Washington State Health Care Authority

Report to the Legislature

Access to behavioral health services for children

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

RCW 74.09.495

December 1, 2021

Access to behavioral health services for children

Acknowledgements

The data collected for this report was provided by various individuals from multiple state departments, including the Health Care Authority (HCA), the Department of Social and Health Services' Research and Data Analysis Division (DSHS/RDA), and Washington State University. Many thanks to Felix Rodriguez, Rose Krebill-Prather, Kent Miller, Grace Hong, Kevin Campbell, Barb Lucenko, Jesica Mikesell, Sazi Wald, Rachel Burke, and Kari Samuel for contributing to this report.

Division of Behavioral Health and Recovery
P.O. Box 45502
Olympia, WA 98504
Phone: (360) 725-1580
Fax: (360) 763-4702
www.hca.wa.gov

Table of contents

Executive summary 4
Background 6
Reporting requirements 6
Effects of COVID19 6
Children Youth Behavioral Health Workgroup 7
Addressing the housing crisis for transition age youth 8
Results 10
Client access data 10
Received mental health services 10
Behavioral health services by type and provider 11
Follow-up post emergency department visit 12
Children's mental health provider accessibility and availability 15
Provider language 15
Eating Disorders and Treatment 17
Eating disorder treatment including place and diagnosis comorbidity 17
Conclusion 19
Appendix A 20
Appendix B 21
Appendix C 22

Executive summary

During 2020, 880,918 children[1] were enrolled in Washington's Apple Health insurance (Medicaid). Apple Health covered approximately half of all children within the state[2]. Apple Health is the largest payor for mental health services within the state. Access to behavioral health care for children and youth on a form of Apple Health insurance is a key driver for contributing to the advancement of integrated care throughout the state of Washington. As Washington continues to transform our system of care, it is important to track the availability of providers, coordination of care, and the cultural responsiveness of the network.

Using data from ProviderOne, Behavioral Health Data System (BHDS), 2020 Behavioral Health Provider Survey, and network adequacy submissions from Managed Care Organizations (MCOs), this report provides information regarding the following items:

1. Children who received mental health services during the reporting period.
2. Children receiving services from MCOs, including the types of services they received.
3. Follow-up after an emergency department visit for mental illness or alcohol and other drug dependence[3] within 7 days and within 30 days.
4. Children's mental health providers available in the previous year.
5. Children's mental health providers who were actively accepting new patients.
6. Languages spoken by children's mental health providers.
7. Mental health and medical services for eating disorder treatment in children and youth, place of service, and availability of providers specializing in eating disorders.

In 2020, 115,196 children and youth, enrolled in Apple Health, received substance use disorder (SUD) or mental health services. Regarding client specific access, almost 80 percent of children and youth receive an intervention for symptoms of mental illness or intentional self-harm within 30 days of an emergency department (ED) visit, however, only 17 percent of the youth seen in the ED for SUD symptoms receive the same level of follow-up care. Youth identified as being from any minority background, received follow-up services at a disperate rate. Additionally, only 64 percent of children and youth identified as having a mental health concern within 2019 and 2020 received a mental health service within 2020.

During 2019 and 2020 there were 5,254 children and youth who were diagnosed with an eating disorder, with 3,535 or 67.3 percent carrying a co-morbid behavioral health condition. There were 1,870 males and 3,384 females who received a diagnosis of an eating disorder; 76.8 percent of the diagnosed children/youth were identified as White or White with one or more other races.

There was great variability in reporting during 2020 by the MCOs regarding network access and appointment availability for children's mental heatlh providers. Approximately 10 percent of the youth-

[1] Health Care Authority (n.d.). Apple Health Client eligibility dashboard. Retrieved on September 17, 2021.
[2] Calculation created from the Office of Financial Management's population data and the Apple Health Client eligibility dashboard.
[3] Per the language of the corresponding Healthcare Effectiveness Data and Information Set (HEDIS) measure.

serving staff working for licensed Behavioral Health Agencies that responded to the 2020 Behaviorial Health Provider Survey are bilingual. Washington State does not certify, record provider attestations of expertiese, or otherwise officially designate providers as specializing in treatment for eating disorders, therefore data about availability of such providers is not available. There is a need to create more data collection infrastructure surrounding behavioral health providers.

Background

Reporting requirements

The Revised Code of Washington (RCW) 74.09.495[4] directs HCA and Department of Social and Health Services (DSHS) to report annually on the status of access to behavioral health services for children birth through age 17. Reporting must include:

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

Data results within this report will be provided in three sections: client access data, provider centered, and eating disorder and treatment. Additionally, three other topics have been highlighted in their connection with children and youth gaining access to behavioral health services during 2020: effects of COVID 19, the Children Youth Behavioral Health Workgroup's legislative recommendations, and addressing the housing crisis for transition age youth.

