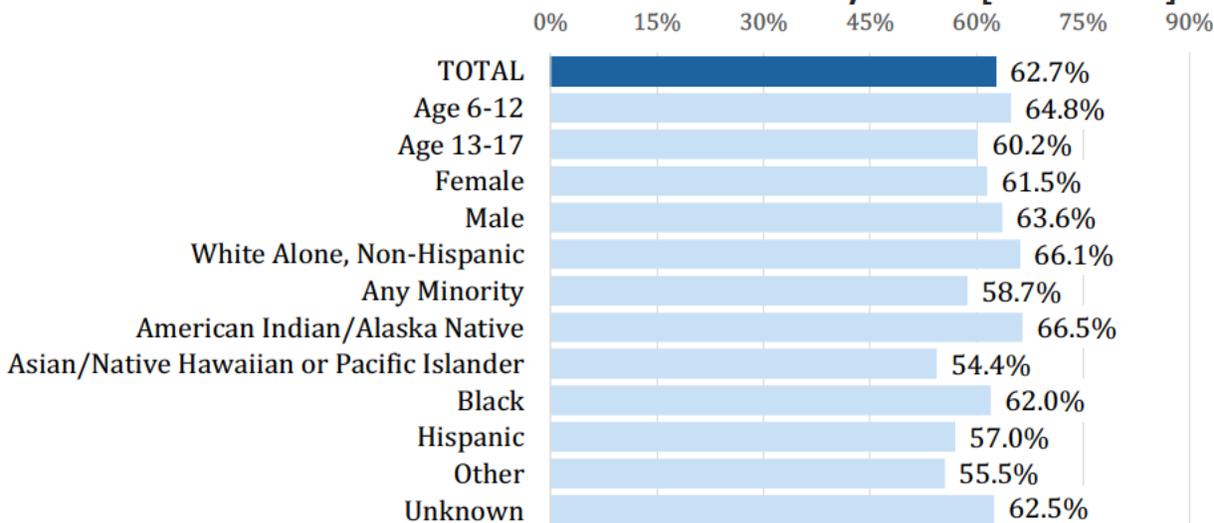
⁹ Measure is within the 2017 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf>.



Receipt of Mental Health Service

In 2016, 62.7% of Medicaid children with an identified mental health need received mental health services during the reporting period. Some racial/ethnic groups had lower levels of mental health treatment penetration, including Asian/Native Hawaiian or Pacific Islander (54.4%) and Hispanic (57%) populations. Appendix B provides additional demographic information.

TABLE 3. Mental Health Treatment Penetration¹⁰ in 2016—Broadly Defined [SUPPL-MH-B]



SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, September 2017.

Behavioral Health Organization Services

Between April 2016 and March 2017, 5.7% (49,108) of Medicaid covered children (866,526) received mental health services through BHOs. During the same time frame, 1.4% (4,449) Medicaid covered children ages 11-17 (318,808) received substance use disorder treatment (SUD) services through BHOs. The smaller SUD denominator reflects the population of children was limited to ages 11-17, who are within the typical age range for this service type. Appendix C describes the types of services provided and demographic profiles of those receiving this service.

Access to Mental Health Providers

Provider Availability

RCW 74.09.495 requires this legislative report to include the ‘number of children’s mental health providers available in the previous year.’ Provider availability data is not collected comprehensively by DSHS for BHO-served clients or by the Health Care Authority for FFS clients. However, limited proxy data is available. For example, 139 distinct facilities in Washington were

¹⁰ Measure is within the 2017 Statewide Common Measure Set, <https://www.hca.wa.gov/assets/program/2016.12.20.Common-Measure-Set-Health-Care-Quality-Cost-Approved.pdf>.



paid by Behavioral Health Organizations for children’s mental health services in 2016. However, numerous providers may be within each facility.

There are five MCOs offering health care services to Medicaid recipients. With the exception of the FIMC regions, MCOs typically provide behavioral health services to children with less acute behavioral health needs. Children with higher acuity behavioral health treatment needs are usually referred to the local BHO. Information for Medicaid providers contracted with MCOs as part of the ongoing monitoring by the HCA of MCO network adequacy also helps provide partial information on provider availability. Appendix D identifies the number of behavioral health providers serving children within each MCO in each county as indicated in their quarterly reports.

To fully provide this information in future legislative reports, one recommendation for this data collection would be the existing *Behavioral Health Provider Survey* (BHPS), administered by the University of Washington on behalf of the DSHS. An expansion of this survey could address provider availability and accessibility. Additional resources would be necessary to expand this survey.