Effects of COVID19

On February 29, 2020, Govenor Inslee proclaimed a State of Emergency throughout all of Washington that limited physical contact between people, closed school facilities, shifted physical and mental health treatment from in-person to phone or telemedicine, and drastically changed multiple aspects of how individuals could access care[5]. Social distancing, limitations on physical contact, and affects on the economy have played a serious role in creating a child and youth behavioral health crisis with increase hospitalizations, reports of suicidal ideation, and symptoms of depression and anxiety[5]. Additionally, secondary effects of unemployment, social distancing, and other public health measures have changed or

[4] RCW 74.09.495, Behavioral health services access by children report accessed September 7, 2018.

[5] Inslee, Jay (2021). Emergency Proclamation of the Governor 21-05 Children and Youth Mental Health Crisis. Retrieved on September 16, 2021

terminated children's health insurance[6] and access to key items such as housing, transportation, and extended family support. The COVID 19 pandemic impacted every aspect of our lives during 2020, and therefore, played a role in how children, youth and families were able to access care. Due to the pandemic, this year's results, along with subsequent years, may not match previous trajectories. We are only just learning how multiple years of managing a public health crisis can affect behavioral health and an individual or family's ability to access care.

Children Youth Behavioral Health Workgroup

In 2020, the Legislature passed Second Substitute House Bill 2737 which renamed and reauthorized through 2026 the Children's Mental Health Work Group to the Children and Youth Behavioral Health Work Group (CYBHWG).

The work group, as a whole and each of its subgroups, include representatives from the Legislature, state agencies, health care providers, tribal governments, advocacy groups, and community health services, as well as parents of children and youth who have received services, and youth and young adults with lived experience. The work group provides recommendations to the Legislature to improve behavioral health services and strategies for children, youth, and families, and has been increasingly focused on cross-system solutions.

The CYBHWG has adapted its structure to leverage cross-system efforts for the full continuum of children, youth, and family services. In 2021, the following subgroups addressed topics in a lifespan model:

- Prenatal through Five Relational Health
- School-Based Behavioral Health and Suicide Prevention
- Youth and Young Adult Continuum of Care
- Workforce and Rates
- Behavioral Health Integration

In 2020, the CYBHWG's primary focus was addressing the dramatic rise in behavioral health needs resulting from the pandemic. All of the prioritized recommendations were passed by the Legislature, along with other measures targeted to improve behavioral health services for the system as a whole and, especially, for children, youth, and families.

One issue that underlies all systemic barriers to access is the behavioral health workforce shortage. The CYBHWG's recommendations to support workforce development and retention were:

- Increases in Medicaid rates for behavioral health services in both primary care and behavioral health settings.
- Establishing a work group to develop a behavioral health teaching clinic enhancement rate.
- Expanding the Student Loan Repayment Program for those seeking to enter the field and reducing existing barriers within the program.

[6] Department of Health (2021). COVID 19 Youth Behavioral Health Impact Situation Report: DOH 821-135-04. Retrieved September 16, 2021

Prioritized recommendations aimed at addressing existing barriers were:

- Establishing the Washington State Mental Health Referral Service for Children and Teens as a permanent program.
- Expanding youth mobile crisis services statewide.
- Changing Medicaid policy to match best practices for mental health assessment and diagnosis of children 0-5.
- Preserving and expanding existing investments in infant and early childhood mental health consultation.
- Establishing a complex needs fund to expand access to consultant support for behavioral health challenges of children ages 0-5.
- Directing HCA to explore Medicaid waiver options for respite care for youth with behavioral health challenges, without adversely impacting existing respite waivers.
- Expanding availability of youth and family peer services across the continuum of care, reducing barriers to entry and retention, enhancing diversity, and ensuring peers are supported in their recovery.

More information regarding the CYBHWG, including mission, background, and contact information can be found on the Children and Youth Behavioral Health Work Group website.

Addressing the housing crisis for transition age youth

HCA's Division of Behavioral Health and Recovery is exploring best practices to transition youth and young adults ages 16-25 who experience homelessness from inpatient to outpatient behavioral care and stable housing[7]. The 2018 A Way Home Washington reports two out of three 13 to 24-year-olds experienced homelessness after they had discharged from a public system of care from inpatient behavioral health treatment[8]. The Office of Homeless Youth (OHY) presented 2017 data from Research and Data Analysis illustrating that within 12 months of exiting inpatient behavioral health treatment, one in five young people ages 13-24 would be homeless. 82-84 percent of these young people were between the ages of 18-24[9] [10]

After reviewing best practice literature and consulting with 216 stakeholders through survey or interview, many of whom were transition age youth with lived experience of homelessness and inpatient treatment,

---

[7] American Academy of Child and Adolescent Psychiatry. FAQs for Child, Adolescent and Adult Psychiatrists Working with Transitional Age Youth. Published July 31, 2020. Accessed July 31, 2020.

[8] McCann E, A Way Home Washington. From Inpatient Treatment to Homelessness: Envisioning a Path toward Healing and Safe Housing for Young People in Washington State; 2018. Accessed March 11, 2021.

[9] Washington State Department of Commerce. Improving stability for youth exiting systems of care: Pursuant to RCW 43.330.720. Published online January 2020:40.

[10] Washington State Department of Social and Health Services Division of Research and Data Analysis, (Commerce) Washington State Department of Commerce. Homelessness among Youth Exiting Systems of Care in Washington State.; 2020. Accessed March 11, 2021.

HCA published a comprehensive report that overviews how to assist youth and young adults, that have experienced homelessness, into safe and stable housing within strong and supportive communities.

The four priority recommendations include:

- Intertwining diversity, equity, and inclusion into all recommendations and practices.
- Creating linkages with basic needs (such as housing, money, and food).
- Supporting healthy relationships (such as family reunification and couples/family counseling).
- Recovery support (such as therapeutic support, living skills, and mentorship).

The full report may be accessed through the HCA website.

Results

Data from ProviderOne, BDHS, the Behavioral Health Provider Survey, and network adequacy reports submitted by MCOs have been accessed to provide information for this report. Results will be provided in three sections: client access, provider centered, and eating disorder treatment.

Client access data

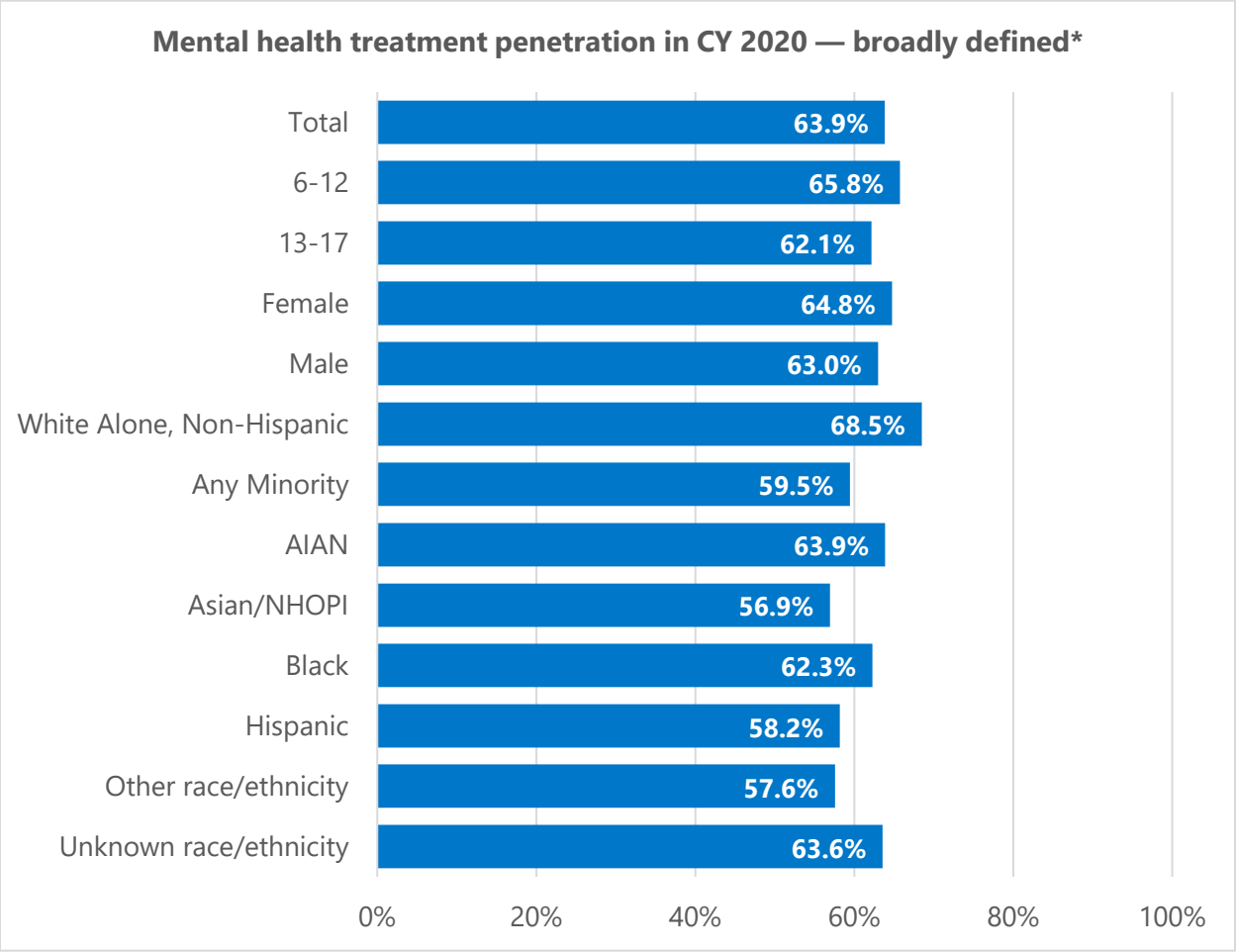
As with previous years, there were changes in how data were collected for this report. Eight former Behavioral Health Organizations (BHOs) migrated to Managed Care Organizations/Behavioral Health Administrative Service Organizations/Fully Integrated Managed Care/Behavioral Health Service Organizations (MCOs/BHASO/FIMC/BHSO) in 2019 and 2020. Those MCOs/BHASO/FIMC/BHSO submitters needed to adopt the IMC Service Encounter Reporting Instructions for data submission into BHDS. To improve data quality, HCA has provided MCOs and BHASOs with error analyses and implemented new validation rules. The majority of the 2020 data errors have been corrected through these efforts. HCA is currently reviewing the extract, transform and load process for how encounter data (ProviderOne) is loaded into BHDS tables, and, therefore, BHDS was not available as a primary data source for reporting this year. For reporting of behavioral health service utilization, RDA primarily used data from ProviderOne following an RDA algorithm to identify behavioral health services. Data from BHDS for mental health community hospital (CH) or evaluation and treatment (ET) services were also incorporated. Due to the differences in data sources and algorithms, the reported service utilization in 2020 may not be comparable to data reported in previous years.