Language Access

The spoken language of children’s mental health providers’ is not currently reported to the HCA or DSHS. Although limited data on spoken language for Medicaid MCOs providers is available, it does not differentiate children’s mental health providers from other provider types. Services to clients whose primary language is not English may be offered through other methods, most notably medical interpreter services. Even if a provider speaks an additional language, without certification as an interpreter, there may be no assurance they are skilled at conveying the necessary medical terminology appropriately.¹¹ Washington was the first state in the nation to establish a healthcare interpreter certification program,¹² with the standard applying to Medicaid interpreter services as well.

In line with 42 C.F.R. § 438.10(c)(4)), Medicaid providers, whether contracted through BHO, MCO, or FFS, are required to make available interpreter services and translated written materials for clients with a primary language other than English. Medicaid providers are mandated to provide free language access services to any client who experiences trouble speaking or understanding English, is deaf, or hard of hearing. Interpreter and Translation Services contracts used by Washington state agencies require contractors to ensure the competency of their employed or contracted interpreters and translators.

Medicaid 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

¹¹Title 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>.

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>.
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help eliminate health care disparities by providing a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services.”¹³

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

Provider Access

Comprehensive data, for BHO and MCOs, is not available to address children’s access to mental health providers. However, MCOs report quarterly to the Health Care Authority regarding their currently enrolled providers, specialty, and whether the provider is accepting new patients. Appendix E illustrates the volume of children’s mental health providers within each plan and, of those, who is accepting additional children in their practice. Based on the second quarter report, every MCO has a majority of children’s mental health providers accepting new patients. However, those provider types may not be distributed proportionally across the state.

Conclusion

RCW 74.09.495 requires annual reporting to the Legislature on the measures discussed. In future iterations of this report, new data may be available from other sources. New mandated reporting, as part of the implementation of Substitute Senate Bill 5779, requires MCOs and BHOs to maintain an accurate list of providers of children’s mental health services. Other new data sources could help fulfill the legislative requested information. For example, the DSHS could potentially expand the *Behavioral Health Provider Survey* to include questions on provider availability, access, and spoken language.

There are still barriers to improving access to children’s behavioral health services. In 2016, the Children’s Mental Health Work Group (<http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>) identified recommendations on how to improve mental health service delivery for children. Recommendations identified methods to address the following themes:

- Improve system capacity by addressing workforce shortages;
- Increase access to Culturally and Linguistically Appropriate Services; and
- Improve collaboration across health care, early learning and education.

¹³ Culturally and Linguistically Appropriate Services, <https://www.thinkculturalhealth.hhs.gov/clar>.
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In addition, studies have recognized that adequate and consistent funding are imperative for maintaining children’s behavioral health services access.¹⁴ Even brief periods of funding gaps can create long-term damage to direct-service infrastructure and workforce.

Statewide interventions should address the scarcity of behavioral health care providers available. An example of this is the Partnership Access Line¹⁵ (PAL), a telephone-based child mental health consultation system for primary care providers. The PAL program is financially supported by funds from the Health Care Authority and staffed by child psychiatrists affiliated with the University of Washington’s School of Medicine and Seattle Children’s Hospital. With supportive case consultation, primary care providers are more able to effectively treat children with more complex care needs without requiring children to meet with a specialist, likely reducing additional travel and obstacles. Additional efforts, including those specifically aimed at increasing the number of behavioral health providers available for screening and treatment, are needed to comprehensively address workforce shortages. In 2016, the Children’s Mental Health Workgroup proposed a tuition loan repayment program targeted for child psychiatrists, therapists, and clinicians working for BHO- or MCO-funded agencies that serve a high percentage of children, youth, and families on Medicaid.

Targeted interventions should consider the needs of rural communities and minority populations. Approaches such as tele-health may increase access in rural areas and help address experienced or perceived stigma. Purported benefits of tele-health include improved health care service access to specialty care providers, such as psychiatrists, removal of barriers for clients who have mobility or transportation challenges, and cost effectiveness.¹⁶ As cultural or demographic factors may also influence an individual’s decision to access behavioral health care, telehealth may prove to be a suitable option. Though some research has indicated that navigating cultural differences between patient and provider may be more challenging during tele-health encounters¹⁷, it is a valuable tool when providers are trained and able to deliver culturally and linguistically appropriate services.¹⁸ The HCA will further address this topic in the 2018 legislative report required by RCW 74.09.325(9).