Received mental health services

During the calendar years of 2019 and 2020, 113,622 children and youth aged 6 to 17 enrolled in Apple Health insurance were identified as needing a mental health intervention. Out of the identified children and youth, 63.9 percent received mental health care during the year 2020. Therefore, approximately 36 percent of youth who were identified as having a mental health care need, did not receive treatment by a mental health provider within 2020.

This item is tracked using the HEDIS measure SUPPL-MH-B Mental Health treatment penetration-broadly defined. Mental health service penetration (broadly defined) is the percentage of children and youth on Apple Health who received mental health services during 2020. These children and youth were enrolled in Apple health for at least 11 months during 2020. 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. Children and youth that received mental health service during the measurement year received at least one treatment service or were identified as receiving management of a mental health condition within a primary care setting.

Figure 1. Mental Health treatment penetration in CY 2020



SOURCE: Data produced by DSHS Research and Data Analysis Division, September 2021, using the DSHS Integrated Client Databases. See Appendix A for a detailed description of this measure. A full table with information regarding this HEDIS measure can be found in Appendix A.

Behavioral health services by type and provider

In 2020, 115,196 children and youth in Washington, enrolled in Apple Health, received SUD and/or mental health services. There were 2,677 children and youth, representing .30 percent of the eligible population, who received SUD services and 114,121 children and youth, representing 12.95 percent of the eligible population who received mental health services.

SUD services provided to this population include detoxification, residential treatment, case management, medication assisted treatment, and outpatient treatment. Mental health services include crisis, inpatient, medication management, peer support, family treatment, case management and psychoeducation. A full list of included services can be found in Appendix A along with information regarding the age, racial identity, gender, and geographic location of the children and youth who received SUD and mental health services paid for through Apple Health.

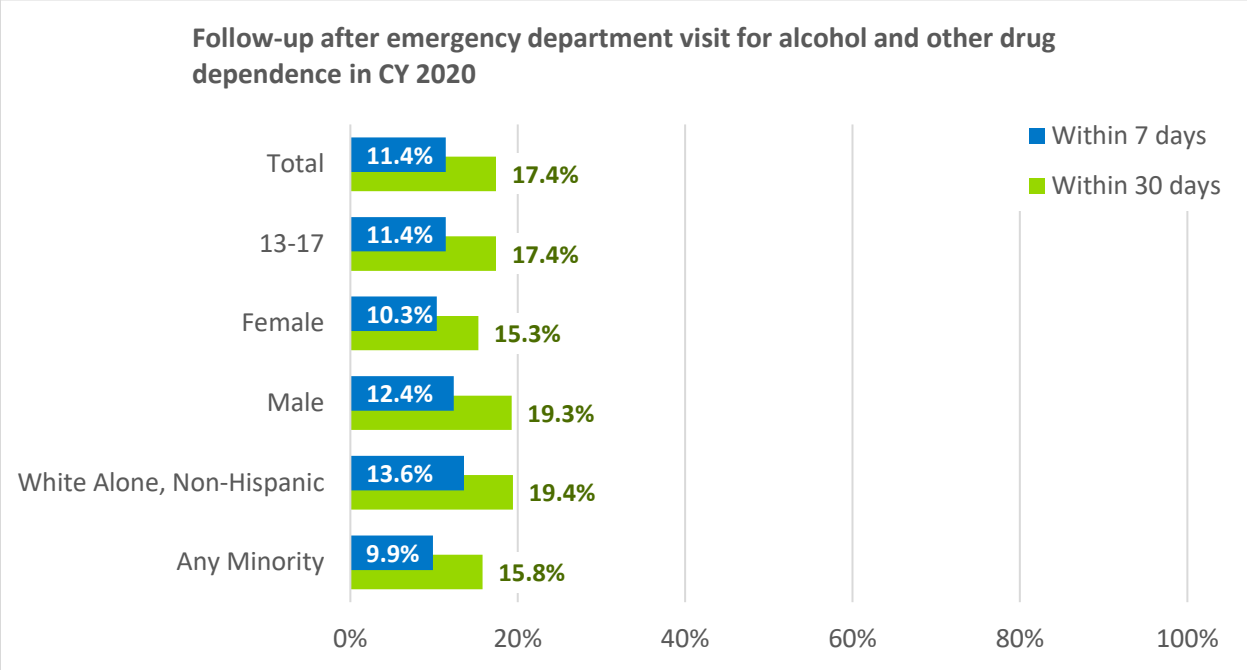
Follow-up post emergency department visit

Apple Health measures four HEDIS 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:

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

In 2020, 517 youth enrolled in Apple Health, ages 13 to 17, were seen in an ED due to SUD symptoms. Out of the 517 youth, 59 received a follow-up service within seven days, which increased to 90 by 30 days after their ED visit; only approximately 17 percent of youth receiving emergency department interventions for substance use had documented follow-up care.

Figure 2: Follow-up after emergency department visit for alcohol and other drug dependence in CY 2020

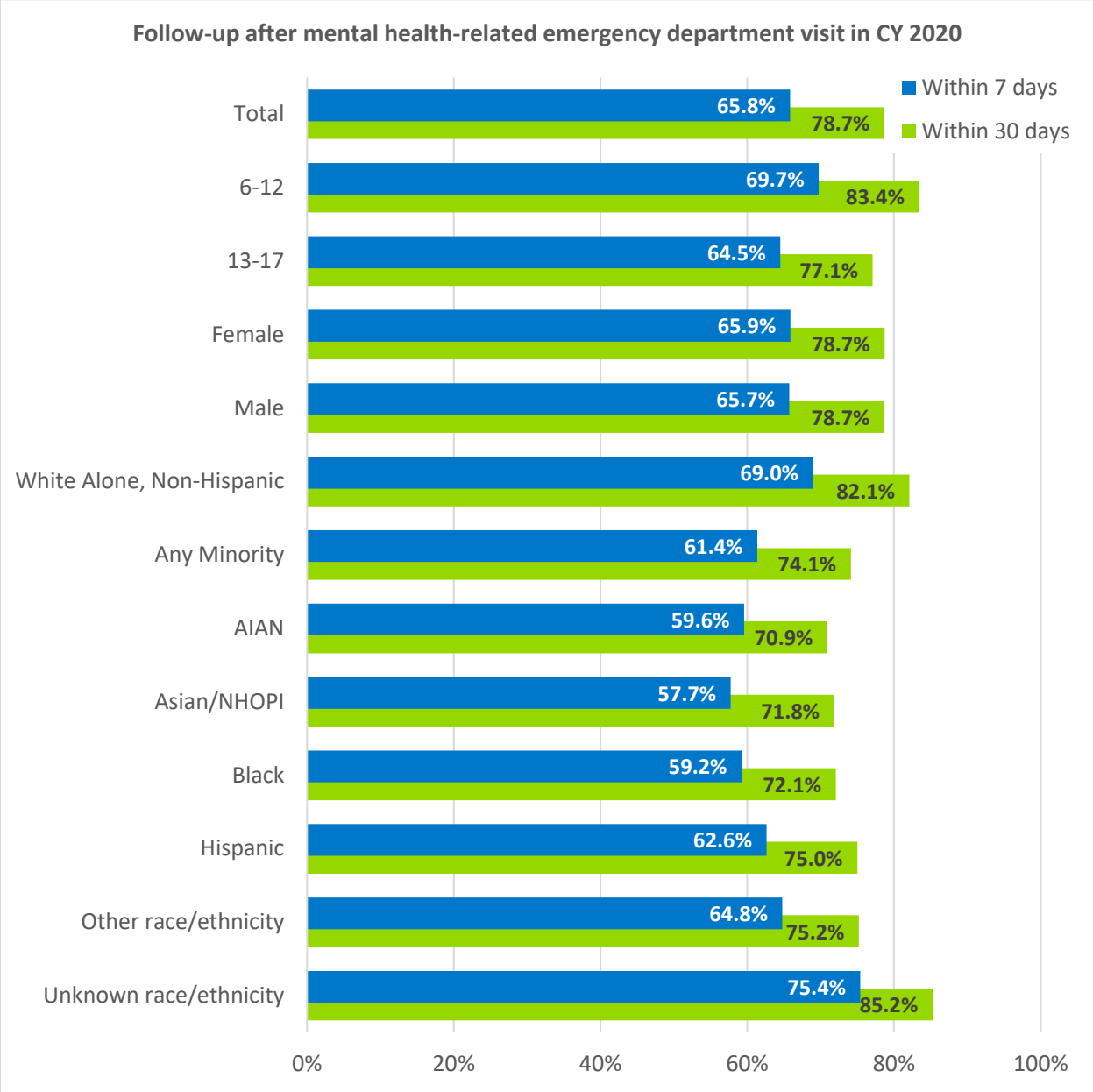


SOURCE: Data produced by DSHS Research and Data Analysis Division, September 2021, using the DSHS Integrated Client Databases and HEDIS 2020 Technical Specifications. HEDIS technical specifications and measure calculation may change from year to year. Technical guidelines can be obtained from the National Committee for Quality Assurance.