As noted previously, certain populations may have an increased need for behavioral health treatment due to a wide variety of environmental and social factors. Evidence-based prevention programs for children with risk factors or early indications may play a role in helping to offset this disparity. Increased investment in the prevention of mental health and substance use disorders

¹⁴ Improving Access to Children’s Mental Health Care: Lessons from a Study of Eleven States. 2013. Behrens, et al. Center for Health and Health Care in Schools, George Washington University, http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1066&context=sphhs_prev_facpubs.

¹⁵ Partnership Access Line, <http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/>.

¹⁶ Increasing Access to Behavioral Health Care Through Technology. 2012. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration.

¹⁷ Using e-Health to Enable Culturally Appropriate Mental Healthcare in Rural Areas. 2008. Peter Yellowlees, et al. Telemed J E Health.

¹⁸ Telecounseling for the Linguistically Isolated. 2014. Yuri Jang, et al. Gerontologist.

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may help avert the downstream challenges associated with access to children's behavioral health disorders.

Strategic, cross-agency efforts may help improve disparities in access to children's behavioral health treatment services. Alternative service modalities, such as tele-health, may aid in improving access to behavioral health services. However, it is critical for these policy efforts to consider and address the specific needs of rural communities and minority populations as part of service delivery improvement strategies.



Appendix A: Follow-up after Emergency Department Visit

TABLE 4. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 7 Days [HEDIS-FUA]

Demographic Breakdown, Calendar Year 2016	Numerator	Denominator	Rate
TOTAL	107	596	18.0%
AGE CATEGORY			
13-17	107	596	18.0%
GENDER			
Female	56	285	19.6%
Male	51	311	16.4%
RACE/ETHNICITY			
White Alone, Non-Hispanic	56	252	22.2%
Any Minority	50	326	15.3%
American Indian/Alaska Native	11	70	15.7%
Asian/Native Hawaiian or Pacific Islander	1	19	5.3%
Black	9	73	12.3%
Hispanic	27	175	15.4%
Other	18	112	16.1%
Unknown	1	18	5.6%



TABLE 5. Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence within 30 Days [HEDIS-FUA]

Demographic Breakdown, Calendar Year 2016	Numerator	Denominator	Rate
TOTAL	142	596	23.8%
AGE CATEGORY			
13-17	142	596	23.8%
GENDER			
Female	70	285	24.6%
Male	72	311	23.2%
RACE/ETHNICITY			
White Alone, Non-Hispanic	68	252	27.0%
Any Minority	72	326	22.1%
American Indian/Alaska Native	20	70	28.6%
Asian/Native Hawaiian or Pacific Islander	3	19	15.8%
Black	9	73	12.3%
Hispanic	40	175	22.9%
Other	28	112	25.0%
Unknown	2	18	11.1%

TABLE 6. Follow-up after Emergency Department Visit for Mental Illness within 7 Days of Emergency Department Visit [HEDIS-FUM]

Demographic Breakdown, Calendar Year 2016	Numerator	Denominator	Rate
TOTAL	1,410	2,092	67.4%
AGE CATEGORY			
6-12	393	576	68.2%
13-17	1,017	1,516	67.1%
GENDER			
Female	768	1,143	67.2%
Male	642	949	67.7%
RACE/ETHNICITY			
White Alone, Non-Hispanic	826	1,197	69.0%
Any Minority	512	783	65.4%
American Indian/Alaska Native	68	102	66.7%
Asian/Native Hawaiian or Pacific Islander	39	74	52.7%
Black	117	189	61.9%
Hispanic	270	391	69.1%
Other	181	269	67.3%
Unknown	72	112	64.3%

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TABLE 7. Follow-up after Emergency Department Visit for Mental Illness within 30 Days of Emergency Department Visit [HEDIS-FUM]

Demographic Breakdown, Calendar Year 2016	Numerator	Denominator	Rate
TOTAL	1,633	2,092	78.1%
AGE CATEGORY			
6-12	462	576	80.2%
13-17	1,171	1,516	77.2%
GENDER			
Female	875	1,143	76.6%
Male	758	949	79.9%
RACE/ETHNICITY			
White Alone, Non-Hispanic	956	1,197	79.9%
Any Minority	590	783	75.4%
American Indian/Alaska Native	82	102	80.4%
Asian/Native Hawaiian or Pacific Islander	43	74	58.1%
Black	138	189	73.0%
Hispanic	307	391	78.5%
Other	205	269	76.2%
Unknown	87	112	77.7%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, September 2017.