In comparison, 1,873 children and youth enrolled in Apple Health were seen within an emergency department setting for mental health disorder symptoms during 2020. Sixty-six percent of the children received follow up care within seven days and that rate increased by to almost 79 percent by the 30-day mark. Rates of follow-up were more consistent across racial and ethnic categories and never reached below 70 percent, however the lowest rates of follow-up care continued to be with the American

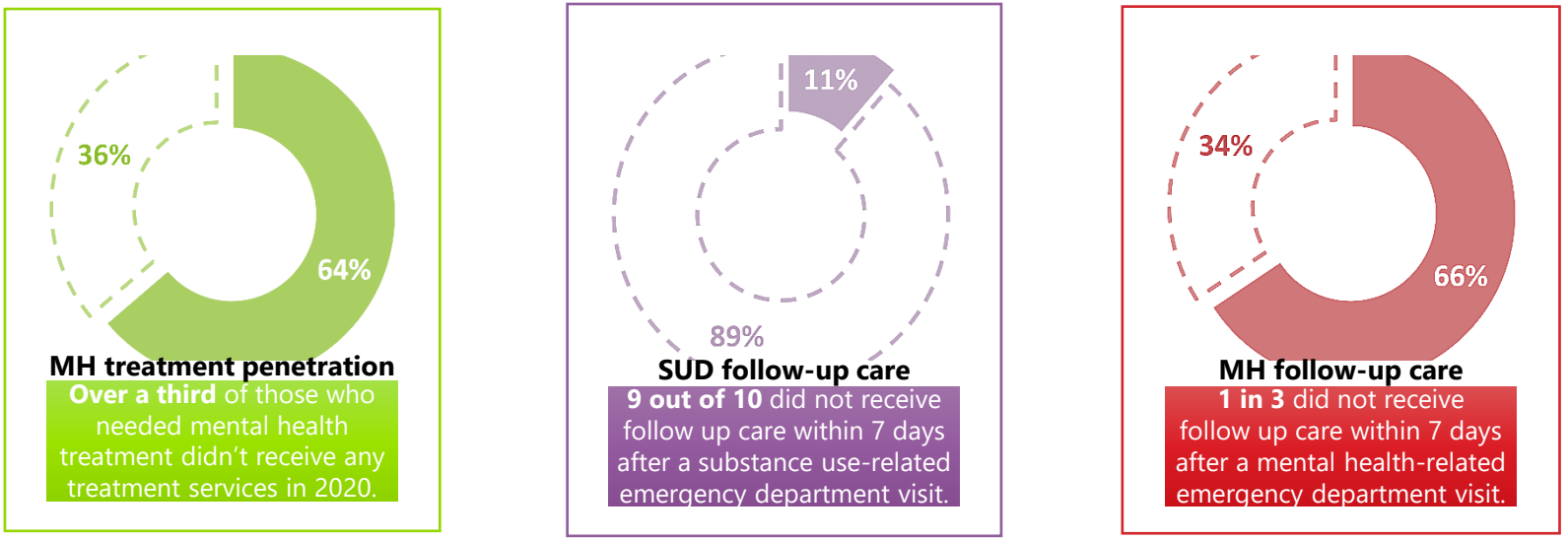
Indian/Alaskan Native (70.9 percent), Black (72.1 percent), and Asian/Pacific Islander (71.8 percent) populations.

Figure 3: Follow-up after mental health-related emergency department visit in CY 2020



SOURCE: Data produced by DSHS Research and Data Analysis Division, September 2021, using the DSHS Integrated Client Databases and HEDIS 2020 Technical Specifications. HEDIS technical specifications and measure calculation may change from year to year. Technical guidelines can be obtained from the National Committee for Quality Assurance.

Figure 4. Key gaps in access to behavioral health services for children and youth enrolled in Apple Health



NOTE: A full table with information regarding these HEDIS measures across demographic populations can be found in Appendix A.

Children's mental health provider accessibility and availability

The data to assess accessibility and availability comes from network adequacy reports submitted by MCOs quarterly. The network adequacy mental health data includes professional mental health services and Behavioral Health Agencies, SUD providers and not included in this report. This process has been evolving over the past few years and there are some inconsistencies within the data set:

- During the second quarter of 2020, the reporting process moved from retrospective to prospective, which resulted in a change of how MCOs configured their lists and a lack of data for the second quarter.
- Per the MCO contract, they should only be reporting contracted mental health providers who are available to see new patients (therefore columns Total and Accepting New should be the same for each managed care provider).
- It is unclear if all providers listed "could" see children or if all the providers "will" see children.

HCA is engaging MCOs in on-going discussions and contract modifications to reform and enhance data collection regarding network adequacy.

Appendix B contains three tables reporting submitted data from MCOs regarding the availability of mental health providers who see children. These data show a great variability in availability and access throughout the state and by MCO.

Provider language

Information regarding languages spoken by children's behavioral health providers (mental health and SUD) comes from the 2020 Behavioral Health Provider Survey. These data are a result of an online survey that was conducted from April through September 2020. The survey was sent to the 578 agencies that hold a license as a Behavioral Health Agency through Washington's Department of Health. Information in this report regarding language capacity of children's behavioral health providers does not include practitioners in private practice or who have a contract with a MCO to provide services for children on Apple Health who practice outside of an agency that holds a license as a Behavioral Health Agency.

The survey had a response rate of 60.9 percent. Of the 352 responding agencies, 213 indicated that they provide behavioral health services to children and youth. The survey asked: "How many of your behavioral health clinical staff are bilingual or multi-lingual and are able to provide behavioral health services in a non-English language?" and "How many of your behavioral health clinical staff speak a language other than English?"

The 213 children and youth serving behavioral health agencies that responded to the survey reported having 8,671 total behavioral health staff and 6,326 behavioral health clinical staff. Of the 6,326 behavioral health clinical staff, 665, or approximately 10.5 percent, were reported to be bilingual or multi-lingual.

Table 1. Total number of Behavioral Health clinical staff who speak the following languages

Language	Total	% of bilingual
American Sign Language	8	1.2%
Arabic	10	1.5%
Chinese	60	9.0%
Dutch	1	0.2%
Finnish	2	0.3%
French	11	1.7%
German	13	2.0%
Greek	2	0.3%
Hebrew	1	0.2%
Hindi	6	0.9%
Ilocano	2	0.3%
Indonesian	1	0.2%
Italian	1	0.2%
Japanese	16	2.4%
Khmer	3	0.5%
Korean	14	2.1%
Laotian	11	1.7%

Language	Total	% of bilingual
Malay	2	0.3%
Mien	5	0.8%
Native American	3	0.5%
Persian (Farsi)	5	0.8%
Portuguese	2	0.3%
Romanian	2	0.3%
Russian	8	1.2%
Somali	6	0.9%
Spanish	390	58.7%
Swahili	1	0.2%
Swedish	1	0.2%
Tagalog	17	2.6%
Thai	11	1.7%
Turkish	2	0.3%
Ukrainian	1	0.2%
Vietnamese	24	3.6%
Other	59	8.8%

Table 1 highlights

- Spanish is by far the most common language spoken other than English with 390 BH clinical staff.
- Chinese is spoken by 60 out of 665 bilingual BH staff.
- Vietnamese (3.6 percent), Tagalog (2.6 percent), Japanese (2.4 percent), Korean (2.1 percent), German (2.0 percent), Thai (1.7 percent), Laotian (1.7 percent), French (1.7 percent), Arabic (1.5 percent), American Sign Language (1.2 percent), and Russian (1.2 percent) are the next most common languages spoken.

The full report (Languages spoken at behavioral health agencies serving children and youth in Washington state) along with further information regarding the Behavioral Health Survey data and other relevant reports can be found on the Reports section of the Children and Youth Behavioral Health Work Group website.

Eating Disorders and Treatment

Revised Code of Washington (RCW) 74.09.495 requests data related to mental health and medical services for eating disorder treatment in children and youth, including the number of: (1) eating disorder diagnoses; (2) patients treated in outpatient, residential, emergency, and inpatient care settings; and (3) contracted providers specializing in eating disorder treatment and the overall percentage of those providers who were actively accepting new patients during the reporting period. However, provider-based information is not readily available. There is no established specialty facility or provider certification in Washington for eating disorders; therefore, HCA cannot provide data regarding the number of or availability to accept new patients for providers with a capacity to treat eating disorders.

Eating disorder treatment including place and diagnosis comorbidity

Table 2: Eating disorder diagnoses covered by Apple Health

ICD 9	
Code	**Long Code Description**
3071	Anorexia nervosa
3075	Other & Unspec. disorders of eating
30750	Eating disorder, unspecified
30751	Bulimia nervosa
30752	Pica
30753	Rumination disorder
30754	Psychogenic vomiting
30759	Other disorders of eating

ICD 10	
Code	**Long Code Description**
F5000	Anorexia nervosa, unspecified
F5001	Anorexia nervosa, restricting type
F5002	Anorexia nervosa, binge eating/purging type
F502	Bulimia nervosa
F508	Other eating disorders
F5081	Binge eating disorder
F5082	Avoidant/restrictive food intake disorder
F5089	Other specified eating disorder
F509	Eating disorder, unspecified
F9821	Rumination disorder of infancy
F9829	Other feeding disorders of infancy and early childhood
F983	Pica of infancy and childhood

During 2019 and 2020 there were 5,254 children and youth who were diagnosed with an eating disorder, with 3,535 or 67.3 percent carrying a co-morbid behavioral health condition. There were 1,870 males and 3,384 females who received a diagnosis of an eating disorder; 76.8 percent of the diagnosed children/youth were identified as White.