Appendix B: Receipt of Mental Health Service

TABLE 8. Mental Health Treatment Penetration—Broadly Defined [SUPPL-MH-B]

Demographic Breakdown, Calendar Year 2016	Numerator	Denominator	Rate
TOTAL	62,805	100,216	62.7%
AGE CATEGORY			
6-12	34,231	52,786	64.8%
13-17	28,574	47,430	60.2%
GENDER			
Female	28,457	46,241	61.5%
Male	34,348	53,975	63.6%
RACE/ETHNICITY			
White Alone, Non-Hispanic	33,215	50,220	66.1%
Any Minority	25,675	43,728	58.7%
American Indian/Alaska Native	3,143	4,723	66.5%
Asian/Native Hawaiian or Pacific Islander	2,037	3,746	54.4%
Black	4,957	7,989	62.0%
Hispanic	14,559	25,537	57.0%
Other	9,879	17,805	55.5%
Unknown	3,915	6,268	62.5%

SOURCE: DSHS Research and Data Analysis Division, Client Outcomes Database, September 2017.



Appendix C: Services by Behavioral Health Organizations

TABLE 9. Medicaid Eligible Youths Ages 11-17 Receiving SUD Treatment Services

Medicaid Eligible Youths Ages 11-17 Receiving SUD Treatment Services through Behavioral Health Organizations			
Number of Medicaid Eligible Youths Ages 11-17 Receiving Any SUD Treatment Services		4,449	
% of Total Medicaid Eligible Youths		1.40%	
RACE	# of Clients	% of Those Who Received Any SUD Treatment	% of Total Medicaid Eligible Youths in the Demographic Category
African American	356	8.00%	1.53%
American Indian/Alaska Native	295	6.63%	2.92%
Asian	41	0.92%	0.31%
Multi-Race	81	1.82%	1.42%
Pacific Islander	63	1.42%	0.62%
White	2,526	56.78%	1.54%
Other	894	20.09%	1.31%
Unknown	193	4.34%	0.80%
HISPANIC			
Yes	1,591	35.76%	1.71%
No	2,820	63.39%	1.50%
Unknown	38	0.85%	0.10%
GENDER			
Female	1,825	41.02%	1.17%
Male	2,624	58.98%	1.61%



TABLE 10. Children Ages 0-17 Receiving Mental Health Services

Children Ages 0-17 Receiving Mental Health Services through Behavioral Health Organizations			
Total Unduplicated Number of Children Ages 0 - 17 Receiving MH Services			49,108
% of Total Medicaid Eligible Youths			5.667%
RACE			
	Client Count	% of Those Who Received MH Services	% of Total Medicaid Eligible Youths in the Demographic Category
African American	3,842	7.82%	6.324%
American Indian/Alaska Native	1,783	3.63%	6.982%
Asian	754	1.54%	2.494%
Multi Race	1,305	2.66%	7.159%
Pacific Islander	688	1.40%	2.557%
White	29,273	59.61%	6.989%
Other	7,884	16.05%	4.925%
Unknown	3,579	7.29%	2.842%
HISPANIC			
Yes	14,952	30.45%	6.126%
No	33,427	68.07%	7.115%
Unknown	729	1.48%	0.478%
GENDER			
Female	23,720	48.30%	5.610%
Male	25,388	51.70%	5.722%
AGE			
0-5	3,432	6.99%	1.139%
6-12	22,263	45.33%	6.649%
13-17	23,413	47.68%	10.169%

SOURCE: DSHS BHA, August 2017.



TABLE 12. Types of Services Provided through BHOs

Services Provided	Type
Withdrawal Management	Substance Use Disorder
Intensive Inpatient Residential Services	Substance Use Disorder
Case Management	Substance Use Disorder
Outpatient Treatment	Substance Use Disorder
Opiate Substitution Treatment	Substance Use Disorder
Recovery House Residential Services	Substance Use Disorder
Alcohol/Drug Information School	Substance Use Disorder
Assessment	Substance Use Disorder
Brief Intervention	Substance Use Disorder
Interim Services	Substance Use Disorder
Involuntary Commitment	Substance Use Disorder
Pregnant, Post-partum, or Parenting Women Housing Support Services	Substance Use Disorder
Recovery Support Services	Substance Use Disorder
Sobering Services	Substance Use Disorder
Community Hospital	Mental Health
Children's Long Term Inpatient Program	Mental Health
Freestanding Evaluation and Treatment Services (E&T)	Mental Health
Care Coordination Services	Mental Health
Child And Family Team Meeting	Mental Health
Co-Occurring Treatment Services	Mental Health
Crisis Services	Mental Health
Day Support	Mental Health
Engagement And Outreach	Mental Health
Family Treatment	Mental Health
Group Treatment Services	Mental Health
High Intensity Treatment	Mental Health
Individual Treatment Services	Mental Health
Intake Evaluation	Mental Health
Integrated Substance Abuse MH Screening	Mental Health
Interpreter Services	Mental Health
Medication Management	Mental Health
Medication Monitoring	Mental Health
Mental Health Services Provided In A Residential Setting	Mental Health
Peer Support	Mental Health
Psychological Assessment	Mental Health
Rehabilitation Case Management	Mental Health
Request For Services	Mental Health
Respite Care Services	Mental Health
Special Population Evaluation	Mental Health