Children and youth that carry eating disorder diagnoses received a mixture of inpatient, emergency, and outpatient mental health services. Approximately 20 percent experienced medical hospitalization and 10 percent received a mental health community inpatient hospital treatment.

Table 3: Service Utilization for children and youth with an eating disorder diagnosis

Title 19/CHIP Youth (Age 0-20) with an Eating Disorder Diagnosis

CY 2019-2020

Medical and Behavioral Service Utilization	Male		Female		All Gender Groups	
	TOTAL	PERCENT	TOTAL	PERCENT	TOTAL	PERCENT
Visited emergency department at least once	1,009	54.0%	1,957	57.8%	2,966	56.5%
Had medical hopitalization at least once	308	16.5%	731	21.6%	1,039	19.8%
Received SUD Treatment Services	20	1.1%	99	2.9%	119	2.3%
Outpatient	20	1.1%	93	2.7%	113	2.2%
Residential	.	.	30	0.9%	36	0.7%
Detox	.	.	.	.	.	.
Received Community MH Treatment Services	859	45.9%	2,294	67.8%	3,153	60.0%
Outpatient	856	45.8%	2,291	67.7%	3,147	59.9%
Crisis	15	0.8%	73	2.2%	88	1.7%
Community Hospital or E&T	70	3.7%	463	13.7%	533	10.1%
Population:	1,870	100%	3,384	100.0%	5,254	100.0%

ADMINISTRATIVE DATA NOTES

1. The data source is from DSHS Research and Data Analysis (RDA), Integrated Client Databases (ICDB). The cases of eating disorder include but are not limited to, anorexia nervosa, bulimia nervosa, and other eating disorders. The diagnosis codes are listed in the DX tab.
2. Any cell with size smaller than 11 was suppressed.

NOTE: Further information regarding comorbid diagnosis, gender, race, and other demographic data can be found in Appendix C.

Conclusion

During 2020, out of the 880,918 children and youth enrolled in Apple Health, 115,196 received a mental health or SUD service paid for through Apple Health. During the calendar years of 2019 and 2020, 113,622 children and youth ages 6 to 17 enrolled in Apple Health insurance continuously were identified as needing a mental health intervention. Out of the identified children and youth, 63.9 percent received mental health services during the year 2020. Lastly, during 2019 and 2020 there were 5,254 children and youth aged 20 years or younger who were diagnosed with an eating disorder, with 3,535 or 67.3 percent carrying a co-morbid behavioral health condition.

HCA and DSHS seek to provide the legislature with all the information requested within RCW 74.09.495. To do so, HCA and DSHS will continue to enhance our queries within ProviderOne and the BHDS data sources to provide needed data regarding children and youth receiving mental health and SUD services when Apple Health is the payor. Additionally, HCA will continue to work with MCOs to develop the utility of the network adequacy submissions and subsequent reports. To that end, HCA has formed workgroups to modify and reform data submissions, including adding information regarding specialty providers (e.g., eating disorder treatment).

Network adequacy report requirements are outlined within Apple Health contracts with MCOs. Currently, availability and access of behavioral health providers who see children is considered a critical provider category that is included in the network adequacy reports that must be submitted by MCOs for contract compliance each quarter. Eating disorder specialty providers have recently been added to the Apple Health MCO contract and this information will be available in network adequacy reports in the future. At this time, languages spoken by providers is not included as a critical provider and is not available or planned to be included in the network advocacy reports.

Due to data limitations and the impact of the COVID 19 pandemic, this year's results may not be in line with previous trajectories. As data systems improve in quality and service utilization/access create their new normal, on-going reports could include multi-year comparisons. HCA and DSHS will continue to monitor the children's behavioral health network and seek to improve access through the work of the Children Youth Behavioral Health Workgroup and other initiatives, such as the Safe and Supportive Transition to Stable Housing for Youth ages 16-25 report.

Appendix A

Appendix A is a collection of data regarding Title 19/CHIP Youth (0-18 yrs) Receiving Substance Use Disorder (SUD) Treatment, SUD Detox, or Community Mental Health (MH) Treatment Services.

This data was produced by DSHS Research and Data Analysis Division in September 2021 using the DSHS Integrated Client Databases.

To access this appendix, please see HCA's website.

Appendix B

Appendix B contains three tables reporting submitted data from MCOs regarding the availability of mental health providers who see children.

To access this appendix, please see HCA's website.

Appendix C

Appendix C is a collection of data regarding Title 19/CHIP Youth (Age 0-20) with an Eating Disorder Diagnosis. This data was produced by DSHS Research and Data Analysis Division in September 2021 using the DSHS Integrated Client Databases.

To access this appendix, please see HCA's website.