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Stabilization Services	Mental Health
Supported Employment	Mental Health
Testimony For Involuntary Treatment Services	Mental Health
Therapeutic Psychoeducation	Mental Health

SOURCE: DSHS BHA, August 2017.



Appendix D: MCO-Contracted Mental Health Providers Serving Children by County, 2016

TABLE 13. Medicaid Managed Care Organization Mental Health Provider

Medicaid Managed Care Organizations (MCO)					
COUNTY	AMERI-GROUP	COORDINATED CARE	CHPW	MOLINA	UNITED
Adams	1	1	2	1	0
Asotin	7	25	2	8	1
Benton	64	69	84	94	25
Chelan	41	51	127	119	13
Clallam	3	4	3	46	14
Clark	65	39	82	313	46
Columbia	1	2	3	3	0
Cowlitz	59	65	66	97	12
Douglas	3	8	5	19	0
Ferry	8	1	4	4	0
Franklin	9	4	22	11	2
Garfield	1	0	0	2	0
Grant	9	48	28	22	2
Grays Harbor	14	3	7	24	5
Island	27	51	32	34	11
Jefferson	31	30	20	23	6
King	919	694	1065	1422	204
Kitsap	47	37	96	105	43
Kittitas	12	3	4	23	5
Klickitat	7	0	2	5	1
Lewis	30	5	30	34	11
Lincoln	14	1	1	4	0
Mason	10	9	10	11	2
Okanogan	8	8	12	28	2
Pacific	2	1	1	7	0
Pend Oreille	3	2	1	5	2
Pierce	622	247	372	609	110
San Juan	4	1	6	14	1
Skagit	29	21	44	66	6
Skamania	1	9	4	6	1
Snohomish	172	131	160	282	76
Spokane	262	230	272	536	127

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COUNTY	AMERI-GROUP	COORDINATED CARE	CHPW	MOLINA	UNITED
Stevens	21	1	7	20	2
Thurston	86	62	161	130	41
Wahkiakum	0	0	0	0	0
Walla Walla	12	11	18	41	5
Whatcom	94	37	123	230	17
Whitman	31	31	13	39	9
Yakima	78	164	115	98	27
Total **	2807	2106	3004	4535	829

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs. Notes: Medicaid 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. CHPW is Community Health Plan of Washington. Totals do not include providers outside of Washington State. Providers included only when serving children <19 years of age. Data may duplicate providers who are serving more than one managed care organization or work at more than one county within a MCO. Please note not every MCO is contracted in each county.



Appendix E: MCO-Contracted Mental Health Providers Serving Children by Type, Q2 2017

Table 14. Managed Care Organization Contracted Mental Health Providers by Type

Type of Mental Health Providers							
MCO	TOTAL	PhD	PY	ARNP/MD/DO	COUNSELORS	TOTAL COUNT	PERCENT ACCEPTING NEW CLIENTS
Amerigroup	Network	1	880	167	1759	2807	86.3%
	Accepting New	1	790	123	1509	2423	
Coordinated Care	Network	180	132	523	1223	2058	92.3%
	Accepting New	167	130	471	1177	1945	
CHPW	Network	324	88	720	1874	3006	96.4%
	Accepting New	310	88	677	1821	2896	
United	Network	89	0	147	596	832	99.1%
	Accepting New	89	0	143	590	822	
Molina	Network	380	132	1222	2801	4535	98.2%
	Accepting New	377	132	1190	2756	4455	

SOURCE: HCA Network Adequacy Reporting by Medicaid MCOs. Notes: Totals do not include border state providers from Oregon and Idaho. Providers included only when serving children <19 years of age. Data may duplicate providers who are serving more than one plan.

